Emotional Skills Groups:
A qualitative study exploring client experiences of online group work in an Improving Access to Psychological Therapies Service

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Abstract

Background: Many people treated in National Health Service (NHS) Talking Therapies services (previously known as Improving Access to Psychological Therapies) have highly complex needs which are not always met by the length and type of treatment offered. Some services have offered emotional skills groups to meet complex needs, but little is known about client experiences of these. The evidence base for transdiagnostic applications of Dialectical Behavioural Therapy (DBT) is growing but further research is required.

Aims: To gain insight into client experiences of online emotional skills groups in NHS Talking Therapies.

Methods: 12 participants were recruited from a Talking Therapies service who had attended an emotional skills group. Semi-structured interviews focused on client experiences and were analysed using Reflexive Thematic Analysis.

Results: Participants found the emotional skills group to be a positive experience. The central organising concept, 'My journey from disconnection towards connection' is split into three main themes: 1) Finding life hard; 2) Maybe this group will make a difference; and 3) Re-evaluating the importance of connection. These themes are broken down into sub-themes allowing for a more in-depth analysis which revealed the importance of the therapeutic relationship as a mechanism for change.

Implications for counselling psychology: This is the first known study to enquire into client experiences of online adaptations of DBT within an adult NHS Talking Therapies service. Validation, empathy, safety, and emotional warmth were all seen as important and highly valued by group participants. Findings from this study suggest that counselling psychologists should not shy away from getting involved in the process of running adaptations of DBT in a much wider range of settings.

Findings: This research finds support for the idea that the emotional skills component of DBT may have some value as a stand-alone transdiagnostic group. Increased access

to emotional skills groups in Talking Therapies services should be considered to better meet the mental health needs of more complex clients.

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Terminology

Dialectical Behaviour Therapy (DBT)

DBT was initially developed by Marsha Linehan (Linehan, 1993) for chronically suicidal patients diagnosed with borderline personality disorder (BPD). In its original conceptualisation, DBT is an integrative treatment that combines behavioural theory, dialectics, and principles from Zen Buddhism. It is based on a biosocial theory which proposes that biological vulnerability (e.g., high emotional sensitivity to internal and external stimuli, poor impulse control, slow return to emotional baseline) combined with an invalidating environment can create difficulties with emotional regulation and cause problems in interpersonal interactions. In its pure form, DBT works as a multi-component intervention comprising individual therapy, skills group training, therapist group consultation and out-of-hours telephone coaching for clients.

NHS Talking Therapies (previously known as Improving Access to Psychological Therapies)

Talking Therapies is a National Health Service (NHS) initiative in England that provides psychotherapy in primary care (NCCMH, 2020). In 2023, Improving Access to Psychological Therapies (IAPT) changed names to NHS Talking Therapies but the service structure remained the same (NHS England, 2023b). It was developed to deliver evidence-based psychological therapy in a highly structured and systematic manner. It uses a stepped care model (NHS England, 2023a), where the least intrusive interventions are offered first and specific types of therapy are matched to the client's primary diagnosis based on recommendations from the National Institute for Health and Care Excellence (NICE, 2023).

Stepped care

According to this model, Step 1 involves prevention and/or signposting to community based mental health services; Step 2 involves advice and brief interventions in primary care; Step 3 offers short term psychological interventions in primary care; Step 4 involves treatment from specialist teams in secondary care; and Step 5 involves inpatient treatment. Talking Therapies services work at Steps 2 and 3. Therapeutic treatment at Step 2 is highly manualised and provides guided self-help and/or psycho-educational groups whereas Step 3 offers evidence-based models of intervention (NICE, 2023) which have a protocol rather than a manual (NHS England, 2023a).

Transdiagnostic adaptations of DBT

Transdiagnostic psychotherapeutic interventions target the core underlying processes that are thought to lead to the development and maintenance of emotional and psychological problems across a range of disorders (Koerner et al., 2021). In this study the term transdiagnostic is used to describe the wider application of emotional skills groups (adaptations of DBT) across different presenting problems (Linehan, 1993; 2015). The emotional skills group in this study is a transdiagnostic application of the skills component of DBT run as a standalone 12-week group.

Emotional regulation

Emotional regulation as a term has been criticised for being poorly defined (Moore et al., 2022). For this study emotional regulation is taken to mean the complex and multifaceted process whereby people manage their emotional experiences for social and personal purposes.

Introduction

It is perhaps not surprising that people have found it difficult to access treatment for intense and unstable emotions in NHS Talking Therapies, (previously known as Improving Access to Psychological Therapies or IAPT). Structurally, the National Health Service (NHS) has not offered treatment for this client group because it was assumed that intense and unstable emotion was predominantly experienced by people with a diagnosis of Bipolar Personality Disorder (BPD) (American Psychiatric Association, 2013). In the United Kingdom (UK), personality disorders have historically been categorised alongside more severe and enduring mental health problems and treated in secondary care services where Dialectical Behavioural Therapy (DBT) is more available. NHS Talking Therapies teams are based in primary care and provide the general population with access to psychological services however, they rarely offer emotional skills groups.

There is increasing evidence to suggest that many psychological problems can be understood as an inability to modulate painful negative emotions without engaging in unhelpful coping strategies (Berking & Wupperman, 2012; Gratz et al., 2015; Hallion et al., 2018; Kraiss et al., 2020; Miola et al., 2022). Therefore, DBT may be effective in a much wider context than originally envisioned (Ritschel et al., 2015). Adaptations of DBT in the form of stand-alone emotional skills groups may be an important intervention that is currently underused in primary care mental health services.

This research explores the experiences of a group of people who were referred to NHS Talking Therapies and attended an emotional skills group which provided an adaptation of DBT. These were people who described their life as limited by their struggle with intense and unstable emotions. By developing a greater understanding of their experiences, this research hopes to develop new knowledge and insight into the use of groups that offer adaptations of DBT.

Currently DBT is not considered an NHS Talking Therapies compliant intervention. It is not one of the evidence-based treatments listed in the NHS Talking Therapies Manual (NHS England, 2023a). The National Institute for Health and Care Excellence (NICE) guidelines only recommend DBT as a treatment for BPD (NICE, 2009). NHS Talking Therapies services are structured around recommendations from NICE (NICE, 2023), which means that emotional skills groups that offer an adaptation of DBT are rare. Despite this, one or two Talking Therapies services do offer emotional skills, possibly when someone in management has a personal interest in DBT. Talking Therapies has a rigid top-down service structure, but the evidence base (NICE, 2023) which is predominantly from randomised controlled trials, often bears very little relation to how things operate and function in clinical practice. This practice-based study provides an opportunity to think more along the lines of what works, for whom, why and under what circumstances.

Originally, DBT (Linehan, 1993, 2015) was developed as a treatment for people with a diagnosis of BPD (National Institute of Mental Health, 2023) also known as Emotionally Unstable Personality Disorder (EUPD) and this group of people is generally considered to be at higher risk of suicide and self-harm (Paris, 2019). Despite growing support for adaptations of DBT used as a transdiagnostic intervention for a wide range of mild-moderate mental health problems, this model continues to be strongly associated with the client group it was originally designed to treat (Childs-Fegredo & Fellin, 2018; Dimeff et al., 2021; Schaeuffele et al., 2021). This study hopes to provide new knowledge that will encourage clinicians to use adaptations of DBT more frequently and with people who don't necessarily have a diagnosis of BPD.

I have worked as a psychological therapist within the NHS for the last 10 years. For much of that time I have been running emotional skills groups using an adaptation of DBT. The people attending these groups seemed to find the emotional skills group experience different from other treatments they had received in the NHS. This intrigued me and I wanted to find out more. Groups that deliver an adaptation of DBT within NHS primary care are rare because DBT is not considered a Talking Therapies compliant treatment (NHS England, 2021). However, with the introduction of Comprehend, Cope and Connect as an integrative model bringing together ideas from Third Wave CBT (Clarke & Nicholls, 2018b) there seems to be a growing interest in offering adaptations of DBT to people who do not respond to standard Talking Therapies therapeutic interventions.

Central to Reflexive Thematic Analysis (RTA) is the idea that the researcher and their subjectivity is not something to avoid but integral to the process (Braun and Clarke, 2013; 2022). Reflexivity in this study will enable me to be aware of my own beliefs about emotional skills groups and reflect on the way that they may be influencing data collection and analysis. I have therefore deliberately chosen to move between first person and third person in this thesis to highlight the way in which my own values and beliefs impact my interpretation of the data. In choosing to write in this way, I have attempted to present knowledge as situational, as an interaction between the researcher and the data. Not only does this align with my chosen method (RTA) but it is hoped that it will enable me to provide an analysis that is both compelling and characterised by thoughtfulness and depth.

As someone who struggled with intense and unstable moods during my adolescence and early 20s, I am passionate about improving access to DBT psychoeducation. I have found ideas from DBT helpful in understanding my own story and developing a compassionate relationship with myself as a sensitive and emotional person. I expect to find that other people will have similar positive experiences, however, I am also aware that some participants' stories may be very different from my own and that I need to allow room for discussion about negative as well as positive experiences.

On a personal level, I remember how distressing and difficult it was to experience intense and unstable emotions as an adolescent. If someone had been able to provide me with a no-blame model (Crowell et al., 2009; Linehan, 1993) and some emotional skills at that point in my life, I would have found it very helpful. I was keen to become involved in delivering emotional skills groups in my Talking Therapies service and it is these two strands, personal and professional, that have driven my interest in researching this topic. My hope is that this research will generate new knowledge that can be used to help a greater number of people who struggle with intense and unstable emotions.

Literature Review

This chapter will look at some of the literature that informs the way we think about emotional skills groups. It sets the context by exploring the debate around the use of the medical model, considers the argument about fidelity to DBT and looks at the evidence that provides support for transdiagnostic adaptations as stand-alone emotional skills groups. Subsequently, it goes on to discuss the effectiveness of DBT as an intervention and explores some of the many theories of causation in relation to BPD (American Psychiatric Association, 2013).

Although this research project is not looking specifically at people with BPD, it is helpful to have some understanding of the literature pertaining to this diagnosis because it is a label that is often given to people who struggle with intense and unstable emotions. The literature review concludes by looking at attachment theory and what it tells us about emotional regulation and the importance of the therapeutic relationship in working with people who struggle with emotions that feel overwhelming.

Searches of the literature were completed using Sage Journals, Scopus, PubMed, British Psychological Society (BPS) journals, Google Scholar, and the University of the West of England (UWE) library using a combination of the terms Dialectical Behaviour Therapy, DBT, adaptations of DBT, emotional skills groups, attachment theory, medical model, therapeutic relationship, NHS Talking Therapies, Improving Access to Psychological Therapies and IAPT. Only articles and books published in English were included because the researcher does not have the ability to read information presented in other languages.

Prevalence

A review of the literature reveals a need for more research into the epidemiology of BPD in Western countries (Volkert et al., 2018; Winsper et al., 2020). Government statistics are quite dated (Department of Health, 2009) but suggest that personality disorders are relatively common in the general population (5-13%). This number increases significantly in other settings (30-40% of psychiatric outpatients, 40-50% of psychiatric inpatients and 50-78% in forensic settings). Therefore, a significant proportion of Talking Therapies clients are likely to have this additional complexity when they present with anxiety and/or depression.

The debate around the use of the medical model

Counselling psychology training (Douglas et al., 2016; UWE, 2023) places an emphasis on deconstructing the medical model to develop a more dialectical stance to the generation of knowledge and gain a better understanding of ourselves, our world, and other people. Historically, the way that we think about health in the western world has been dominated by the medical model, also referred to as the bio-medical model. This model proposes that we can understand health based on biological factors and that illness can be attributed to biological dysfunction. It excludes any environmental, psychological or social influences. The medical model has been criticised for being reductionist, for creating an artificial and unhelpful split between the mind and body, and for emphasising deficits because it thinks about illness in terms of what is absent or impaired (Engel, 1977). By contrast, bio-psycho-social models take a wider view that does account for the social, psychological, and environmental aspects of illness (Tripathi et al., 2019)

Ideas from the Power Threat Meaning Framework (PTMF) (Boyle & Johnstone, 2020) have heavily influenced my thinking throughout this project, including the assumption that emotions need to be understood in the context of life experiences, that injustice and inequality are strongly associated with the way we experience distress in the here-and-now, that distress is normal and part of the human condition and that it is a shared experience. I value how this moves us away from thinking about people who are distressed as ‘ill’ and being in some way different or less (Boyle & Johnstone, 2020). It also provides a better fit with the counselling psychology values of ‘fairness, equality and social justice’ and emphasises the importance of an equal relationship (BPS, 2023). There is a similarity between these values and the values that DBT therapists subscribe to (Linehan, 2016).

There is a longstanding debate in helping professions around whether diagnostic labels are helpful or stigmatising (Garand et al., 2009; Sims et al., 2021; Werkhoven et al., 2022). This has been particularly prominent in relation to the diagnosis that is often given to people who struggle with intense and unstable emotions (BPD) because of the stigma that has historically been attached to this label. This diagnosis has also been criticised for its lack of diagnostic validity because it was originally conceptualised with no reference to an evidence base (Krueger & Markon, 2014; Tyrer et al., 2019). People with this label have often been classified as 'difficult' or 'high risk' (Sims et al., 2021; Sulzer, 2015) because they have long been thought of as a group that present with higher levels of self-harm and suicidal behaviour. There seems to be plenty of convincing evidence to support the idea that this group of people do often have higher levels of self-harm and suicidal behaviour (Colle et al., 2020; Linehan et al., 2006; Soloff & Chiappetta, 2019), however, both the PTMF (Boyle & Johnstone, 2020) and the DBT Bio-social model (Linehan, 1993) propose that these behavioural responses make sense in the context of individual life experiences and argue for a more understanding, compassionate and validating response.

The structure of Talking Therapies services can be seen to be strongly influenced by the medical model. It relies on diagnostic labels to direct decisions about treatment options and guidance documents tend to use medical terminology (NHS England, 2023a; NICE, 2023). However, many of the therapeutic interventions on offer lean more towards a broader bio-psycho-social understanding of mental health, for example Dynamic Interpersonal Therapy (DIT) which is rooted in psychodynamic concepts and Mindfulness Based Cognitive Behavioural Therapy (MB CBT) which emphasises the link between mind and the body whilst drawing on ideas from Buddhist philosophy.

There is a hierarchy of evidence in medical research (Glover et al., 2006) which emphasises findings from quantitative research over qualitative (NHS England, 2023a; NICE, 2023). This literature review acknowledges the debate around hierarchies of evidence (Wallace et al., 2022) and the way in which quantitative research is often seen as more powerful but does not offer scope to explore this in depth. Never-the-less, evidence-based practice is considered fundamental to health care in the UK. It impacts on service development, funding, and governance within the NHS and despite the historic emphasis on quantitative evidence, there is growing recognition of the value and importance of knowledge gained from qualitative studies (Stickley et al., 2022).

The group of participants involved in this study were not assessed as high risk of suicide or self-harm, although some did have a diagnosis of BPD or EUPD. However, many people struggling with intense and unstable emotions can present with behaviour that is difficult for other people to cope with, which is perhaps why some of the stigma around this diagnosis has been difficult to combat (Klein et al., 2022). Another criticism of BPD focuses on the use of language itself (Lyons et al., 2018), stating that the very words 'personality disorder' are unhelpful because they situate the problem in the individual rather than in life stressors or neurology. These words suggest that in some way the very essence of the person is flawed and as such this diagnosis has the capacity to bring with it a sense of shame and worthlessness. The use of language is important here given that the terminology clinicians use has the power to 'inadvertently disempower or stigmatise' (Dyson & Gorvin, 2017).

Goodman (Goodman, 2016) argues that an emphasis on 'empirically supported treatments' risks moving us onto an 'evaluative axis related to evidence and effectiveness which completely misses the rich complexity of human experience and limits therapeutic interventions'. This is certainly a criticism that has been raised in relation to Talking Therapies services (Bruun, 2023). Too great an emphasis on the medical model and we become limited in our ability to understand the intersection between individual subjectivity and society. However, many people do find it helpful to have a diagnosis for a range of reasons: to access services and support; to validate their distress; to make sense of their experiences; to locate the problem in health rather than in self; and to provide a simple explanation to give to others. Current research findings reflect this complexity and suggest that the medical model may not always be the most helpful way to conceptualise problems (Sims et al., 2021).

The debate around fidelity to DBT

Although historically DBT has been associated with treating personality disorders, it is now generally accepted that it can also be used to treat a much wider range of mental health problems (Koerner et al., 2021). There has been a growth of research over the last 20 years looking at the transdiagnostic application of DBT in the form of stand-alone emotional skills groups for eating disorders, substance use disorders, psychosis, post-traumatic stress disorder (PTSD) and bipolar disorder as well as anxiety, depression and working with neurodiversity (Holmqvist Larsson et al., 2023; Howells et al., 2020; Linehan & Wilks, 2015; Ritschel et al., 2015).

It is difficult to make comparisons across studies that look at emotional skills groups because they are not a homogonous group. For example, there is considerable variation in training and expertise amongst the therapists, differences in length of groups, differences in number of participants attending groups, differences in the chronicity and intensity of the presenting emotional regulation problem etc. However, collectively there does seem to be some support for the use of transdiagnostic adaptations whilst acknowledging the need for further research (Dimeff et al., 2021; Koerner et al., 2021).

Ben-Porath and colleagues (Ben-Porath et al., 2020) suggest that different DBT adaptations could be effective with different client groups. Overall, their findings state that for people with comorbid disorders who have mental health problems where a key factor is difficulty regulating emotion, adapted versions of DBT may be effective. They recommend further investigation to establish which intervention processes and mechanisms are most beneficial for which groups.

Despite DBT being considered non-compliant in terms of treatments offered by Talking Therapies (NHS England, 2023a), Isabel Clarke and Hazel Nicholls (Clarke & Nicholls, 2018a) discuss an integrative, relational model currently in use called Comprehend, Cope and Connect (CCC) which incorporates ideas from Third Wave approaches (Hayes et al., 1999) and applies them to psychotherapy within the NHS. Third Wave CBT is a term that brackets models of therapy (Acceptance and Commitment Therapy, Compassion Focussed Therapy and Dialectical Behavioural Therapy) that look at the way people relate to their inner experiences. The CCC model has been taken up by several NHS services including a Talking Therapies team (Southern Health NHS FT, 2023).

CCC can be seen to align well with the integrative relational approach to psychotherapy taught to trainee counselling psychologists (UWE, 2023). In terms of its underlying theory, this approach integrates ideas from cognitive analytical therapy, CBT, and psychodynamic theory to put relational work at the heart of therapeutic work. Interestingly, despite the emphasis on relational work in CCC there is no discussion about family therapy or any reflection on the limitations of group working as pointed out by McGuire et al. (McGuire et al., 2020). The use of CCC shows that adaptations of DBT implemented as stand-alone interventions are already forming part of some stepped care models (Babeva et al., 2020) and since Covid-19 there is also an increased need to research how existing DBT groups can be adapted to be delivered online.

The IAPT (Talking Therapies) handbook (NCCMH, 2020) states that services should work to a 'high-volume specification'. This means that therapists in Talking Therapies tend to have large caseloads and little time. Linehan's original model (Linehan, 1993) is very heavy on resources. However, it is the full DBT programme that has the strongest evidence base (Dimeff et al., 2021). Despite this, many services make adaptations to the model because fidelity to the original model requires more clinical time than most settings can afford (Koerner et al., 2021). This is particularly true of a time-poor service such as Talking Therapies.

From the outset Marsha Linehan (Linehan, 1993) was keen for DBT not to be 'watered down' and advocated the use of as many modes as possible. However, by the time she wrote the preface to the second edition of the DBT Skills Training Manual (Linehan, 2015), the idea of DBT adaptations to meet the needs of different groups of people such as adolescents or people with addictions or eating disorders had begun to surface. The debate around what constitutes DBT and to what extent therapists should maintain fidelity to the model is ongoing. Dimeff et al. propose a dialectical solution by suggesting that DBT can be adapted to fit service needs *and* have fidelity to the model (Dimeff et al., 2021).

Childs-Fegredo & Fellin argue that the NICE guidelines 2009 are perhaps a little 'thin' in recommending DBT only for BPD (Childs-Fegredo & Fellin, 2018). This seems a powerful observation when considering the growth of evidence that supports adaptations of DBT being effectively used as a transdiagnostic treatment (Delaquis et al., 2022; Gupta et al., 2023; Moore et al., 2022a; Ritschel et al., 2015; Schaeuffele et al., 2021; Wilks et al., 2017). Ritschel et al. state that ‘in recent years DBT has become more strongly associated with pervasive emotion dysregulation, rather than with borderline personality disorder specifically’ (Ritschel et al., 2015, p.112).

However, despite the increase in studies looking at adaptations of the DBT model and in particular adaptations of the skills training group as an intervention on its own (Childs-Fegredo & Fellin, 2018; L. A. Dimeff et al., 2021; Ritschel et al., 2015; Swales & Heard, 2017; Valentine et al., 2015), authors continue to reference the need for more clinical studies to provide a stronger empirical base (Koerner et al., 2021; Swales & Heard, 2017).

Transdiagnostic adaptations of DBT

The full model of DBT is labour intensive and high cost, it involves group sessions, individual therapy, telephone coaching and a consultation team (Linehan, 1993, 2015). Therefore, it is not surprising that services have been drawn towards adaptations which are simpler and more cost effective (Koerner et al., 2021). The central component of DBT that translates to stand-alone groupwork, or telephone work is the way in which the therapist can blend acceptance and change strategies (Linehan, 1993).

Adaptations of DBT as standalone skills groups seem to have developed rather haphazardly without much uniformity or empirical evidence (Lyng et al., 2020; Valentine et al., 2015). However, there is a growing body of research that provides support for the viability of skills groups in a range of different settings addressing problems that are perceived to share a common maintaining factor: difficulty with intense and unstable emotion (Childs-Fegredo & Fellin, 2018; Gupta et al., 2023; Linehan & Wilks, 2015; Vickers, 2016).

Effectiveness of DBT

Many authors including Linehan herself (Linehan, 2015) state firmly that there is good evidence to support the use of DBT as an intervention for people with BPD. There has certainly been great interest in this model and many randomised controlled trials (RCTs) have been carried out comparing DBT with treatment as usual (TAU) (Jones et al., 2023; Panos et al., 2014). However there has also been criticism of these RCTs due to the considerable variation in research design, therapist training and adherence to the DBT model (Stoffers-Winterling et al., 2012; Swales et al., 2012; Swales & Heard, 2017).

More recent research, although generally supportive of Linehan's model, concludes that although DBT may well be an effective intervention for treating BPD there are ongoing methodological problems in the studies used to reach this conclusion. Studies supporting DBT are often limited by small sample sizes and the possibility of bias (Jones et al., 2023). Reddy and Vijay suggest that 'the empirical reality is very different from its reputation' and argue that the effectiveness of DBT as shown in the supporting evidence has been somewhat exaggerated (Reddy & Vijay, 2017). However, despite these criticisms, DBT continues to be the dominant treatment model (Choi-Kain et al., 2017).

Borderline personality disorder (BPD): theories of causation

This study is not specifically looking at people with a diagnosis of BPD, however in order think in depth about the way in which an emotional skills group has been experienced it is helpful to take account of the literature around BPD because it is conceptualised as a diagnosis of emotional instability (American Psychiatric Association, 2013). Many of the ideas in the literature around theories of causation can be seen to relate to the data collected in this project even though in Talking Therapies, emotional skills groups have been offered as a transdiagnostic primary care level intervention for a wide range of different diagnoses rather than as a treatment for BPD.

How we think about BPD has changed considerably over the last 80 years. What originally emerged from psychoanalytical literature (Stern, 1938) has grown into a considerable body of empirical research. Studies in the 1980s looked at the possible link between this diagnosis and early childhood trauma with the hypothesis that sexual abuse was a key factor. These studies were criticised for being overly simplistic and research soon moved on to consider multifactorial models based on ideas relating to diatheses and stressors. The diathesis-stress model proposes that psychological problems occur because of the interaction between biological vulnerability (diatheses) and environmental stress factors (Practical Psychology, 2020).

There is general agreement that BPD is associated with problematic relationships early in life and people with a diagnosis of BPD often have high rates of early life trauma including sexual abuse, neglect, and violence (Fitzpatrick et al., 2021; Verbist et al., 2021). Currently, there are many different theories of causation, and these tend to focus on either developmental or biological causes (Gunderson et al., 2018; Winsper, 2018). However, it is most likely that BPD occurs due to a combination of both environmental and biological factors and more recent research provides support for an integrative model (Fitzpatrick et al., 2021).

Object relations theory

Drawing on ideas from psychodynamic theory, object relations theory differs slightly from Freudian theory in that it proposes relationships are more important than biological drives in forming a sense of self (Greenberg & Mitchell, 1983). Object relations theory extends the thinking of Melanie Klein about the unconscious relationship between mother and child to include ideas from other theorists like Donald Winnicott and Ronald Fairburn.

Later in the 20th century, Bowlby expanded on object relations theory (Bowlby, 1969). Attachment theory sets out to explain how adult relational style is shaped by family experiences during early childhood. For example, someone who experienced neglect or criticism as a child might anticipate similar behaviour from other people who remind them of the person who behaved like this towards them in the past. Object relations theory proposes that these relational experiences turn into ‘objects’ in the unconscious which are then used to predict behaviour in current relationships and social situations.

This approach argues that BPD develops due to a lack of integration between positive and negative object relations which then causes problems with identity development. The early defense of splitting good and bad affect (good object and bad object) fails to become synthesized and flexible. Someone with BPD is therefore left with rigid black and white, unstable patterns across emotion, cognition, and social relationships (Clarkin, Lenzenweger, et al., 2007).

Transference focused therapy

Kernberg (1984) considered BPD to be caused by the projection and splitting of self. Transference is a psychodynamic concept that explains how early relational patterns (object relations) are repeated in other relationships, and how they bring distorted negative perceptions of other people and their behaviour through defenses like splitting and projection. The analysis of transference can be seen to underpin this therapeutic model.

Transference focused therapy (TFP) (Clarkin, Levy, et al., 2007; Doering et al., 2010) extends the idea that BPD occurs due to a lack of identity integration, therefore treatment encourages reflection to improve awareness of self and others, improve behavioural control and increase identity integration (Gonzalez-Torres, 2018). Studies provide mixed support for treatment based on psychodynamic theory (Clarkin, Levy, et al., 2007; Cristea et al., 2017; Doering et al., 2010) and there are some problems with the methodology used, for example double-blind studies have not been possible, sample sizes have been small and there is considerable variety in the technical skills of the therapists involved (Gonzalez-Torres, 2018).

Dialectical behavioural therapy

This has been one of the most influential models explaining the etiology of BPD and it is based on the idea that emotionality alienates others. Linehan’s bio-social model proposes that BPD develops because of transactions between biological vulnerability and an invalidating social environment (Linehan, 1993, 2015). The environment tends to invalidate because other people struggle to cope with intense expressed emotion.

Musser et al. writing in 2018 (Musser et al., 2018) point out that although invalidation as a term has been widely used, there is a lack of uniformity in the supporting evidence base in the way that it is used and measured.

Linehan (Linehan, 2015) goes on to argue that extreme emotional lability interacts with the social context which in turn both shapes and maintains the dysregulation. The individual then responds to this by developing several maladaptive coping strategies which in turn exacerbate emotional lability, interfere with social functioning, and disrupt normal emotional development.

The consequences of this are particularly noticeable in the way that strong emotion redirects behaviour. Deficits in the ability to up-regulate or down-regulate are thought to be common to many mental health problems and to have a powerful impact on the sense of self. A study by Neacsiu et al. provides some support for the idea that people struggling with emotional dysregulation have a skills deficit (Neacsiu et al., 2010). On the other hand, there is a large body of evidence, including many RCTs, that provides support for Linehan's bio-social model whilst acknowledging the complexity of DBT and the need for further research (Bortolla et al., 2019; Crowell et al., 2009; Dimeff et al., 2021; Keng & Soh, 2018; Lee et al., 2022; Reeves et al., 2010; Sauer & Baer, 2010).

Failed mentalisation

This model (Fonagy & Luyten, 2009) is based on the idea that BPD arises due to an incapacity to read self and others. It agrees with Linehan that the core features of BPD are affect dysregulation, unstable relationships and impulsivity but suggests this may be due to impairments in the ability to think about thinking (mentalisation) relating to deficits in underlying neural circuits. This is thought to cause problems in the sensitivity of the attachment system which makes it more difficult to differentiate between mental states (in self and others). Fonagy & Luyten (Fonagy & Luyten, 2009) hypothesise that this emerges early on in development due to a failure of communication between parent and child. This means that children don't learn to accurately identify and verbalise their own feelings or those of other people. Interventions based on this theory promote further development of mentalisation, particularly in social settings. Evidence supporting this theory seems positive but suffers from similar methodological problems as that for psychodynamic approaches (Gonzalez-Torres, 2018).

Interpersonal hypersensitivity

This theory argues that hypersensitivity has a genetic basis (Gunderson, 2008) and that catastrophic meanings tend to be attributed to interpersonal events. Therefore, the hypersensitive child is likely to over-react even to very mild stimuli and perceived failures of support are understood as either 'I'm bad' or 'others are bad'. The idea of being alone and unsupported in a difficult world presents such a high level of threat that it triggers impulsive and extreme behaviour (to attract support) or dissociation to cope (Gunderson et al., 2018).

Current evidence suggests that there is hypervigilance towards neutral facial expressions and eyes, but further research is needed to investigate whether this is specific to BPD (Rosenthal et al., 2016; Seitz et al., 2021). There are also some studies that show mixed results or do not support the idea that people with BPD have heightened emotional sensitivity (Gratz et al., 2019; Sauer et al., 2014).

These are not the only theories that attempt to explain the etiology of BPD, however it is hoped they provide enough of a range to allow DBT to be seen within a wider context and demonstrate the way in which the underlying theory might determine the focus of the intervention.

Attachment theory and emotional regulation

Attachment theory does not explain everything about human behaviour but has never-the-less become one of the most influential theories of the 20th century, shaping how we understand the developmental process (Holmes & Farnfield, 2014). Developed by John Bowlby (Bowlby, 1969) after the Second World War following a stint working in a progressive school (Neill, 1960), this theory linked emotional and behavioural problems with disrupted and unhappy early life experiences.

Bowlby proposed that our very early experiences of care affect the way in which the brain develops to regulate behaviour and physiology. He argued that attachment has a biological function because it enables children to make the most of any care offered. Children with disorganised attachment were seen to show deficits in self-control or self-regulation (Hutchings et al., 2023).

There are several criticisms of attachment theory. Firstly, that it assumes nurture triumphs over nature. Harris referred to this as the *nurture assumption* and argued that in fact many personality traits stem from genetics (Harris, 1998). She argued that attachment theory is overly simplistic, that it underestimates the capacity of the developing mind to adapt to different situations and ignores the complexity that babies can be securely attached to one caregiver and at the same time insecurely attached to another (Harris, 2009). Harris cites evidence from separated twin studies to support her suggestion that genetic influence might be stronger than environmental (Harris, 2007).

Secondly Bowlby's methodology is criticised. Field argues that attachment theory is limited because it is based on the observation of 'momentary stressful situations' rather than more naturalistic interactions between the child and primary caregiver (Field, 1996, p.543). She points out that Bowlby underestimates the importance of attachment to a wide range of other people that are not confined to early childhood or the primary caregiver, for example siblings, friends, romantic relationships etc.

More recent criticisms include the tendency towards confirmation bias in attachment researchers (Mesman, 2021), that attachment theory is weakened by 'conceptually fuzzy concepts and explanatory processes' (Keller, 2021) and that it shows cultural bias by using methods that are tailored to white western middle-class parents and therefore fails to have cross-cultural validity (Keller, 2018).

Adshead and Sarkar (Adshead, 2018; Sarkar & Adshead, 2006) draw on biological concepts in discussing the link between attachment theory and emotional regulation. They consider the way in which human attachment relationships involve care giving and care-eliciting and propose that it is through this attachment response that children learn to identify their emotions and regulate them. As a baby we respond to environmental threat with a high level of emotional arousal (distress). In a secure attachment relationship this is responded to and soothed. Soothing activates the parasympathetic nervous system which calms the autonomic nervous system response and the baby's body returns to homeostasis. Therefore, attachment security not only affects the way that a parent responds to their baby but also how the baby's attachment system develops in response.

Current research involves thinking about issues such as what kind of relationships constitute secure attachments, how we might be able to measure the security of attachment, developing a greater understanding of internal working models of attachment and how we might be able to improve stability and resilience to change in attachment relationships (Thompson et al., 2022).

Trauma

Early studies found that childhood sexual abuse (CSA) was higher in BPD populations (Bailey & Shriver, 1999; Briere & Zaidi, 1989; Waller, 1994). In response researchers began to propose that BPD might be a trauma spectrum disorder (Menon et al., 2016). This idea was compounded by the high level of comorbidity between BPD and Complex Post Traumatic Stress Disorder (CPTSD) (Pagura et al., 2010; Powers et al., 2022; Rosenstein et al., 2018). A recent meta-analysis of 97 studies (Porter et al., 2020) suggests that people with a diagnosis of BPD are 13 times more likely to have experienced trauma. Neglect and emotional abuse also seem to be very high in this group. Half of those diagnosed with BPD also meet the criteria for CPTSD (Pagura et al., 2010).

Therefore, at a first glance CPTSD and BPD seem very similar. They share some common symptoms, for example impairment in relational functioning, lability of emotion and high levels of impulsivity. However, there are important differences: symptoms of CPTSD are experienced as ego-dystonic whereas in BPD they are ego-syntonic. CPTSD is often marked by a persistently negative sense of self which contrasts with BPD which tends to be associated with an unstable sense of self. Behavioural responses also show a difference, BPD often triggers extreme strategies to regulate affect and avoid abandonment whereas CPTSD tends show disconnection and avoidance (Powers et al., 2022). Current thinking suggests that BPD and CPTSD are potentially comorbid but distinct (Powers et al., 2022). Early life trauma including CSA is therefore conceptualised as intersecting with a range of biological and psychosocial factors that combine to shape the development of BPD (Ford & Courtois, 2021).

Emotional regulation and the importance of the therapeutic relationship

The idea that the therapeutic relationship may be central to the effectiveness of all psychotherapeutic interventions irrespective of the model used has been an area of considerable research interest (Finsrud et al., 2022; Flückiger et al., 2012; Martin et al., 2000). In addition, there is growing evidence to support the importance of therapeutic alliance between group members although this is still an area of debate (Lo Coco et al., 2022). Perhaps this is because in comparison with individual therapy, alliance in groups has a smaller effect, possibly due to the increase in relational complexity.

Although there is plenty of interest in the idea that the therapeutic relationship is a good predictor for change and that this works across different models of therapy, there are some methodological problems associated with the research base to support this. Firstly, there is a lack of consistency in the way that the common factors involved in the construct of therapeutic alliance are conceptualised. There is considerable variation in the literature in the way that researchers have thought about therapeutic alliance (Finsrud et al., 2022) and to compound this, different terminology has often been used to name similar constructs.

Another problem is the range of different measures and the overall lack of consistency in the measurement of factors involved in a good therapeutic relationship. Furthermore, Falkenstrom et al. point out that when measures are used repeatedly over time, you need to be confident that what they are measuring is consistent and stable (Falkenström et al., 2015). Problems with longitudinal measurement invariance can mean that what you measure may not be change in the construct under investigation, but a change in the way that the client is understanding the item being measured.

On balance however, the literature seems to provide consistent support for the idea that a good therapeutic relationship (empathy and genuineness) plays an important role in psychotherapy irrespective of the model being used (Aerts et al., 2023; Faith et al., 2022; Nienhuis et al., 2018; Probst et al., 2022) although there is scope for further research looking in more detail at specific factors that impact on the development of a good therapeutic relationship (Watson, 2023). Given the overall level of agreement on the importance of a good therapeutic relationship, it is not surprising that Marsha Linehan states that the therapeutic relationship should be a central component of DBT (Linehan, 2015, 2016).

Current research looking at adaptations of DBT as transdiagnostic stand-alone emotional skills groups

Ritschel et al. write about the way that DBT has been adapted for various populations and age groups and point out that there are a growing number of studies looking at this (Ritschel et al., 2015). In addition, Marwaha et al. point out that there is evidence to suggest that emotional dysregulation may be much more prevalent across the general population than previously envisaged (Marwaha et al., 2013). It is not possible given the limitations of this research project to provide an overview of all research into adaptations of DBT, but some recent studies are discussed to provide context.

Kraiss et al. (Kraiss et al., 2020) present a meta-analysis that looks at the relationship between emotional regulation and well-being in patients with mental health problems. This study supports the idea that emotional regulation contributes to the development and maintenance of a wide range of psychological problems, but it was limited by the small number of research studies involved and the way in which transdiagnostic factors were common to many different diagnostic groups. There are also problems with attributing causality because the effect sizes were based on correlational data. However, findings suggest that emotional regulation plays an important role in maintaining good mental health and wellbeing.

Bharmal et al., (Bharmal et al., 2022) in their evaluation of a transdiagnostic intervention in a primary care service were able to demonstrate the effectiveness of group treatment drawing on CBT and DBT. Further support can be found from Felix & Sand (Felix & Sand, 2023) who argue that although DBT was originally developed to treat people who struggle with suicidal behaviour, it is now often used in an adapted version as a transdiagnostic skills group for a range of different mental health problems.

One or two recent studies show an interest in DBT skills groups as a transdiagnostic treatment for Generalised Anxiety Disorder (GAD) (Malivoire, 2020; Wilks & Ward-Ciesielski, 2020). DBT provides considerable flexibility as a model in terms of focusing on problem behaviours and GAD clients who tend to have a low tolerance of emotional arousal can use skills groups to improve their tolerance of aversive emotional states. Outcomes suggest that for GAD clients who struggle with CBT, emotional skills training may be a more helpful approach.

Wittkamp et al., (Wittkamp et al., 2023) show slightly mixed results from their study that compared an 8-week affect-regulation training group with 8 weeks of self-help bibliotherapy. Participants were people with depression and/or anxiety aged 18-65 who were not currently receiving psychological therapy. Findings showed a greater improvement in emotional regulation in the participants that attended affect-regulation training but there was no evidence to suggest that emotion regulation training had a more powerful impact than bibliography in preventing the transition to other disorders. Although these findings seem to contradict the idea that emotional regulation may be a transdiagnostic factor that contributes to the development and maintenance of other mental health problems (Cludius et al., 2020) this was a very small study, and the lack of a control group may limit any conclusions drawn about emotional regulation as a change mechanism.

Another study by Barrow et al. (Barrow et al., 2023) looked at client experiences of an 8-week group based on an adaptation of DBT which was delivered in a secondary care service. In this setting participants were encouraged to use photographs to enhance connection with others. Evaluation questionnaires asked participants about their satisfaction of the group but also more specifically about their experience of the use of photographs. Analysis revealed the power of images to elicit a strong emotional response. This suggested that creating a rich shared emotional experience seemed to lead to the development of stronger therapeutic relationships and potentially transformational experiences. Findings provide support for the idea that connecting with emotions in a therapeutic setting is an important factor in achieving psychotherapeutic change (Lane et al., 2015).

Childs-Fegredo & Fellin(Childs-Fegredo & Fellin, 2018) in their study looking at a 12-week transdiagnostic DBT group in a private psychiatric hospital, identify that there is a lack of research looking at transdiagnostic adaptations of DBT and specifically very little research that allows the client's voice to be heard. Lamph et al. (Lamph et al., 2019) also state that very little research has been done looking at treatment in primary care for people who present with anxiety and depression and also have problems with emotional regulation. Bharmal et al. (Bharmal et al., 2022) go on to say that almost nothing has been written about adaptations of DBT in primary care. This gap in the literature is commented on again by Gillespie et al. (Gillespie et al., 2022) who point out that more qualitative studies are needed, specifically about client experiences of DBT.

Rationale

Emotional skills groups are currently available in NHS Talking Therapies, but little is known about them. They are not a standard Talking Therapies intervention, never-the-less they are an intervention that is in use therefore we should know more about them. There is currently a gap in the literature about client experiences of online adaptations of DBT delivered in primary care Talking Therapy services (Childs-Fegredo & Fellin, 2018; Lamph et al., 2019; Lakeman et al. 2022). To know whether a treatment is helping people or not we need to know about their experience of it.

Research Aims

The main aim of this project is to improve understanding of client experiences attending online emotional skills groups in an NHS Talking Therapies service.

However, it also has two secondary aims:

1. To ensure that client experiences influence service development.
2. To contribute to the growing body of knowledge about adaptations of DBT.

There is less known about the way in which clients experience DBT influenced groups as opposed to the full DBT programme (Childs-Fegredo & Fellin, 2018; Flynn et al., 2019; Lakeman et al., 2022; Swales, 2018; Valentine et al., 2020) and little known about adaptations of DBT as stand-alone emotional skills groups in primary care (Kelly et al., 2022; Lamph et al., 2019). This research project addresses a gap in the literature by considering the question *'How do clients experience online emotional skills groups in Talking Therapies?* It seeks to provide a voice for clients who participate in these groups and contribute to a growing body of knowledge about adaptations of the DBT model.

Much of the literature around DBT uses medical pathology and draws on a quantitative evidence base. This research doesn't aim to dismiss the medical model or the evidence base, but rather it attempts a dialectical stance that holds the literature lightly whilst simultaneously shaping it in a way that allows us to ask where is the individual in this? There is an inherent tension between the position taken by a service that is structured around the medical model with a strong emphasis on the importance of 'evidence-based practice' (NHS England, 2023) and a qualitative research project analysed using RTA. However, it could be argued that the unique strength of this research is that it has been written from within the culture of the Talking Therapies system.

Qualitative analysis will enable the researcher to counter some of the negative stigma associated with DBT (due to its historic association with BPD) because it provides an opportunity to capture the complexity and nuance of individual and group experiences (Holleman et al., 2020). The way that Talking Therapies services are constructed (NHS England, 2023; NICE, 2023) gives a great deal of power to quantitative research as opposed to qualitative and here again the voice of the individual gets lost. This research aims to redress the power imbalance and bring individual experience to the discussion around a wider and more flexible use of DBT.

In terms of service development, it is hoped that this research will inform important outcomes from the perspective of clients, when thinking about future service evaluation or any future research. The NHS Constitution for England (Department of Health, 2023) sets out that services should be informed by the people who use them. This research provides a means to ensure that the views and experiences of clients influence service development and delivery.

The researcher recognises that there is a debate around fidelity to the model and use of DBT (Childs-Fegredo & Fellin, 2018; Koerner et al., 2021) and acknowledges that DBT was originally designed as an intervention for people with a diagnosis of BPD (Linehan, 1993, 2015). However, the groups in this study were not set up to treat BPD, but rather they aimed to offer people who described feeling threatened by their emotions or emotionally out of control, the opportunity to understand their emotional responses in a more compassionate and accepting manner.

Methodology

Theoretical Framework

In designing this research project, I began to understand the importance of ensuring that in any research design, the underlying theory, the methodology and the research question should align. This alignment provides a structural framework that supports new knowledge and ensures that the researcher's theoretical assumptions about the nature of reality, what constitutes knowledge and the role of language in constructing different versions of reality fit together and make sense (Braun & Clarke, 2022b).

I also spent time reflecting on my ontological position and epistemological paradigms so that these would align with my research question. Gough et al., (Gough et al., 2003 cited in Braun & Clarke, 2013) point out that qualitative research questions 'should have some social relevance and originality'. As discussed in the literature review, there seems to be little known about client experiences of transdiagnostic adaptations of DBT, particularly in primary care (Childs-Fegredo & Fellin, 2018; Kelly et al., 2022; Lamph et al., 2019).

Counselling psychology in the UK emphasises the importance of valuing people's subjective experiences (Douglas et al., 2016). As a trainee counselling psychologist, I wanted my research to connect with counselling psychology values, and I was therefore drawn towards qualitative methods which allow participants to tell their story. Ussher also talks about the importance of thinking about an alternative to a 'unilinear' approach and choosing models that enable research to capture the richness and complexity of human experiences (Ussher, 1999).

The aim of this project is to explore people's experiences of attending an emotional skills group, therefore I wanted to position my philosophical lens so that I could discuss 'situated, interpreted realities' (Braun & Clarke, 2022c). A critical realist approach provides some separation between ontology (the nature of reality) and epistemology (how we know what we know) (Archer et al., 2016). Ontologically, the critical realist perspective is positivist (there are some things we know to be real), but it remains epistemologically relativist, thus acknowledging the role of the individual, the context, perspective, and perception in shaping what we understand to be ‘real’.

Bhaskar (1975, cited in Braun & Clarke, 2022) provides a memorable example of this: two people watching the same event from different viewpoints – one sees the sun rising and the other the sun setting. There is something ’real’ happening but their experiences are different. From Braun and Clarke’s perspective (Braun & Clarke, 2013), critical realists treat knowledge as provisional and a product of the context in which it occurs, however at the same time they acknowledge that in some settings there is knowledge that can be understood as ‘valid and true’.

Therefore, critical realism seems to provide a good fit with a research question that posits an emotional skills group took place, but that individual experiences of the reality of this group may differ. Bhaskar (Bhaskar, 2016, p.4), best known for his influential writing about the philosophical movement of critical realism, states that ‘the most general goal of critical realist philosophy is enhanced reflexivity’. A critical realist approach with its emphasis on reflexivity and the idea of ‘open systems’ aligns well with my chosen method for data analysis, RTA (Braun & Clarke, 2022c).

I am also interested in what we might be able to learn from client experiences that could influence service development and improve the delivery of these groups. Fryer (Fryer, 2022) argues that if we take a critical realist position, we should ultimately be looking for causal relationships or explanations in our research, that explanatory research should follow on from exploratory (Bhaskar, 2008). This might involve thinking about ‘what influences a positive experience of online emotional skills groups?’ and lead to the generation of knowledge with potential to influence development.

Williams (Williams, 1999) states that critical realism is particularly helpful when researching chronic illness and disability. In this case I am interested in intense and unstable emotion in the context of chronic mental health problems because it brings the body back in, steps away from a binary model and helps us to think about the ethics of care and questions of identity and difference. A critical realist position enables the researcher to move away from a role as ‘expert’, as critical realists take the position that all voices are equal (Bhaskar, 2010; Pilgrim, 2020). Again, this aligns well with counselling psychology values of 'fairness, equality and social justice' (BPS, 2023).

Before deciding to use TA as an analytical method I considered a range of other options. In the first instance I wondered about the possibility of using mixed methods. I reflected on whether mixed methods might provide the generalising power of qualitative research with the fuller picture that comes with quantitative. However, I dismissed it because it didn't allow enough distance from the quantitative methods that currently dominate NHS Talking Therapies (NHS England, 2023). In my choice of a qualitative method, I have attempted, albeit in a small way, to redress this historic imbalance. In addition, mixed methods can be time consuming and require an understanding of both qualitative and quantitative paradigms.

Another method that was considered but quickly dismissed was Action Research (AR) (Lewin, 1946 cited in Bargal, 2008). AR attempts to simultaneously investigate, explore and solve an issue. This method is often used to intervene and evaluate change. As such it doesn't provide a good fit with a research question which is looking to explore experience and understand them rather than provide a solution. However, it does share some similarities with TA, Interpretative Phenomenological Analysis (IPA) and Grounded Theory (GT) in that it uses an iterative process and incorporates a high level of reflexivity.

Another qualitative method that I considered was GT. This method was developed by Glaser and Strauss in the 1960s (Chun Tie et al., 2019). It uses a systematic set of guidelines to analyse and manage data so that new theories can emerge. GT would have enabled an inductive approach which was part of my design, but it didn't fit with a research question that set out to explore experiences. GT might have been more appropriate had the research question been slightly different and written in a way that searched for an underlying theory, for example, 'what motivates people to attend emotional skills groups?'

Having decided against GT, I then considered IPA (Smith et al., 2009). IPA is informed by three key areas of the philosophy of knowledge: phenomenology, hermeneutics, and ideography. It attempts to understand lived experience, and this seemed to fit with the research question quite well. It argues that to make sense of the meanings people impose on their experience the researcher must engage with participants' written or verbal statements. However, IPA tends to focus on the detail of individual experiences using a small sample whereas TA uses larger sample sizes to identify overarching patterns across a dataset. Both TA and IPA emphasise the importance of reflexivity but in IPA researchers use bracketing to set aside their own biases and assumptions to gain a better understanding of the participants' unique experiences. This concept of bracketing did not fit well with the way in which I hoped to make use of my own experience as a group facilitator and my insider position as a member of the Talking Therapies staff team. Therefore, TA with its ability to fully incorporate researcher reflexivity seemed the method most suited to my research question.

Braun and Clarke (Braun & Clarke, 2021a) point out that TA as a method is widely used in counselling psychology and psychotherapy research because it provides researchers with the flexibility to choose a theoretical lens that matches the philosophical orientation of their research question (Braun & Clarke, 2006, 2017, 2019, 2022b). It is this flexibility that appealed to me as a novice researcher because it provided a method that not only enabled me to identify, interpret and analyse themes or patterns of meaning across my data set (Braun & Clarke, 2017), but it also meant that TA could be applied across a range of theoretical perspectives.

Some authors have argued that TA is a process rather than a separate method, an aid to analysis (Boyatzis, 1998; Holloway & Todres, 2003; Nowell et al., 2017). However, I have aligned myself with the opposing view that TA should be considered a method in its own right, provided that researchers make their epistemological assumptions explicit (Braun & Clarke, 2006; King, 2004). Braun and Clarke (Braun & Clarke, 2022b) explain that when they started writing about TA it was a less established approach and they didn't provide a clear definition. They have now agreed that due to the range within TA (all of which share an interest in patterns of meanings but differ in their conceptual framework), it is important to clarify exactly which version of TA is being used. It is in this context that they have developed the term RTA (Braun & Clarke, 2019). They observe that it is not unusual for researchers to assume that TA is ‘atheoretical’ but this is not the case (Braun & Clarke, 2022b). For any researcher, including those using TA, theoretical assumptions sit behind the production of knowledge, in a similar way to the way that beliefs sit behind assumptions in CBT.

Victoria Clarke discusses this in her four-part lecture on TA (Braun, 2021) where she states that TA is not inherently realist or atheoretical but capable of a flexibility that enables the researcher to choose the underlying philosophical approach that best fits with their research question. She goes on to explain that within TA there are different versions which means that TA can be used to analyse most types of qualitative data. TA can be used for smaller and larger data sets and works equally well with heterogenous as with homogenous data. However, the challenge for any researcher is to decide which version of TA they intend to use and why.

Victoria Clarke (Braun, 2021) describes TA as being like a family of methods, each with common elements but also different procedures and different underlying research values (Fryer, 2022). Within TA, I chose RTA because it operates within a ‘Big Q’ qualitative paradigm (Braun & Clarke, 2006). ‘Big Q’ refers to a creative process which is actively shaped by the researcher. In ‘Big Q’, the researcher aims to reflect on their own values and experiences and understand how these may have impacted on their research as opposed to mitigating this subjectivity to strive for a more reliable or accurate analysis which would fit with a more positivist philosophy. The reflexive approach can be seen to fit well within the critical realist paradigm whereas other versions of TA do not.

I was particularly interested in the quality and texture of client experiences during their attendance of the emotional skills group, and it was this focus that led me to RTA. I wanted to position myself as an ‘insider’ researcher and RTA with its emphasis on reflexivity seemed to be ideal for this purpose. RTA recognises the subjectivity of the researcher and rather than see this as problematic, values it as integral to the process of analysis. The reflexive style of RTA also aligns well with counselling psychology which aims to develop both the ‘reflective practitioner’ and the ‘scientist-practitioner’ (Douglas et al., 2016).

At the start of this research, I had a superficial understanding, a general sense that TA might be a good fit. However, as time passed, I became more convinced that RTA was indeed a particularly good fit with my research question, my philosophical orientation and my style of working. Coming from a musical and artistic family, the open-minded creative aspect of RTA appealed to me. RTA can be used for inductive or deductive research (Braun & Clarke, 2022a) and here again the flexibility it offers suited the exploratory nature of this study which is not approaching the data through an a priori theoretical lens and developing coding and themes based on existing concepts or ideas, but aims to categorise and compare data using an inductive approach i.e., coding and theme development are directed by the content of the data (Maxwell, 2005).

Reflexivity

As previously discussed, reflexivity is central to a 'Big Q' qualitative approach. It also aligns with the underlying ontological position of this study (critical realism) and the method used (RTA). To consider my previous experiences, beliefs and assumptions and critically reflect on the way that they impact on and influence the research, I used a reflective diary to record my thoughts, feelings and experiences throughout the research process using Rolfe et al.'s Framework for Reflexive Learning (Rolfe et al., 2001).

Health research is often criticised for being tokenistic (Green & Johns, 2019). Majid (Majid, 2020 p.1) states that 'tokenism represents unequal power relationships in favor of health care professionals' and argues that this can result in limited or no meaningful change or alternatively that any change is primarily aligned with people in a position of power: managers and clinicians. I have attempted to redress this by paying particular attention to the effects of any power imbalance in my interactions with potential participants. Romsland, Milosavljevic & Andreassen (Romsland et al., 2019) suggest that taking the power imbalance into account and showing respect for participants and their ability to contribute to research and service development, is an important feature in any non-tokenistic research design.

Having been part of the first cohort of trainee graduate mental health workers who were employed to work in the newly established Improving Access to Psychological Therapies (IAPT) service (NHS England, 2023b), the lens I bring to this research is that of someone who has lived through the development of Talking Therapies from the very start. I have seen the way in which ideas about what should and should not be offered as a Talking Therapies treatment have changed over time. This impacts on my sense of possibility in terms of this research. If a decision has been made that adaptations of DBT as stand-alone emotional skills groups should not be routinely offered, this does not mean it is a final decision. Service structure is fluid and changes in response to a variety of different factors, including findings from research. Therefore, I have an expectation that although this particular research project on its own may not directly bring about change, it has the potential to contribute to a growing body of research that as it accumulates will impact on service development decisions.

However, this does bring with it a bias towards finding emotional skills groups helpful and effective. In this research I will need to be aware of this and endeavour to pay attention to difficult client experiences and take care not to minimise these when analysing the data.

Background to emotional skills groups in Somerset Talking Therapies

Although DBT is not considered a Talking Therapies compliant intervention (NHS England, 2023a), Somerset was one of three demonstration sites that offered treatment to people with personality disorders (Stirzaker, 2015). This interest in DBT coincided with the appointment of a senior management team who had previously managed a personality disorder service. In 2015, a group of step 3 therapists were funded to attend training in running DBT informed skills groups (Linehan, 1993; 2015). Since then, Somerset Talking Therapies has offered a 12-week DBT informed emotional skills group delivered in primary care to people with moderate emotional regulation and interpersonal problems. These groups are run by two qualified therapists. It is standard practice for all psychological groups offered in NHS Talking Therapies to be run by at least two therapists. Emotional skills groups have been established in Somerset as a treatment for people with a wide range of different diagnoses who also have difficulty with emotional regulation and have not responded to other step 3 interventions (predominantly CBT).

Context for this research

Prior to March 2020, emotional skills groups were delivered face-to-face. However, following lockdown restrictions during the Covid-19 pandemic, the NHS actively promoted a move from face-to-face to remote consultations (video and telephone). All face-to-face therapeutic or psycho-educational groups in Somerset Talking Therapies were suspended in March 2020 but in August 2020, emotional skills groups were reinstated using an online video platform.

Insider Positioning

There has been much written about the advantages and disadvantages of insider research (Mercer, 2007; Ross, 2017; Snounu, 2021), the main issue being positionality (Greene, 2014). I am an NHS trainee counselling psychologist with a history of involvement in DBT influenced emotional skills groups. I have not been a member of any of the groups involved in this study as a client, therapist, or group facilitator, but as a member of staff it is likely that my insider positioning will provide both advantages and disadvantages.

My socially constructed professional identity has potential to be helpful because it connotes certain positive characteristics for example the capacity to listen, to empathise and to care (Leslie & McAllister, 2002). These qualities support a non-tokenistic, respectful style of interviewing that acknowledges the power imbalance whilst allowing space for participants to be heard. On the other hand, my previous knowledge of these groups may lend itself to structuring questions and leading the interview based on my own experiences rather than allowing the participant space to be able to express their own individual and unique experience (Dwyer & Buckle, 2009; Hockey, 1993).

Dual-role experiences are common in therapist led research (Hay-Smith et al, 2016). However, therapist and researcher roles do not always align and can cause ethical and methodological problems. Smith and Thew (Smith & Thew, 2017) talk about the advantages that come with a background that trains a researcher in psychology, therapy, and research. However, managing the boundaries between researcher and therapist is not always straightforward once empathy has been engaged (Jesrani, 2018). In structuring this project I have attempted to separate out the role of researcher and therapist to follow up on client experiences rather than address any clinical issues (Fleming, 2018).

Anyone that I have previously had clinical contact with was not invited to participate in this research because prior clinical contact might reduce the richness and complexity of the data. For example, some negative experiences of the group might have been screened out if the participants had wanted to please me or make a good impression. I drew on my experience of facilitating groups, but research participants were not aware of this. The Patient Information Sheet (PIS) (see Appendix A) outlined that I was part of the clinical team. All participants had also received more general NHS information about the group prior to starting it (See Appendix B). Participants therefore related to me as an NHS researcher-practitioner rather than a group facilitator or a therapist. At the start of each interview, I repeated this information which may have implied I was able to provide some therapeutic care and to some extent suggested that I have a degree of belief in the therapy. RTA as a method does not seek to eliminate my previous knowledge and experience, rather it strives to incorporate my values and experiences and reflect on the part they play in shaping the data (Braun & Clarke, 2013).

Planning the data collection process

There is considerable flexibility around dataset composition in RTA and how datasets are generated (Braun & Clarke, 2022b). For this project I want a smaller number of ‘thicker’ data items because I am particularly interested in gathering data that contains rich, complex, nuanced, and detailed information. I considered three different methods of collecting this type of data: discussion groups, individual interviews, and questionnaires (Braun et al., 2017).

Discussion groups might be more efficient and faster than individual interviews, but they lack the confidentiality that interviews provide. They are also vulnerable to becoming unbalanced if some group members dominate more than others (Mansell et al., 2004). Questionnaires on the other hand can enable a much larger number of participants to be involved. However, questionnaires are not interactive, so you only get the opportunity to ask a question, you don't get the opportunity to check out your understanding of what participants are saying, and you only collect written data as opposed to verbal (Bell, 2005). The scope of data collected from questionnaires can be somewhat limited and may not capture in full the depth and complexity of emotional responses. Ultimately, I decided that semi-structured interviews would be the best data collection method because they allowed me to gather in-depth information but also provided flexibility to pursue additional topics. Confidentiality was more straightforward to manage than in a discussion group and interviews allowed space for participants who struggle to express their thoughts and feelings to be heard as well as those who have no difficulty talking.

Interviews with participants took place via the secure NHS Microsoft Teams video platform rather than face to face. This was due to Covid-19 pandemic restrictions. The semi-structured format was designed to ask the same set of questions to all participants whilst enabling flexibility in the discussion which allows 'scope for participants to raise issues that the researcher has not anticipated' and talk at depth about their experience (Braun & Clarke, 2013).

Sample size

Specifying a sample size before starting data collection can be a contested issue in qualitative research, (Braun & Clarke, 2016) but it is often a requirement for funders, ethics committees and study teams. Malterud (Malterud et al., 2016) proposes that sample size in qualitative research can be guided by information power. According to Malterud, a study with a clear, narrow focus will require a smaller sample population. The idea of a 'knowable' sample size (a concept associated with a positivist ontological position) does not sit well within a critical realist, 'Big Q' RTA study (Braun & Clarke, 2022b). As a trainee counselling psychologist, I held the uncomfortable tension between acknowledging the reality of needing to provide a stated sample size to apply for Health Research Authority (HRA) ethical approval and the knowledge that researchers using RTA are encouraged to dwell with uncertainty and state that the amount of data required to generate meaning is subjective (Braun & Clarke, 2021b).

The sampling for this project was purposive which is common within qualitative research (Braun & Clarke, 2013). Purposive sampling allows the researcher to select potential participants on the basis that they might be able to generate 'insight and in-depth understanding' of the subject being studied (Patton, 2002 p. 230 cited in Braun & Clarke, 2013). Braun and Clarke (Braun & Clarke, 2013) suggest a sample size of 10 or more for a small research project using TA. It seemed to me that potentially 12 interviews would provide a good range of data to enable me to gain insight into client experiences.

Ethical considerations

A classic definition of ethics is that it pertains to 'doing good and avoiding harm' (Beauchamp & Childress, 2009). This project was approved by the NHS Health and Research Authority (HRA) (see Appendix C for a copy of the HRA approval letter). It also received ethical approval from the Health and Applied Sciences (HAS) Faculty Research Ethics Committee at The University of the West of England (see Appendix D for a copy of the HAS approval letter) and adheres to the British Psychological Society's (BPS) Code of Human Research Ethics (BPS, 2023).

Potential participants were given a copy of the PIS (see Appendix A) which provided detailed information about the purpose of the study and what participation entailed before taking part. The PIS informed potential participants that no risks were anticipated but additional support was available for them should the content of the interview cause any anxiety or distress and clarified that any involvement in this research would have no detrimental effect on their future healthcare.

The PIS explained that potential participants could accept or decline an invitation to participate in the research study. Once consent had been given (see Appendix E), they could still withdraw from the study, including the withdrawal of their data, up to the point where it had been analysed. After being interviewed, no one asked to withdraw, therefore all the data collected was included in this analysis.

This NHS service is based in a rural setting where many people know each other or are related. Therefore, confidentiality was particularly important.

Participants

Potential participants were clients who had been assessed and met the criteria for treatment within Talking Therapies. At assessment a primary diagnosis is attached to the referral, and this is used to guide treatment decisions (NHS England, 2023). Potential participants presented with a range of different diagnoses (see Table 1) but reported that their primary problem was difficulty coping with intense and unstable emotions. All potential participants had attended an online emotional skills group. I decided to interview people who had completed a group within the last 6 months because I wanted to ensure they could remember enough detail about their group experience to provide me with data that would be rich and complex (Braun & Clarke, 2021).

Potential participants were informed about the study by NHS emotional skills group facilitators who discussed my research project briefly with each group and asked whether anyone would be interested in taking part in an interview. From this I was able to compile a list, send out an introductory email and arrange an interview date.

Recruitment

I contacted 13 potential participants with an introductory email and attached a copy of the PIS, a consent form and a demographic information form (Appendix A, E and G). All 13 people responded and agreed to be interviewed but one person cancelled their interview and did not reschedule.

The 12 people who took part in an interview were able to sign their consent form electronically using Adobe and return their forms via email. We used email to arrange a convenient time for the interviews to take place. Interviews were scheduled via Microsoft Teams; an online secure video platform used by the NHS and took place between April and August 2022. On average each interview lasted an hour, with the shortest being 28 minutes and the longest 1 hour 20 minutes.

Risk management

In the NHS Talking Therapies service used for this study, emotional skills groups were run as a transdiagnostic intervention. This meant clients could be referred to the groups irrespective of their diagnosis provided their primary problem was intense and unstable emotion. Each group had two facilitators who were experienced therapists from within the team. Risk within these groups was assessed to be at a similar level to any other client treated in primary care, it was the intervention offered that was different.

It was agreed with the Talking Therapies service manager that any concerns regarding risk management would be discussed with my clinical supervisor prior to sending out an invitation to interview. Potential participants were all clients over the age of 18 years, reflecting the boundaries of the adult Talking Therapies service I worked in. I looked at the history of risk relating to each potential participant before making any contact.

Confidentiality would have had to have been broken if anyone involved in the study disclosed information that suggested there might be a risk of harm to them or to others. This was made clear on the PIS provided to all potential participants before they consented to being involved.

It was agreed that any potential participants thought to have high levels of risk or high vulnerability would be excluded from this study. However none of the potential participants fell into this category, perhaps because these groups were situated in primary care rather than secondary care mental health services.

Data collection

Data was collected via semi structured interviews through secure NHS video conferencing (see Appendix F for a copy of the Interview Schedule) and transcribed by the researcher prior to coding and analysis (Braun & Clarke, 2006). During transcription all names were removed and replaced by numbers. Data was anonymised to remove any other identifiable material such as names of places or names of other group members and stored securely on a password protected NHS laptop. Anonymised data was also made available to academic supervisors and UWE examiners. After completion, all transcripts and audio recordings were deleted. The use of data and how it has been stored and managed was made clear to potential participants in the PIS.

Data has been analysed using a six-stage process proposed by Braun & Clarke (Braun & Clarke, 2006). This process involved familiarisation with the dataset, coding, generating initial themes, developing and reviewing themes, refining, defining and naming themes and writing up. (Braun & Clarke, 2022).

Demographics

Participants were asked to complete a standard NHS demographic data form (Appendix G) after they had signed the consent form and before they took part in the interview.

Participants ranged in age from 18-64 years with the majority falling into the 25-44 range (8). They were all cisgender, and most were female (9). Only 2 participants had children living at home. Most participants identified themselves as White British (11) with one exception who was from an African/Caribbean ethnicity. Three participants considered themselves to have a disability. Most participants (7) described themselves as not identifying with any religion although 4 said they were Christian, and 1 person ticked the ‘other’ category.

Table 1: Participant Demographics

(Data collected using the standard NHS demographic information form see Appendix G) n=12		
Ages of participants	Under 25 25-44 45-64	1 8 3
Ethnic background	Black (African/Caribbean/British) White (including White British, Irish and European)	1 11
Sexual orientation	Heterosexual Gay Other Preferred not to say	8 1 2 1
Transgender/are you the same gender ascribed to you at birth?	Yes	12
Gender:	Female Male	9 3
Children under 17 at home Caring responsibility	Yes No Yes No	2 10 1 11
Disability	Yes No Preferred not to say	3 8 1
Religion	None Christian Other	7 4 1

The primary diagnosis for most participants was depression (8); 1 participant presented with Post Traumatic Stress Disorder (PTSD); 2 with an Adjustment Disorder; and one with Mental Disorder Not Otherwise Specified (MDNOS) (see Table 2). There was considerable comorbidity across the group: 2 participants had a formal diagnosis of EUPD; 1 participant was diagnosed with chronic pain; 1 with Chronic Fatigue Syndrome (CFS); and 4 identified as neurodiverse (the population norm for neurodiversity is thought to be around 15% (Henley & Jordan, 2023)).

Table 2: Diagnoses at referral to emotional skills group

Information sourced from Talking Therapies clinical records with clients' consent (see Appendix E) n=12		
Primary Diagnosis	Depression	8
	Post Traumatic Stress Disorder (PTSD)	1
	Adjustment Disorder	2
	Mental Disorder Not Otherwise Specified (MDNOS)	1
Comorbidity	Dyspraxia	1
	Dyslexia	2
	Attention Deficit Hyperactivity Disorder (ADHD)	1
	Chronic Fatigue Syndrome (CFS)	1
	Chronic Pain	1
	Emotionally Unstable Personality Disorder (EUPD) or Borderline Personality Disorder (BPD)	2

The Analytic Process

Data from all 12 semi-structured interviews was analysed using the six phases of RTA (Braun & Clarke, 2013). Although each phase is distinct and separate from the others, analysis is not a linear process but rather an iterative one that involves multiple cycles of development, refinement, improvement, and adaptation as the research unfolds (see Table 3).

Table 3 Reflexive Thematic Analysis: 6 Phases

Adapted from Braun and Clarke, 2022 (Braun & Clarke, 2022c)	
Stage	Process
Phase 1: Familiarising myself with the dataset	During this phase I worked to become 'deeply and intimately familiar' with the dataset. This was achieved through a process of immersion which involved reading and re-reading the data and listening to audio recordings whilst making brief notes about any analytical ideas that arose.
Phase 2: Coding	At this point, I worked systematically through the dataset in minute detail, identifying sections that seemed interesting or meaningful and applying descriptive codes (labels) to them (see Appendix H). My coding aimed to capture meaning at a range of levels from semantic (surface meaning) to latent (implied meaning).
Phase 3: Generating initial themes	During this phase I started to identify shared patterns of meaning across the dataset. I clustered these into codes stored on an Excel spreadsheet (see Appendix I). Rather than searching for the meaning to be uncovered, I constructed themes in response to the data. This was an active process that involved using my prior knowledge and experience. Once potential themes had been identified (see Appendix J), I was able to collate the coded data in relation to each theme.
Phase 4: Developing	Here I reviewed my initial themes with the aim of assessing how well they fit with my overall analysis. This involved going back to both the coded data and to the full dataset. My aim at this point in the analysis

and reviewing themes	was to think about whether each theme told a convincing story, whether collectively the themes picked out the most important patterns from the overall data set in relation to the research question and assess their fit with the central organising concept. This involved accepting that there might need to be some change, at this point some themes were collapsed together, others discarded. I began to consider the wider context and started to think about the relationship between my developing themes and other existing knowledge.
Phase 5: Refining, defining and naming themes	In this phase, my goal was to refine and develop the 'story' of each theme by finalizing theme names and writing theme definitions. This ensured that each theme was clear and constructed around a central organising concept. At every phase I was aware of the need to be able to let my analysis go if more development was required.
Phase 6: Writing up	This was my final analytic stage. It enabled me to reflect on themes and refine them, bringing together any ideas from earlier stages (such as familiarisation notes and reflexive journalling) and combine them with my analysis and data extracts to tell a story that addressed the research question.

After transcribing the interviews, the data was electronically stored in password protected word documents which I annotated with familiarisation notes which I later turned into codes using the Review function in Word. I also saved an overview of the codes from all the interviews onto an Excel spreadsheet. Initially I printed a hard copy of the first interview, cut up the codes and tried placing them on the floor and then physically grouping them to identify patterns, but quickly abandoned this when I realised how much paper it would consume if I did this with all the interviews, something that sat uncomfortably with my values in relation to the environment and conservation. During the coding phase I was pleasantly surprised with my ability to work electronically. I found myself going backwards and forwards from recordings of the original interviews to the coded word documents with the transcripts on them, to the overview of codes across all 12 interviews on Excel.

What I found helpful during this process was to change my activities every couple of hours, often moving from one room to another, or from coding to reading. When I was tired, I listened to webinars that discussed RTA (Braun, 2021; Braun & Clarke, 2023, 2022d). I liked to allocate a whole day to my research so that I could fully immerse myself but at the same time it was important to step away for walks or long swims which helped me to think about my ideas in a different setting. Changes of setting and activity impacted on my mood and my energy in a way that enabled me to sustain longer periods of work than I might otherwise have managed. They also allowed time for reflection which helped me to review and refine some of my ideas about codes, themes and develop a central organising concept that would enable me to answer my research question.

I noticed that my experience of the analytic process was not consistent in any way, shape or form. On some days I might be able to make considerable progress but on others I found myself going round in loops, at times deleting the work from the previous day. My emotional responses also fluctuated. There were days when I felt confident that I was following the process (Braun & Clarke, 2013, 2022c), that my codes were relevant and provided a good fit with the data, but there were also times when I was less sure and felt anxious due to my lack of research experience and the enormity of the task.

As I began the process of analysis, I became aware that there were many questions that if I had my time again, I might have liked to ask. As time went on, I noticed topics that with my greater understanding of the project, became more relevant and more interesting. However, these areas of interest did not start to surface until I started moving around the 6 phases (Braun & Clarke, 2022c) and began to develop themes, and as the central organising concept began to firm up. Although I was unable to return to my participants to ask additional questions, in the writing up stage (phase 6) I have been able to think about some of these questions in relation to existing knowledge (Braun & Clarke, 2022c). For example, with hindsight I would have liked to hear more about what life was like before attending the emotional skills group. It would have been interesting to explore the phenomenology by asking more about the 'kinaesthetic, sensory, visceral and 'felt sense'' that the participants experienced when attending the group (Finlay, 2011) and it would have been fascinating to hear more about participants' early life attachment style (Bowlby, 1969).

When I started this research, I was working from home in response to the Covid-19 pandemic. As a trainee counselling psychologist my lectures and my NHS placement were online. Although remote working was practical because it meant I didn't have to travel, I was aware that I felt quite disconnected. The impact of Covid-19 on mental health and on our sense of connection to other people has been widely commented on (Hornstein & Eisenberger, 2022; Mindel et al., 2022; Parent et al., 2021; Pierce et al., 2020).

In my own life I was aware that the disconnection caused by Covid-19 impacted on my sense of identity on multiple levels: as a mother (my daughter was locked down at university); as a daughter (my elderly parents were living nearby but vulnerable); as a friend (I could only see friends via WhatsApp, or connect with them via text or phone); as a colleague (we were all sent home from the office); and on the rich tapestry of my life in which I am usually connected to a multitude of interests, hobbies and experiences none of which I was able to do. Normal connection in all its rich complexity was suddenly and unexpectedly curtailed. The importance of connection with other people and with the world was brought sharply into focus. Being disconnected and distanced from other people made me feel in some way less than I was before. This sense of my own disconnection is likely to have influenced the way that I began to interpret the data and develop the central organising concept.

During the first stages in analysis as I moved between phases 1-3 (Braun & Clarke, 2022c) I was not aware of any central organising concept. The exploratory nature of this project (J. A. (Ed) Maxwell, 2005), meant that I approached coding with a 'consciously curious' stance (Trainor & Bundon, 2021). Writing from a critical realist position, my own experience of disconnection during Covid-19 was something I particularly thought about during phase 4 of the analysis. I remember also wondering about the extent to which I was interested in connection and disconnection as central themes in my data was compounded by the disconnection that I felt whilst spending so much time on my own during the writing up phase.

RTA as a method encourages actively using personal knowledge and insights to construct themes around the data that describe a specific or a broad meaning (Braun & Clarke, 2022c). The analysis process enabled me to look for patterns across the data that told a story about the journey participants experienced through attending the emotional skills group. Inductive RTA was therefore used within a critical realist framework which generated an overarching theme around disconnection which I called 'my journey from disconnection towards connection'.

It is interesting although perhaps not surprising, that participants attending emotional skills groups who use a suppressive 'disconnecting' strategy to regulate emotion (Gross, 2001) talk about their experiences of connection and disconnection during the group. There has been much written about disconnection in relation to BPD and to other experiences of human distress (Card & Skakoon-Sparling, 2023; D'Agostino et al., 2020; Konrad et al., 2022; Little et al., 2018; Miller et al., 2021a; Simpson et al., 2022) and this theme has taken on more significance since Covid-19. What I might understand as 'disconnection' from the self is often referred to in the literature around BPD as 'chronic feelings of emptiness' (American Psychiatric Association, 2013; Ikhtabi et al., 2022).

Writing up the report (phase 6) was not a linear process. I found myself going back to the earlier phases to identify a quote or refine my ideas. This involved questioning my thinking and asking myself whether it truly captured the data and met the aims of the research question (Braun & Clarke, 2022c). Considering my ideas in relation to relevant literature has helped me reflect further on my interpretation and gain a greater depth of understanding of participant experiences.

Data Analysis

This section will provide a description of the data, looking at each of the main themes and associated sub-themes. Participant quotations are used to illustrate the points being made and answer the research question.

I have given the 12 participants pseudonyms to provide anonymity. (See Table 4).

Table 4: Participant Pseudonyms

Pseudonym	Age
Susan	54
Clare	33
Jane	58
Liz	43
Peter	39
Ben	30
Sandra	35
Lisa	31
Mike	32
Sylvia	63
Lesley	43
Sally	25

*Therapist names have also been changed to protect anonymity

My initial thoughts when I considered the data were that there seemed to be two groups, some people were talking about connection and others about disconnection. I remember discussing this observation in supervision and presenting it as a binary pattern, connection versus disconnection. However, at the progress review meeting I was gently encouraged to reflect on where this style of thinking might be coming from. With hindsight I can see how rooted it is in cognitive behavioural styles of thinking, working in NHS Talking Therapies where the culture and the pressure of time often promotes an avoidance of thinking at relational depth (Rizq & Catherine, 2019), in my own tendency to be reductionist and dichotomous, and in my family patterns. Both my father and my paternal grandfather tend to have quite concrete black and white patterns of thought and behaviour. Towards the end of the second year into this research project, the penny dropped, and I began to understand that rather than just identify patterns across a data set, what I needed to do was to structure my analysis of the data to tell a story (Braun and Clarke, 2013; 2022). This led to thinking about how I might be able to express these ideas as a journey.

Analysis, reading and reflection eventually led to the development of a central organising concept 'my journey from disconnection towards connection' which sits as an umbrella over the three main themes, and three sets of subthemes, (as shown in Table 5). The central organising concept explores the experience of participants as they move away from a general pattern of disconnection towards connection in a multitude of ways, highlighting their observations in relation to the impact this journey has on their emotional regulation and sense of self. In short, the central organising concept captures the story of the whole data set.

Table 5: Final Themes

Central organising concept: *My journey from disconnection towards connection*		
Theme 1: Finding life hard	Theme 2: Maybe this group will make a difference	Theme 3: Re-evaluating the importance of connection
Subtheme 1: Overwhelming desperation and chaos	Subtheme 1: Trust and safety	Subtheme 1: Recognising my needs
Subtheme 2: I'm on my own	Subtheme 2: Belonging: 'this group feels like family'	Subtheme 2: Growth and change
Subtheme 3: Identity – 'I'm not too great a person'	Subtheme 3: Learning and understanding	Subtheme 3: Feeling more connected

Central organising concept : My journey from disconnection towards connection

There was considerable difference in the emotional intensity across these interviews. Some participants expressed high emotion and talked in detail about their inner experiences whereas others seemed to express more concrete thinking and responded in a brief, factual, less emotional manner. The overarching theme that ran across all interviews was the way in which participants talked about their experience of disconnection: how they disconnected from themselves; from their feelings; from their body; from the group; and from other people and what changed when they started to connect.

Linehan's Bio-social Theory (Linehan, 1993, 2015) proposes that high negative affectivity, high levels of emotional sensitivity, an intense response to internal and external emotional stimuli with a slow return to baseline, intersect to increase vulnerability to problems with emotional regulation, particularly if there is a poor fit between parenting style and the child's temperament. Problems with emotional regulation create a range of emotional responses including a tendency to dissociate or emotionally disconnect under high levels of stress.

Linehan (Linehan, 1993) was by no means the first to theorise about the way in which people might be managing their emotions. Ideas about unconscious responses to emotion are central to early twentieth century thinking about human psychology (Freud, 1915a cited in Akhtar, 2020). Linehan's model (M. Linehan, 1993) extends Freudian ideas about repression and it is interesting to note that the data reveals examples of disconnection being both a conscious experience for some participants and an unconscious experience for others.

'I've learned over the years to manage my face so that when somebody is saying something, I don't do the eye rolling. I don't do any of that because you know, everybody's got their own journey and it's not fair. So yeah, managing your face….. I've been very aware of it for a long time. I received feedback many years ago … that I came across as cold, unapproachable, and uninterested. You know, I've done the eye roll, that sort of thing. So in the last few years of my career, I have consciously gone into the mode, you know,

straight face unless something good happens straight face. If something I don't agree with happens straight face'. (Susan)

Linehan (Linehan, 1993) proposes that people growing up in an invalidating environment learn that others are unable to tolerate their intense emotional responses and may reject them if they show how they really feel. In response, they disconnect from their feelings and put a mask on to the world. We can see an example of what Linehan is describing when Susan talks about *'managing her face'* to avoid a negative reaction from others and perhaps ultimately avoid social rejection, social disconnection.

Psychodynamic ideas about defence mechanisms (eg. repression) (Akhtar, 2020) seem very similar to the way in which the function of emotional disconnection is understood through a DBT lens (Linehan, 1993). Both models share a common assumption, that trauma disrupts and disconnects processes such as consciousness, identity, memory and perception, and therefore the solution lies in integration, which is achieved by making the unconscious, conscious (Spermon et al., 2010). Many theories that attempt to explain the development of problems with emotional regulation share this assumption and therefore emphasise the importance of integration, for example Object Relations Theory (Greenberg & Mitchell, 1983) or Transference Focused Therapy (Kernberg, 1984). However, other theories that locate the etiology of BPD in deficits in underlying neural circuits or genetics might take a different approach (Fonagy & Luyten, 2009; Gunderson, 2008).

In one of the transcripts, Peter described his behaviour after a coffee break. Like Susan he felt a need to present a 'good' version of himself to the group: *'Alright, good face on, click and you're back'.* Linehan's DBT model for describing emotions (Linehan, 2015 p. 213) tries to simplify what is a highly complex response. One of the automatic processes that she identifies is the way in which our face and body react to changes in the nervous system. Indeed, in Susan's example she talks about the criticism she received for expressing negative emotions and how she learnt to avoid this by '*managing her face'*. Reflecting on this, Susan seems very aware of the way in which her facial expressions signal her inner emotional world.

Sally describes another similar experience of being highly sensitive to emotional stimuli and coping with this by '*disconnecting from it*'. With these examples, Susan, Peter and Sally seem to be conscious of what is happening, able to describe their experience and theorise about the function.

'Sometimes I get a little bit upset myself because I'd be like, ohh, you know, that's sad that they're getting upset and I can feel their pain. Sometimes it was relatable. You know, I can feel why they're upset and other times I would be in a very strange headspace of disassociation where I just disconnect from it. I think I dissociated when I was too emotionally unstable myself and I was like, I can't let myself get emotional about someone else because I'm already emotional myself. Protecting myself, I think, and becoming emotionally disconnected from it. And sometimes I'd sort of just react with like, blank face, which sounds really, really horrible. Umm, but yeah, almost a disconnection from it'.

In Sally's example she describes how she understands the function of disconnection to be protective. This seems more in line with Gunderson's biological model of Interpersonal Hypersensitivity (Gunderson, 2008) where catastrophic meanings are attributed to interpersonal events. For Sally it seems as if the idea of being alone and unsupported in a difficult world presents such a high level of threat that it triggers dissociation to cope (Gunderson et al., 2018).

It could be that no single model accounts for every individual experience but rather there is a range to choose from. It is possible that although the participants share a similar problem (intense and unstable emotions and difficulty with interpersonal relationships) there may be more than one mechanism at play affecting the development of this.

Using dissociation to protect yourself was something that several participants talked about. Sylvia's example shows a similar disconnection response to emotion, although this felt more emotionally intense:

'I know in the first couple of sessions I freeze. I remember freaking out and trying to cut the session off and of being majorly triggered, I think session 1 or 2. Completely losing the

plot and then I phoned up the Talking Therapies thing and I sort of had a bit of a moan and they were very good. He, whoever it was, was very good with me. We had quite a long chat to bring me back round. I think I spoke to my previous therapist as well and I think she said this is just the process and I would encourage you to keep going with it'.

Another participant, Lesley, said that she had not been aware of her tendency to dissociate until starting the emotional skills group. She said that it was about halfway through the course that she *'started to realise that I actually spend a lot of my time disassociated'.*

Moving on, Clare reflected on her early life experience of disconnection and noticed that this was a strong family trait. Her description of family 'explosions' shows the way that emotional suppression can intensify emotion. She explained that normally her family didn't talk about their emotions but when they did it tended to be explosive, confrontational, and difficult:

'Umm, I come from a family that are very like shut off and don't like talking about emotions and would quite often keep things in until they boil over and then they just explode into rage'.

There seemed to be a tension experienced by group participants between wanting to be connected, wanting to be part of a group but at the same time needing to be alone. This can be seen in Clare's comment:

'It's nice talking to other people from other walks of life that you can relate to or see different perspectives of something that you might be going through as well, but I wouldn't say I was looking forward to it, because I kind of dread any kind of social interaction'.

Mike echoed this idea of connection being simultaneously reassuring and comforting but at the same time threatening when he said, '*being in a group is so much better because it's kind of like you're learning as you're doing it but it's kind of scary'.*
Chronic emptiness, often described as feelings of disconnection from self and others (Miller et al., 2021b) together with a longing for intimacy is a pattern that has been

written about extensively in relation to BPD (American Psychiatric Association, 2013; Ikhtabi et al., 2022; Miller et al., 2021b; Palihawadana et al., 2019) but there is evidence to suggest it is more widely experienced, particularly amongst people whose early attachments are not secure (Mikulincer & Shaver, 2012a).

Definitions of dissociation range from a separation of mental processes such as memories, feelings and thoughts which impact on identity, a change in consciousness triggered by an internal psychodynamic event, or the failure of normal association. Most writers agree that dissociation occurs on a continuum from normal (daydreaming) to abnormal (amnesia) (Richardson, 1998). The tension between these dichotomous positions seems to run throughout the data and supports the idea that struggling with connection and disconnection may apply to a wider population than just people living with BPD.

Here Peter talks about his need to disconnect from relationships when the emotional distress becomes too intense:

…'it's like, well, I can't have this. This relationship with my mother as a mother and son because that's where some of the problems came. So let's be adult and part of the same team, but we're not operating in this, in this hierarchy. Umm but then my mom and my brother's personal issues made it pretty untenable for me to be around them, so I had this second time of closing them off'.

Sandra reflected on her experience of feeling disconnected in the session due to the use of Microsoft Teams, although this was not consistently shared across the group. Some people felt more able to connect due to the online nature of delivery.

'I was a bit sad because I tend to get more out of being in person and actually as it went on [the group], I became much more lazy about it because where I live I only have my bedroom, so I would fall asleep very easily, whereas if it was in person I would have been much more engaged'. (Sandra)

Lisa's experience was very similar to that of Sandra, but her view was that there were more disadvantages than advantages attending the group online and she highlighted the effect this had on her sense of connection:

'Definite disadvantage I think, but the advantage is I don't know where physically it would have been if we were attending in person but there would have been costs of petrol which now that it's so expensive would have been irritating and actually getting up and going somewhere I'm not great at and I imagine some of the other people weren't either given that some of the time we spoke about how people weren't so great at leaving the house. So the benefits were that it made attending so much easier, the disadvantage would be the slight lack of connection but I think we all really did bond anyway'. (Lisa)

Jane noticed that on one occasion the therapists running the group seemed to be disconnected from the group process, disconnected from their own emotions, and disconnected from participants' emotions. This meant that the facilitators were emotionally unavailable but in addition their emotional signaling was confusing. She linked this to similar experiences from her childhood. Attachment theory proposes that children whose parents are emotionally unavailable are more likely to develop an anxious style of attachment (Bowlby, 1988). Jane's view was that it was important to be genuine and express the reality of the emotion in any situation rather than put a shiny gloss over an uncomfortable experience or pretend it hasn't happened:

'I mean, this is where I felt that there was a very weird atmosphere. You know, it was very unreal, you know, in some ways. Like they [the therapists] were trying to work out how to delicately deal with things in what felt like a very British and quite old-fashioned way. You know, as opposed to why are there only five people in the group when there should be 12? What? What? OK, let's sort this out. You start doing that. I'll start doing this. I felt like there needed to be some realness. The therapists would very delicately try to sort some things out. But there was never an, OK look there's not many of us. Maybe things are going on for people? We'll carry on. Let's hope some people join, and if not, we'll research it. But don't worry. We'll get in touch with them and find out if they're OK. I felt that there needed some follow up, you know. ….' She went on to reflect further on this experience:

‘There was something missing. I felt that they were the people leading. It was swallowing things as opposed to feeling they were allowed to just say it as it is. And one of the issues probably with a lot of our childhoods was this pretense. Yes, so it needed to be much more real so that the emotion that was in the room was talked about’. (Jane)

This response highlights how sensitive Jane is to any shift in the way that the therapists treat their own emotions. Indeed, she was able to identify several different levels of disconnection at this point: that the therapists were disconnecting from their own emotions; that the group felt disconnected from the therapists; and that she felt disconnected from her own emotions and confused about how to interpret them. In attempting to suppress their own feelings in response to the people who had not turned up that day, the therapists modelled emotional suppression rather than validation. It would be interesting to know to what extent they were aware of this.

Jane was not the only participant to be highly attuned to the therapists running the course:

‘I think it was good that there were two facilitators because they gave each other time to think and they gave me some strength in that they came in knowing each other. They came in with us with a steady relationship. They built this course together. But then also I think that in that kind of environment they would be having their own emotional responses as well as having to keep their intellectual mind going. So I think that that gave them time to fill up their bucket, their empathetic bucket so that they weren’t being drained by the process themselves’. (Sylvia)

The group participants were highly aware of the attachment relationship between the two therapists running the group. A secure therapist-to-therapist relationship is often thought to provide a secure base for participants to explore ideas and feel safe enough to make changes (Petrowski et al., 2021). It is possible that people with less secure attachment relationships in childhood become more highly attuned to minor ruptures in adult attachment.

Theme 1 Finding life hard

The data showed that people referred to the emotional skills group shared a common experience of life before the group, it had not been easy for them. People who experience intense and unstable emotions often struggle to cope with life, themselves, and relationships with other people (Kulacaoglu and Kose, 2018). This pre-group experience of Finding life hard was explored in more detail using subthemes: Overwhelming desperation and chaos; I'm on my own; and Identity – 'I'm not too great a person'.

1:1 Overwhelming desperation and chaos

This theme arose from the way in which many participants talked about experiencing feelings of desperation prior to starting the emotional skills course. Jane was clear that before she was referred to the group she would have accepted any offer of help, irrespective of whether it was likely to be effective, *'I mean, when you're desperate, you don't really investigate that so closely'* and Lisa described feeling desperate for a treatment that offered some hope: *'I don't know, I was at my last port of call for trying to get the appropriate help. I had seen a number of people in [large city] and wasn't happy with the offers they had given me so I was pretty ready to go [to the group] because I wanted any help I could get…. I was in [large city] before and I don't know if these group things are available but it wasn't offered to me after years of going back to my GP looking for help so I totally lost all faith in the medical services being able to help me. I moved down South, and I thought I'll give it another go and see if there is anything that might be a bit more helpful for me. Although I think initially, I had to be very up front with how sometimes my mood would plummet so bad to the extent of feeling suicidal for this to become an option, you know you have to really fight to get seen….I was kind of reaching the end of my tether with other options'.*

Ben's comment, *'it's just that, you know I roller coaster through life'* allows us to glimpse the instability and constant fluctuation in his patterns. Without going into detail, Liz also hints at the chaos and desperation she experienced prior to starting the group when she says, '*I had a bit of a meltdown in January. That's what sort of led me to this* *course'.* This is echoed by Mike when he says *'it was kind of seen as something that would be useful for like outbursts and at the time I was going through crisis'.*

Instability of emotion was something that all participants struggled with and for many this seemed to have been a lifelong problem. Jane explained, '*life for me is so much about running to keep up. With everything I need to keep up with and then crashing and then running and then crashing and running'.*

Susan talked about how much Covid-19 had impacted on her life and how it had disconnected her from the outside world:

'Unfortunately, the last two years have been crazy. So, I'll be as brief as I can. I used to be an out there go rule the world kind of woman and I moved to this house. I have medical issues. When lockdown happened, I had in the space of one week, three calls from the hospital, two calls from my GP surgery, saying you're at risk. Stay in. Stay in. Stay in. Stay in. And so, for two years, I didn't leave the house and I've now become a bit agoraphobic'.

Jane's sensitivity, *'emotionally or mentally, it's just I find I get easily overwhelmed'* also meant that Covid-19 had a big impact. As someone easily overwhelmed, having to approach the world again after lockdown was particularly difficult because even small experiences created very powerful emotional responses. Many of the participants expressed something similar, for example Clare said, *'I find I get easily overwhelmed'.* She went on to talk about how much she thought the group valued being allowed to look after themselves when they felt overwhelmed by their emotions. They were encouraged to take some time out to allow their emotional arousal to settle back down again, '*if someone was upset, they would usually turn off their camera and they would have some time out'*. Participants were advised to return to the group as soon as they felt more able to cope.

Lesley was able to catch herself feeling emotionally overwhelmed during the research interview and we used some grounding to manage this and bring her arousal down, *'well, the main thing is I'm hyper aroused and I go way too fast. It was the STOP skill, which was really, really major …. Hang on I'm doing it now [dissociating]'.*

Dissociation seems to be used here as a defense mechanism, an unconscious automatic psychological response to protect from anxiety (Costa & Brody, 2013) like a circuit breaker. Participants showed a range of different experiences of dissociation but in general these tended to be towards the daydreaming end of the spectrum. Only Lesley and Sally's experiences were nearer to the 'amnesia' end of the continuum. It was noticeable that these were the participants who had the most severe difficulties. They talked about their high level of emotional sensitivity and how easily they could be triggered by witnessing distress in others (Gunderson et al., 2018) . There is some evidence to suggest that the more severe the clinical presentation, the less that someone can benefit from DBT (Sahin et al., 2018). Lesley, the participant who had the most severe problems with her mental health, certainly found the ideas from DBT difficult at times, *'quite a lot of stuff I didn't understand'.*

This sense of overwhelming desperation and chaos seemed to be the lived experience of most of the participants, but it was also what brought them into the group and enabled them to think about change.

1:2 I'm on my own

This theme made sense to me because many participants reported experiences of being on their own or feeling that they didn't fit in with peers or family groups. Lesley encapsulated this when she said, '*at the time I thought I've just got [to have] someone I can talk to. Just someone to contact because I don't talk to anyone from one week to the next'.*

Participants didn't discuss their experience of isolation or loneliness directly but hinted at their experience of sadness and isolation prior to starting the group. This quote from Jane reveals the bleakness of her life and how low her expectations were, '*I felt it was better than sitting at home on my own'.*

Other people were more concerned about whether they would fit into the group or be left out, '*my underlying concern going into it was I hope we're all at a similar level within* *reasonable, you know parameters so that nobody would get left behind. Nobody would feel left out'. (Susan)*

Comments like this one from Lisa show how isolating it can be to be the only person struggling with emotional regulation:

'I found it really useful to hear from other people who were experiencing the same kind of symptoms as me, because I don't know anyone in my day-to-day life who experiences similarities'.

Lisa also talked about feeling anxious about returning to life alone after the group was finished, '*it's a bit scary because 12 weeks and then you are on your own again and that can be quite daunting'.* Mike shared his experience of feeling more connected with other people by juxtaposing his memory of being in the group with a future where he imagines being back on his own again. He talked about the way in which working online prevented him from being able to hold on to any new relationships with other people in the group and how abrupt the end felt:

'And then you've got to the end and you know you then also don't have these people to talk to again, so I think that's one thing that they said about in face-to-face is that people kind of were able to like, then be friends if they wanted to. But when you're online, there isn't any of that. You were just cut'. (Mike)

Although a proportion of the participants were socially isolated, others were very busy with complex family relationships. However, irrespective of the physical presence of others in their lives, there was a shared sense amongst the group members of being alone, of not being understood and not being able to rely on getting any emotional support from the people around them.

1:3 Identity – 'I'm not too great a person'

One of the most powerful themes that I created from the data was in relation to identity. Most of the participants talked about experiencing a negative sense of self. They talked about the way that this caused them distress and difficulty, both in the wider context of their life and in their experience of participating in an emotional skills group. Although scoping reviews are not considered as powerful in the hierarchy of evidence as systematic reviews, a recent study by Norder et al. identifies that internalising shame is a predictor of poor treatment outcome (Norder et al., 2023).

In terms of what is often referred to as Third Wave CBT (Acceptance and Commitment Therapy, Dialectical Behavioural Therapy and Compassion Focused Therapy), the model specifically designed to treat shame is Compassion Focused Therapy (Gilbert, 2014). However, it is possible that all Third Wave CBT approaches reduce shame. All three models target the relationship of the client to their own internal experience and aim to improve self-compassion, something that Stynes et al. suggest may reduce shame and self-stigma (Stynes et al., 2022).

In the participant group, Clare explained how struggling with emotional regulation made her think that she was a failure. She talked about her early life experience and recognised that difficulty expressing emotions was an established pattern in her family and something that she had been exposed to from a young age. Clare said that when she suppressed her emotion and subsequently *'exploded'* it felt as if she was a bad mother, this creates a social identity (the bad mum) that in Clare's cultural setting is highly shameful. Clare's struggle with her negative sense of self and her emotional regulation is something she thinks about in a relational way: in her relationship with herself; with her son; and with the wider community. Her difficulty with intense and unstable emotions seems to reinforce her sense of failure and compound the internal image she has of herself as a poor mother.

'Yeah, well, this is another reason also for my mental health. But it's another reason why I wanted to do the emotional skills group because I don't want to offload how I am on my son. I think, like, nature and nurture, there's always that debate, but definitely nurture, I think has got a lot to do with it. And if you've come from a family that's not used to dealing with emotions and just shows rage, that's something I don't want my son to have'. (Clare)

Jane reacted quite strongly to the sense of people being included or excluded from the group and said, '*I felt there needed to be a bit more of a grip of like have some respect. We are all on camera and if you're not on camera there needs to be a good reason. And when it comes to check-in, you need to speak up. You don't just disappear and leave your name still up like you're still on in the room'.* She seems to be reacting to a perception of poorly held boundaries and perhaps feels uncontained and unsafe. Jane expresses anger, frustration, anxiety, and a sense of injustice at the disengagement of some group members:

'*There would be people whose names were there as if they were attending and then people leading it [the group] would say, OK, what do you want to say now? What's your check-in? And they weren't there. Or there was no reply, so you were in this sort of like really weird land of, like, are they there? Have they gone? Are they pretending not to speak? Are they just watching us without us?' (Jane)*

Jane assumes that if she can make the effort to overcome her anxiety about connecting with others and engage with the group, everyone else in the group should also be able to do this. Her high standards and the increase in emotion here implies a sense of vulnerability and reveals Jane's perception of herself as a sensitive and fragile person.

A shared sense of vulnerability seems to be pervasive across the data. Ben made a direct comment about this when he said, '*there's a lot of people and you know, we're all quite vulnerable actually*'. All the participants had a negative sense of self as someone disconnected from others, someone who didn't deserve love and care. The way that Lesley identifies being triggered by the suggestion that she might receive care from others reveals how undeserving she feels, '*I just did a little one there [dissociation], the words 'looking after yourself'.*

Some participants like Jane saw themselves as lacking emotion, '*I'm not known for my emotion'* whereas others thought they had too much, '*so if I can see pain in someone I'm straight there'. (Lesley)*

Around a third of participants identified as neuro diverse. The population norm is thought to be around 15% (Henley & Jordan, 2023). Given that there is a growing evidence base that supports the idea that there may be a biological basis for greater sensitivity to social and environmental stimuli (Acevedo et al., 2018) it is possible that many people with neurodiversity may also struggle with emotional regulation. In the data, we can see participants talking about their experience of hypersensitivity and they all share some similarities whilst at the same time each experience is unique and particular to the individual:

'I'm easily triggered by other people's emotions, so I try not to show it because I don't want to make anybody else upset, but yeah, it does affect you. It's never nice seeing somebody else upset'. (Clare)

This theme highlights emotionality. Some participants describe themselves as someone emotional, '*I'm really emotional. It's been so intense recently' (Sally)* and some implied that they thought this was a negative attribute '*I was having [emotional] outbursts and not being too great a human' (Mike).* This sense of their emotions being too strong, too difficult to connect with, too much for other people, too out of control, seems to contribute to the negative sense of self that many people talked about at the start of the group and compound their sense of isolation.

Theme 2: 'Maybe this group will make a difference'

The analysis shows the way in which attending the group enabled participants to move away from feeling stuck and develop a sense of optimism. For some clients, this sense of hope began from the moment that they were offered an assessment whereas others were quite cynical at first but started to develop hope as the sessions progressed.

Linehan's aim was to enable people 'to create a life worth living' (Knowlton., 1999) and to achieve this DBT teaches coping beliefs that help people to survive, such as I can cope, life will get better, and life has value. The therapists running the emotional skills groups in this study (adaptations of DBT) shared this goal and aimed to generate a sense of optimism in clients who had often tried many different therapeutic approaches with little or no effect.   Here are some accounts of participant experiences of developing optimism:

'I needed something more than the anxiety thing and I was hoping it would sort of help me to learn techniques to try and manage my emotions a bit better'. (Liz)

'I received a phone call with the group facilitators and so they talked to me about the difference between the groups, the group's plan, or what it kind of is versus the talking therapy that I've just received …. So they made it clear about what some of the boundaries were. They made me feel like I could contribute and that I would be a useful member of the group based on what I was saying to them. They made me feel like it was a cooperative experience rather than, oh, this is what we do. Come along. It's more like I can hear that your point of view would be really interesting in the group'. (Peter)

Peter seemed flattered by the interest shown in him at the assessment appointment. The relational approach established by the therapists enabled him to feel that their relationship was equal rather than hierarchical, which he appreciated. He talked about feeling valued and useful and therefore wanted to be included in the group. It seemed as if the warm, encouraging approach generated a sense of optimism and a positive connection with Peter from the outset.

Sandra said that learning new information helped her to engage and feel optimistic that the group would help her, *'I felt really encouraged with the latter part of the sessions. It was very informational and I enjoyed learning new things'.* However, she added that it would have been helpful to have smaller groups and shorter sessions because she struggled to maintain attention at times.

Lisa reflected on the way that her optimism and engagement fluctuated over the first few sessions. Fluctuating engagement was something that many participants experienced and talked about in the interviews. Lisa described her first sessions and reflected on the way that her engagement and optimism appeared to be linked to whether she perceived other people to be making an effort:

‘Maybe at first a little apprehensive but I was very eager to do my best initially. After the second session my interest tailed off a bit. We had been given things to work on for that week and I had written a bunch of notes and I appeared to be the only one who had done that. So I thought other people hadn’t put in as much effort, but that actually turned out to be false. In the next couple of weeks people started putting a lot more effort and I started dwindling off a bit because of my thoughts around the second meeting. I went through a bit of an up down and then right back up again with the therapy’.

On the other hand, Mike did not attribute a sense of optimism to the therapists or the learning experience but to his own sense of needing to make a change:

‘No, I think I was already on the journey of wanting to change myself anyway. The excitement was to know a bit more about emotional skills. Like no one’s ever, you don't ever have that at school. And I actually think that a lot of boys in particular need that’.

Sylvia described a very positive experience at assessment which drew her into the group and encouraged her, *‘I think in terms of accessing some sort of care this has been one of the nicer pathways I've gone along…… they were very friendly. I kept going’.* In contrast, Lesley’s recollection was very different, ‘*well most members of the group, we were all a bit scared because it was a group and we weren’t very optimistic about it. It was like – more rubbish we’ve got to talk about. Erm … A few of us weren’t that keen, yeah so not all that keen really’.*

Sally, having moved from [large city] said, ‘*to be perfectly honest in my experience I didn't mind because I've never been offered this type of therapy before. Actually, the areas that I've previously lived in don't offer this. So I just counted myself lucky that I was even being offered it in the first place. I didn't mind that I had to wait to be perfectly honest. Like, don't get me wrong, the sooner the better’*.

There has been considerable research into positive psychology (Constantino et al., 2018; Gallagher et al., 2020; Seligman & Csikszentmihalyi, 2000) and good empirical evidence that optimism and hope improve mental health outcomes (Constantino et al., 2018; Laranjeira & Querido, 2022). This theme seems to highlight the importance of a good therapeutic relationship in developing optimism and hope in emotional skills groups.

2:1 Trust and safety

Many of the participants talked about not feeling safe enough as a child to express their feelings. They also talked about similar difficulties in their adult relationships. At interview, they reflected on their experience of sharing emotions within the group and how this impacted on their sense of trust and safety.

Attachment theory (Bowlby, 1988) is often used as a framework to understand emotional regulation (Slade & Holmes, 2019). Understanding how people might experience the emotional skills group from an attachment theory perspective highlights the importance of the therapeutic attachment relationship. It assumes that therapy can reshape attachment relationships and that secure attachment is helpful for affect regulation (Mikulincer & Shaver, 2012b).

Ben mentioned early on that he thought many of the group participants struggled with trust, '*Yeah, there were a lot of trust issues as well'.* He hinted at attachment problems in his relationship with his mother, '*I have quite a difficult relationship with my mum'* and worried about whether he would be taken advantage of if he began to trust other people in the group:

'Concerns just like am I being taken seriously to begin with, you know, like there was a lot of people and you know, we're all quite vulnerable actually……. And you know there were sometimes when we all had a cry over the video but it was just like, you know, no one was taking the mick out of one another….. But there was that doubt. I mean, do I trust them enough to tell some of my deepest, darkest secrets kind of thing. But you know, it was helpful just talking'.

In the context of poor attachment relationships where you are always let down by other people, Lesley talked about fear: '*it was a fear thing. ….. just afraid I suppose. Just the* *fear was the main thing'.* Lesley was the only participant to use the word fear and she was also the participant who experienced the most intense disconnection.

'Like friendships? I've got no friends. What's a friend? I don't even know. I don't trust a soul. I don't trust anybody. I find it very difficult .... Emotional regulation ... and everyone is talking about going out with their friends, with their family and I just don't have any of that and I'm thinking what!!?' (Lesley)

On the other hand, Susan talked about the way in which she experienced the group as a safe space. For her and for many other participants, the sense of safety and support in the group allowed them to take the risk and express their emotions:

'And it was a safe environment for people, you know, even for someone like me who has to manage their face. What I got when people were emotional or upset was this is a safe environment. If they can't do it here, where can they do it? You know? And actually, we all need to be supportive. And I think most people were ok with that actually, because we had a few people getting upset or emotional or starting to lose it, but it was a safe environment and I absolutely support and appreciate that'.

Susan also talked about how she responded to different styles of support from the two therapists. She found the firmer, less warm style more helpful. It can be difficult for people who have experienced neglect or abuse to tolerate empathy and warmth. According to attachment theory (Bowlby, 1988), a disorganised attachment style may mean that in adulthood someone continues to view their attachment figure as unreliable, as a result warmth and support are perceived as a threat. One of the main issues that people with this style of attachment tend to have, is the fear that someone they trust will hurt them. There is strong evidence to support the idea that attachment insecurity is common amongst people who experience poor mental health. Attachment insecurity is also thought to be a dominant feature of personality disorders (Mikulincer & Shaver, 2012b). This may account for Susan's preference for a firmer, more distant, less emotionally nurturing approach.

'Actually, when I felt I was starting to lose the plot they [the therapists] were very supportive. Both of them were very supportive of me. Helena I found [easier] I don't know, maybe because our personalities are more similar, she was the one that went – no, stop it – because I actually used the words pity party and she said 'no, it's not a pity party, it's self-preservation mode. You are looking after yourself and there's nothing wrong with that. It's OK, it's OK to feel that way'. And although Alice was very supportive, absolutely was more soothing and nurturing. You know softly, softly, gently, gently. Umm I personally found the other approach more helpful to me, I don't know whether it would have worked for other people, but it worked for me'. (Susan)

Peter talks about problems in the attachment relationship with his mother and how difficult this has been for him. In his example you can see that the relationship is unreliable, and it makes sense that he would disengage and disconnect to protect himself. However, unlike Susan, Peter found a warmer, more compassionate relational style helpful and enjoyed having his emotional needs met:

'Particularly, one of the therapists took care of times when somebody was referring to other people in the group rather than themselves. And I think of her on several occasions just sort of guiding me back. The thing about that lady was that she is a very warm and gentle personality. And so it never came over at all as any kind of you've done something wrong. It felt more like shepherding or, not even shepherding, not even that much. It was more of a sort of a gentle sway to get you back to, oh, remember that this is something we do. Ah, yeah, yeah. Sorry. Yeah, don't say sorry. This is, you know, how she dealt with that. I don't remember the other therapist coming in to deal with' that. It's not that she's [the other therapist] not empathetic or warm it's just that she was the one that took care of people…. She did it and she did it gently and with a smile. And um, it didn't seem like any kind of we don't do that in this group. It wasn't anything like that - it was positive language. She would say, you know, we do this rather than we don't do that. And it worked a treat. I thought she was excellent in that regard'.

Sandra talked about the therapeutic relationship between her and the therapists running the group. In her example you can see how hard the therapists are working to create a secure attachment and enable Sandra to feel safe. In modelling a good attachment relationship both between them as a duo and between therapists and group members, participants were able to experience what it felt like to have their emotional needs met:

'It was stellar! It was such good care. They were very sweet women, and they gave you the space and encouraged you, you couldn't ever say things like I never feel happy. There was always - I don't feel happy yet and just teaching that kind of support and openness really gives you confidence to go through what you're going through'. (Sandra)

Sylvia's experience echoed this sense of warmth and acceptance:

'The facilitators were very, very good. I think it was the empathy they brought. Not everybody can bring empathy, and they definitely brought it. Wasn't pity. You never felt pity. You just felt you' know, we're here to equip you. You're OK. You're fine. Just the way you are. Just come the way you are. There is no first place here. There is no anticipation of what you should be 'or shouldn't be. Even if you didn't use the tools the week before. You know, if you came with tears to the session. It was just so empathetic and compassionate. And I think we all needed that. I think we were all people who needed to feel that degree of acceptance again. And that really was helpful'.

Although there was considerable effort on the part of the therapists to create a safe environment in the group, the extent to which participants were able to respond to this seemed to vary considerably. In this example, although Sally doesn't talk about fear or state that she was feeling unsafe, it is never-the-less apparent from the extent of her preparation that she didn't feel safe enough to risk making a mistake:

'I would have to take a few hours before the session to prepare and reflect on the week, right? A few bullet points down….. because I feel like I'd make fool of myself if I didn't have something written down, I feel like I'd say something which would just make fool of myself. Whereas if I've got it scripted, I can either just read that or I can go off it and, you know, make a few points attached to that list. Maybe a safety net of things to talk about and also I worry that my head will go blank'. (Sally)

Jane pointed out that group participants tended to be highly attuned to other people's emotional responses like a '*Spidey sense'* and this meant she was quick to notice any dissonance between what people said and what was happening on an emotional level:

'You know. It's difficult because it's a group of very sensitive people, so I'm very sensitive to when I feel someone's angry. Umm. And I pick up on that. Really. Really. You know, like a weird Spidey sense, even on the screen and this whole thing that I was saying before where I felt there wasn't a complete honesty, there was this sort of pretense and there was a voice that was so 'everything is really going to be nice and fine' and that isn't the reality of it'. (Jane)

Jane seems to be saying that it is difficult to develop trust in therapists if they put a gloss on life and present a view that doesn't match up with lived experience. Indeed, this could be seen as invalidating in terms of relational style (Linehan, 1993; Musser et al., 2018). The importance of safety in DBT skills groups is raised as a theme in research by Smith et al. (Smith et al., 2023). In this paper the authors point out that disorganised attachment is a strong predictor of a later diagnosis of BPD but fail to link this with the importance of feeling safe in the group. Indeed, it may be the modelling of secure attachment relationships by the group facilitators that enables participants to feel safe in DBT skills groups in a way that they did not in their families.

Another factor that many participants said helped them to feel safe was the mode of delivery, the fact that it was an online group.

'In some ways online relieves you of that small talk side but that side gives you a broader impression of people, a judgment of people. It's a horrible way of saying it, but how you form, how you think about them, you don't have that when you are online. You come together knowing that we're all working in this little square and in these little squares. And we're safe because that's all you see o' me. That's all you get to know of me. I don't need to know anything more about you. You don't need to know anything more about me. We aren't here to be friends. We're here to be a shared group. And I don't know if you would get to the safe level of culture in a face-to-face environment as quickly as you can on

online, when you do have that, I'm just here in fact, I can turn my camera off if I didn't want you to see me, I'll just listen for a while'. (Sylvia)

There is a sense of control in the way that Sylvia is talking about switching off the camera and choosing to listen and this seems very powerful. This is particularly interesting when thinking about what Brene Brown says about the intersect of 'feeling trapped, powerless, and isolated' and how this might impact on identity (Brown, 2006). It also contributes to Sylvia's sense of safety.

2:2 Belonging: 'This group feels like family'

Although most participants found their emotional tolerance improved as they moved from disconnection towards connection, some people experienced the opposite whilst at the same time expressing a value in their experience of connection and an improved understanding of why they might dissociate, switch of the computer, or need to disconnect in other ways.

Saunders et al. (Saunders et al., 2015) have written about the way in which emotional availability as a construct can be applied to relationships other than just parent-child and how it might play out in family systems. Other writers have taken this further and looked at therapist-client relationships (Petrowski et al., 2021; Söderberg et al., 2014) suggesting that a therapist, like a parent, can provide a secure attachment from which the client is able to explore their world and a safe space to return to when times are difficult. The client is therefore seen to move towards autonomy provided the therapist is attentive, empathic, and reliable.

'Towards the end I was so sad when it finished because we all liked it. It felt like a family. Towards the end we had all shared these experiences and like we were all looking after one another, you know, talking, reassuring each other'. (Ben)

What Ben particularly responded to was validation from other members of the group:

'I would say the group helped because you didn't feel so alone it wasn't just you and a room with someone. There were other people that would be like, you know, they would speak after you and they could relate back to what I had said and say – I feel like you. This made me feel like I'm not alone out there. So, I mean we all kind of go through similar things and we also handle things the same sometimes when you're not in the right state and so it just didn't make me feel so bad anymore'.

Being in the group seemed to provide Ben with a strong sense of connection, '*it was just very relative, which I mean we could relate. I could relate to the group. I could feel it almost'.*

Lisa agreed that '*the group aspect was really helpful, it was comforting and validating….. The group aspect helps, the fact that I liked it. I liked all the people and the two counsellor ladies running it'.* She went on to describe the way that sharing her emotions in the group and experiencing group validation had impacted on her:

'I felt very comforted after my initial wobble with my crying. After I left the session, I felt a little guilty because I did have another job lined up but I was still very upset because being fired is never nice. So, I felt a little guilty that they all seemed so sorry for me. It reaffirmed my feelings that we were a group, we were all in it together, we were all going through ups and downs and life carries on even though we were all going to the sessions together, life carried on in the background good and bad. So, I felt really supported and it helped with the solidarity of the group'.

Brene Brown (Brown, 2006) proposes that to build shame resilience into groupwork, therapists need to develop mutually empathic relationships, acknowledge vulnerability and encourage clients to develop a sense of critical awareness (cognitively restructuring individual pathology as contextually normal and understandable). Acknowledging vulnerability, developing critical awareness, and relational working are also central ideas in DBT (Linehan, 1993) although the language used is different. DBT is based on the bio-social (no blame) model, the need for a relationship of equality between therapist and client and the importance of validation (Linehan, 2016). Perhaps it is not surprising therefore that participants in this study talk about their experience of vulnerability, about becoming more critically aware and how they relate to the therapists and others in the group.

Although many participants commented on how much they felt they belonged in the group, some talked about not belonging. Mike said the group was '*not from my demographic and from my demographic I was the only one to complete it. There was one other guy that was in it at one point, but he dropped out after session six, I think'.*

Lesley talked about how difficult it was for her when the group didn't meet and how much she was beginning to value connection:

'Yes each week it was having a connection, reading the notes, being in the group….. another thing I complained about was we had two lots of sessions and then all of a sudden somebody was ill and there was a holiday. And I thought you can't open people up and then just disappear for two weeks. I found that quite hard. But I got over that. I was so needing, so wanting Friday group that when there was a holiday or an illness or something I thought, you can't leave me like this, I need to speak to you about what has happened in the week. With the homework you see. You have homework and I needed to talk to somebody about it. Because I'm on my own, I've got no one to talk to'.

On the other hand, Sally noticed that as the connection in the group increased, she felt an increased need to disconnect. As relationships within the group developed her emotional intensity increased and she found this difficult to tolerate. This could be understood as another example of the way in which positive experiences are felt to be threatening due to the way in which the individual is anticipating abandonment (Bowlby, 1969; Mallinckrodt, 2010).

Like Lesley, Sharon used dissociation to cope when the connection with other people and with her emotions became too intense, *'I participated more in the beginning, actually, than the end. I think because I was more enthusiastic at the beginning and then throughout it as it got more intense and more real it I ended up…..No, I engaged less with it because it was more intense I think'.*

As time went on people began to settle into the group and develop a stronger sense of connection. Here is Sylvia talking about her experience of this:

'Everything I had been worried about wasn't there and I think there were a few people who didn't feel the group was right. They fell away during the first few sessions and that was actually really nice because the group shrunk and it was just this core group of one man and all women that just needed to bounce off with each other as we picked up these tools. So it became good. I was actually really enjoying it. And every Friday I was like looking forward to the group'.

This theme reflects the value placed by participants on the growing sense of connection within the group. Participants reflected on a sense of loss when the group ended and for some this was the catalyst to go out and find other means to connect with people.

2:3 Learning and understanding

All the participants expressed positive experiences of the learning they achieved during the group. For example, Susan talks about being able to use the skills that she learnt in the group and apply them to her life outside the group, '*actually, if I am starting to feel out of sorts, if I'm feeling clunky if you know, I'm feeling overwhelmed with anything whether that be my partner or we've had a visitor' and that's thrown me off course, I'll go out to the garage, and you know, I will look at the notes and I will do it specially the STOP one'.*

Ben's comment reveals the way that his expectations have changed and become more realistic*, 'I just thought that I would be able to learn how to handle my emotions better and I have learnt, you know, certain ways of coping with different things, you know, certain things better. But yeah, I'm still learning….. you know it doesn't happen overnight'.*

Mike pointed out that some of the handouts were difficult for people with dyslexia because of the heavy use of acronyms. Other participants also found the use of acronyms in the DBT handouts (Linehan, 2015) difficult to remember or irritating:

'They're brilliant [handouts]. I found that I can't remember exactly all of the lessons, but it was very interesting to hear the theory behind it, that was very helpful for me. And for me, the unhealthy point might have been that, like the acronyms for me as a dyslexic. Difficult to remember an acronym and especially all the time….Uhm, I'm not a big fan of acronyms and stopping myself and going what does the E stand for? It's not something that turns me on'.

Sylvia also commented on the support materials and the heavy use of acronyms.

'I don't think there was anything that wasn't helpful. There are slides and things and they were all on point. They were all very applicable and they allowed you to engage because you put yourself into situations - you could say' Ohh that's me. I fit into that. That mould. I fit into whatever that example is. And so it made it very applicable. Applicable, that's probably 'he word I'm going for - and that was useful. I don't really know about acronyms. I'm a bit dyslexic and I find actually talking without the kinesthetic side of life a little hard. That's the worst I can say' Maybe it's about limiting how many you use so that you can actually remember the few and be able to build on them as opposed to being given a myriad amount that actually just become an alphabet in the end. And all I remember is STOP'.

Clare said that she had started to teach other people some of the skills she had learnt from the group, ' *I found them [the skills] really useful because my brain is always thinking about a million things at once, so having something to look back to, especially like the acronyms and things like STOP and all that stuff like I find that useful and I still use that now and I tell other people as well. So yeah'.*

She went on to talk about the difference in her ability to communicate with her husband since attending the emotional skills group:

'Oh 100% yeah, even if it's just taking the time to think about how you like, let's say, if we snapped at each other for something. Before the group I would just shrug it off and be real stubborn and then it never really got resolved. Whereas I think even since doing the individual therapy and then doing the group I'm using actions and words a lot better than

I used to before. Don't get me wrong, I still have bad days as well like everybody does but if I've snapped at something or something has happened that is out of my control then I take time to reflect on it and I know there's a reason why I've snapped. Now I can think it through - This is why this and This is why this and actually, yeah, you were really bad. You probably should go and say sorry. I can apologise now'.

Jane liked the use of imagery to demonstrate learning points. Her comment about sharing skills with a friend shows how this helped her to absorb new information and ideas:

'I was learning about biological and environmental impacts on my development. We were looking at reasonable mind and emotional mind that was extremely useful…. yeah … there was one drawing I think I actually shared with some friends of mine, which is a ladder…. So I messaged a friend of mine recently. She's doing a PhD and she's struggling, and I just said, right, one small step every day it the smallest step doesn't matter. But just take one every day. I think it's something that really stayed in my head. So, this combination of drawings and bullet points I felt was very clear and I thought the level of that was very good'.

Liz found listening to examples from other people in the group was a good way to learn, '*Yeah, but let's say it was very helpful sort of listening to other people as well. So them saying about what worked for them and then sort of saying what worked for me and didn't work for* me'. Peter's experience was different. He noticed that he felt better after the group but didn't find the teaching particularly helpful or think he had adopted any new strategies:

'I definitely feel better for having gone through the process with the group. I haven't adopted any of the specific skills because some of them weren't appropriate for my problems and some of them are slightly patronising versions of other things that I've already read and already practised……. I'm much more likely to do the breathing techniques that follow in line with my Buddhist practice so it hasn't created new habits for me'.

Ben seems to show a new acceptance of himself and his emotions. The way that he is relating to his emotions has changed, he is no longer seeing them as a threat or something that needs to be avoided, suppressed, or controlled:

'I still have my moments where like you get a bit of anxiety or stuff. But I just feel like now you're gonna have these moments where you are gonna feel really low. But I kind of just think, you know if things are always gonna get better, they're sometimes gonna get a bit worse'.

These examples reveal the extent to which Ben has learned to connect with his emotions and tolerate them rather than avoid them. This has enabled him to change the meaning that he attaches to his emotions so that they feel less threatening. He seems to have accepted that it is normal to feel anxious at times and that he is able to cope with this.

'Actually, something happened with the car a few weeks back, there was a horrible sound coming from it and I was just like Oh no. I got really, really stressed but actually handled it a lot better than I would have in the past. And I was just like wow, if only I can keep doing that for every little thing that goes wrong then great.' (Ben)

Marsha Linehan (Linehan, 1993) talks about emotions as a full-system response and is supported by a growing body of evidence that highlights both the complexity of our emotional system and the way in which is a 'multi-component, motoric event' (Straulino et al., 2023). In the first instance improving emotional regulation requires an ability to experience and label emotions. Once emotions are experienced, the individual is then able to learn how to reduce stimuli that reactivate or amplify emotions and learn to disrupt the system by changing cognitions, expectations and behaviours. According to Linehan, people become 'negative emotion phobic' when their first response to an emotion is suppression or avoidance because they fail to learn that they can tolerate their emotion.

Sandra explained that the check-in at the start of each session was difficult for her because of her ADHD, *'I felt really encouraged with the latter part of the sessions. It was* *very informational and I enjoyed learning new things. I found it tricky the first half hour. It was very much where we were all at and because of my Attention Deficit Hyperactivity Disorder [ADHD], I just couldn't focus for that long. And then as soon as the mindfulness started, the mindfulness really helped… because I was relaxing'.*

Something that Jane talked about was how difficult it felt translating learning from the group into changed patterns of behaviour. At the same time, she was able to recognise that it was the change in her behaviour that was going to help her to absorb the learning:

'But there are still things that are not my default. Then they need to become more of my default setting and boundaries is definitely one of them. I mean, I did have a very difficult situation that I had to respond to. Not last week, the week before, which was about boundaries. And it nearly killed me writing this message, which was basically putting my boundary in place, and I put off doing it for about four days. But obviously I did do it and it was about a boundary'. (Jane)

What is interesting is that she is commenting on the development of her conscious awareness and how this enabled her to identify her own emotional responses, understand her patterns and identify opportunities to make changes. This seems very much in line with psychodynamic ideas about the need to make the unconscious, conscious.

'Uh, there were incremental building blocks that were helped by this course because boundaries was definitely one where I noted that's an area that's really difficult for me and I haven't worked out why. And I tried to sort of do a bit of that when I was thinking, why am I finding this so hard? What do I feel is gonna happen if I put this boundary in place? So I think there's a thinking that is now going on and an awareness of thinking that's come out of the work that we were doing and what we were learning'. (Jane)

After observing another group member, Mike realised that he is also someone who tends to go into 'fix' mode and how this can often invalidate emotional experiences:

‘And the other guy …. it was interesting the dynamics of that… because from a guy perspective we can take over. Every time he was there he talked a lot and I thought well that person was offering advice or saying well what I do is this and it’s like ….. and I'm probably that way and I think that that was a big learning for me’.

Most participants found learning from the group helpful, and Jane’s comments summarise this:

‘I think the DBT emotional skills group gave us a sense of being able to hold our emotional struggles, our trauma, our stories, and at the same time practice some things which would eventually help us deal with the day-to-day of life, whilst acknowledging and holding all of this other stuff’. (Jane)

This theme identifies that not only was psycho-education helpful, but participants particularly valued the kinesthetic learning style of the group in which they were encouraged to tune into their body, interact with the emotional group environment and learn by doing.

Theme 3: Re-evaluating the importance of connection

The final main theme considers the way in which participants gradually developed an awareness that connecting with other people was important. This change in thinking seemed to occur in response to the lived experience of connection through shared emotion in the group.

Since Lockdown during the Covid-19 pandemic, we have all re-evaluated the importance of connection and there has been a flurry of interest in this topic (Cosco, 2022; Konrad et al., 2022; Pierce et al., 2020; Simpson et al., 2022). Many participants in this study identified that being with other people who experienced similar difficulties was something they valued and that connecting with other people was a positive experience.

3:1 Recognising my own needs

For all participants, the experience of connection in the group led to an increased awareness of their own emotional needs. Emotional validation which was initially modelled by group facilitators began to spread and by the end of the group many participants were validating each other's emotional experiences and looking for opportunities to get their emotional needs met in their wider relationships.

Susan talked about wanting to extend connection with people in the group. In this excerpt she recognizes the value of being able to share her emotional experiences and receive a validating response. Having completed the emotional skills group she is able to recognise that rather than disconnect from other people ('*I'm a bit agoraphobic'*) she would like to be more connected to other group members by meeting in person rather than online:

'*Going forward though, you know there are some people who may share certain ideas that may help, you know, is that still a no go or can people stay in touch?... If somebody who's had a particularly difficult week, or somebody who's said something that really resonates with you, you can talk to them afterwards and go 'you know, it's really interesting that you said that I've had a similar experience. You know, would you be interested in sharing going forward? Your brain works completely differently than mine and I'm really intrigued by that. I'd love to, you know, touch base with you occasionally'. Can't do that online. There's that personal element where you can't even go up to someone afterwards and say,' do you know what, thanks for sharing – I'm sorry you got upset. I really understand where you are coming from and you are absolutely justified in feeling the way that you feel', you know validating someone. Up close and personal, patting them on the back. It's significantly better than on-screen'. (Susan)*

Clare shows how she has developed insight into her own emotional needs and a greater awareness of the emotions she feels since attending the emotional skills group:

'I compare it to my dad, for example, his temper, he's got a really bad temper and he just doesn't know how to deal with any of those sorts of emotions. And like back when I was

growing up, I thought that was just the norm, because why would I think any different? And that's probably what's failed me in relationships in the past because I've never known how to deal with things'.

Jane identified that there were some aspects of the group experience that didn't meet her needs, for example when one of the other participants was too dominant:

'There were a couple of things that I do want to point out. A group like that and the way it's led is obviously trying to be inclusive and supportive. But there was one person in particular who I found quite offensive and felt he needed a bit of a talking to because he was rude and it impacted the group. And it needed to be dealt with separately. There needed to be something separate, because then towards the end, I think he just started not coming and there was no sense of - Has someone spoken to him? Is he OK? He's got a lot of issues going on and I thought that wasn't handled very well. So, there were things about my feelings about the group that were quite distinct and strong'. (Jane)

Jane's reaction to this echoes her earlier comment where she talks about having a *'Spidey sense'* that alerts her to any dissonance between what is said or acted on and what she feels. Bringing this into conscious thought allows her to become aware of her emotional needs, her values and what she would like from the group facilitators.

Liz considered the way in which the slight disconnect that occurs when working online had helped her to get her emotional needs met without triggering an over-compassionate response towards others in the group. Wanting to look after other people and fix their problems was a pattern that many participants struggled to manage. By resisting this Liz acknowledges that she is more likely to get her own needs met:

'I think sort of maybe if we have been in person people might have formed closer relationships within the group, which can be a good thing in some ways and a bad thing in other ways. I think people may have sort of opened up a bit more and stuff like that and might have found it easier to talk about things more if they had closer relationships or face-to-face. Well, probably because of the people in the group, because they have

problems with their emotions, it might have been that we got too involved with each other and end up taking things on that probably wouldn't have been good for our mental health'. (Liz)

Some participants found it very difficult to recognise their emotional needs which may be indicative of the lack of attachment and care experienced early on in life (Bowlby, 1988). Being cared for, having their emotional needs met and distress validated was perhaps not something they had experienced.

3: 2 Growth and change

This sub-theme picks up on the way that participants began to increase not only their tolerance of emotions but their emotional awareness. Very much in the way that psychodynamic theory sets out the importance of making the unconscious, conscious (Freud, 1915 cited in Akhtar, 2020) participants talk about the way that attending the group enabled them to become more consciously aware of their emotion. This awareness gave them a sense of understanding and control which in turn allowed them to make behavioural and psychological changes.

Lisa observed that everyone attending the group appeared to show some signs of improvement irrespective of their different diagnoses and her experience supports findings from another recent study looking at transdiagnostic applications of DBT (Childs-Fegredo & Fellin, 2018).

'I found it really useful to hear from other people who were experiencing the same kind of symptoms as me, because I don't know anyone in my day-to-day life who experiences similarities. I know some depressed people, but I don't know anyone who can't regulate their mood. That was comforting and that helped my initial worries (about not having BPD so will this be applicable?) It was helpful to hear that whatever their issues were, we were all really similar in what we were struggling with, and really, really helpful to hear how they benefitted from trying out each skill week by week. It was pretty evident by the end of the course how much better quite a few people had got so that was nice'. (Lisa)

Sandra commented *'emotions are very much in charge of you. But just knowing that there's actually a system to get back in control. It was very empowering talking about that'.* She seems to have moved from feeling out of control at the start of the emotional skills group to feeling in control at the end of it. That this has a powerful impact, chimes with Brene Brown's idea that addressing 'feeling trapped, powerless, and isolated' is central to connection (Brown, 2006).

Liz noticed that she is responding to people differently at work since completing the emotional skills group, she is more confident about boundary management:

'I have noticed a change in myself because previously I was working with mental health services and I've had people open up to me about things and I found it very difficult to switch off from that in the past. But now I find that I've got better with that sort of. I've passed whatever they've said on to the relevant people and things like that and I'm not thinking about it so much after appointments'.

Ben observed a change in his emotional responses, '*now I look back I feel a lot more calm'.*

Mike explained that the psycho-education element of the group was helpful for him because the group provided him with information that he had never come across before. Interpersonal skills training and the idea of balancing extremes (sharing too much versus sharing too little) was helpful because extremes at either end of the continuum are likely to result in other people wanting to disconnect from you (Linehan, 2015) which then impacts on identity (eg. other's don't want to be with me '*because I'm not such a great person'*).

'It was difficult…. because I didn't know about oversharing and stuff like this before, so the one thing about it is that it is a lesson in trying to find the right thing to talk about. Which I don't think anyone ever tells you to do before. It's like you are just quirky or you've just, you know, got to be yourself and it's like people forget that actually. There's a lot of things that go through your mind and you shouldn't just say everything that you want to. So, in that way, that was very helpful'. (Mike)

Lesley's reflection on completing the group suggested that even for participants who struggled to engage with the content at times there was some helpful change:

'Well I'm taking my meds. The main thing for me is the slowing down, the stopping, I never used to be very good at self-care but I am a little better since the group. My food, I was anorexic in the past. My food groups, I try but I'm fairly anorexic. I eat enough, just. So my diet is good, I'm just not eating much of it. The sleeping. I'm better than I was before the group. I'm up more. Before I was in bed a lot. I use catastrophising a lot, I use STOP a lot, I do my knitting, I do my mindful piano playing, I need to get more active though'. (Lesley)

Mike showed change in the way that he was thinking about his emotional responses although he also made the point that this was a work in progress:

'Yeah, it's quite confusing though I think but it has definitely meant that I do try and use more of a rational against emotional mind. Not always very good at it but it is there and it was something that was needed. And you know…. something that I didn't go over which was the validation. When talking, I find that quite difficult. I may have ADHD, I don't know. Umm. And so it's quite difficult and I've been told that like, I don't really validate as much as I could and I think I missed that lesson and so like I am trying to do that all the time and it is quite useful to do all day every day. I do use it [the skills] *like with my boundaries and try and set up the way that I want to be with others. But I feel like I need to go over it again for sure'. (Mike)*

This sub-theme reveals a virtuous cycle whereby increased awareness and increased tolerance of emotions promotes a sense that ideas from DBT might be helpful, which in turn makes it more likely that participants will attempt to be more consciously aware of their emotions and more willing to tolerate them.

3:3 Feeling more connected

Feeling alone combined with a longing for connection is a common feature of BPD Although the emotional skills group in Talking Therapies (American Psychiatric Association, 2013) was designed for people with a range of different mild-to-moderate mental health problems, loneliness may be much more widely experienced in the general population. Indeed, recent research suggests that feeling alone is very common since the Covid-19 pandemic (Dettmann et al., 2022; Hornstein & Eisenberger, 2022; Mindel et al., 2022; Parent et al., 2021; Pierce et al., 2020; Simpson et al., 2022; Vinnakota et al., 2021). This sub-theme looks at what the data reveals about the way in which participants experienced connection with others during the group and how this impacted on their sense of self and their wider relationships.

When Clare reflected back on the way she felt at the start of the group, '*I wouldn't say looking forward to it because I kind of dread any kind of social interaction anyway'*, it provided a stark contrast with what she said about the group once it ended:

'I miss it. Right now, I wish I could go back and talk to them again because it's just nice having that weekly thing where you know you can talk to somebody but what I have done more recently is join another group in a town close to where I live. So, I go to that. It's very small, like mums and kids that have been referred so they are all trained family workers and there to help. So that was good. And now another lady, who I think does a session where it's just mums and no kids. But I'm not sure I'll be able to do that, but I'll try but yeah, I feel like I need something because I don't have a lot of close friends and I'm very, you know, solitary bird. So, it's nice to have it. I like being able to talk to people, but I often have that shut off'. (Clare)

Although Clare says that she had always been someone who avoided social situations, when the emotional skills group ended, she missed the feeling of connection with other people that she had experienced. As a result, she sought out other ways to feel more connected. Clare seems to be showing an important change in her behaviour after attending the emotional skills group by seeking out connection with other people rather than avoiding connection. This connection-seeking behaviour has the potential to reduce feelings of loneliness and disconnection. There is good evidence to show that increased social relationships are protective in terms of increased resilience during a mental health crisis (Conversano et al., 2020; Li & Nishikawa, 2012; Magson et al., 2021).

Liz said that being in the group was overall a helpful experience. What she is talking about in this example is how much she values the process of bringing awareness to the surface, becoming conscious of her emotions and being able to understand them in context.

'Well it was all helpful. So, there's a lot of things that this group brought up that I sort of didn't realise. I learned a lot about myself during the course about why I might be doing particular things and how to sort of manage that. Having greater understanding of why I do things - I found that really helpful. I can't think of anything off the top of my head that wasn't particularly helpful. I found it all interesting'. (Liz)

Liz's comments provide a good example of the idea that Brene Brown (Brown, 2006) discusses when she talks about developing critical awareness and how this helps us to express emotions, connect with ourselves and connect with others. The importance of developing critical awareness is a psychodynamic idea that is discussed in the literature around object relations and transference focused therapy (Greenberg & Mitchell, 1983; Kernberg, 1984).

'I feel I've got sort of a greater understanding of my emotions and myself in general and I can solve or sort of spot behaviours when they're coming. And then take steps to do something so they don't get so overwhelming and things like that…. Before when I was feeling anxious about things, I used to sort of run away from them. But now I'm sort of confronting them. So doing the opposite of what the thought is telling me to do'. (Liz)

Her smile when discussing this change was very noticeable. It implied a change in the way that Liz was viewing herself, from someone who was failing or *'not a great person'* to someone who is able to confront their own emotions, understand them, tolerate them and act on them in a more helpful way. There seems to be a positive shift in identity here that corresponds with Liz's improved ability to connect with her emotions and her ability post group to confront situations rather than avoid them. To a greater or lesser extent this experience was shared by other participants. This sub-theme reveals the impact that moving towards connection is already having on participants, even after such a short time in the group (12 weeks).

Discussion

This research posed the question how do clients experience online emotional skills groups in a Talking Therapies service? The main aim of this study was to explore individual experiences to discover new knowledge that may be of help to people who find it difficult to manage intense and unstable emotions. Allowing the voice of the individual to be heard is perhaps of particular importance when it comes to this group of people who tend to experience a high level of invalidation and have frequently not been listened to. In addition, it could be argued that within Talking Therapies, with its emphasis on 'evidence-based practice' there needs to be more practice-based evidence to balance the way that we are valuing different types of knowledge. There is a political argument around the power differential between qualitative and quantitative research and how it is used to shape services (Karnieli-Miller et al., 2009) which makes it even more important to ensure the voice of the individual doesn't get lost.

Cacioppo's evolutionary theory (Cacioppo et al., 2014) proposed that loneliness is adaptive and that the uncomfortable emotion we feel when socially isolated motivates us to stay in groups which increases our chance of survival. In a recent study (Eres et al., 2021) found that difficulties with emotional regulation were 'uniquely associated with loneliness' and loneliness was found to be associated with poor mental health. Subsequent research supports this (Hayes et al., 2022; Laslo-Roth et al., 2023; Preece et al., 2021; Tan et al., 2022) but loneliness is a complex construct and the link between loneliness and emotional regulation is not well understood.

Hayes et al. (Hayes et al., 2022) identify a gap in the literature when it comes to understanding the intersection between emotion regulation, social identity and loneliness. They highlight two different models: the emotion primary model (Dingle et al., 2013) which proposes that adaptive emotion regulation is the foundation for social connection and important for improving social relationships; and the social primary model which proposes that groups and social identities provide access to a range of psychological and emotional resources (Haslam et al., 2019). Hayes et al. (Hayes et al., 2022) conclude that there is growing support for both models and some evidence to suggest that there may be a bidirectional relationship between the two.

Validation, empathy, safety, and emotional warmth were all seen as important and highly valued by group participants. Sharing emotional experiences was experienced as difficult but helpful and participants talked about moving away from feelings of isolation and loneliness towards a desire to connect with other people. Key findings are discussed within the context of the wider literature base followed by a consideration of the implications for counselling psychology and a discussion about the limitations of this study and recommendations for future research.

Key Findings

Participants found the emotional skills group to be a positive experience, and this is in line with findings from other studies looking at adaptations of DBT and can be seen to meet one of the secondary aims of this research project by contributing to the growing body of knowledge about adaptations of DBT (Ben-Porath et al., 2020; Childs-Fegredo & Fellin, 2018; Dimeff et al., 2021; Koerner et al., 2021; Moore et al., 2022b). The emotional skills groups were generally experienced as more helpful than CBT '*which was a bit more like blanking'* although some participants reflected that it was helpful to have completed individual therapy before attending the emotional skills group because it enabled them to talk about aspects of their life that would not be appropriate to share in a group setting. Given the central organizing concept, 'My journey from disconnection towards connection', it seems to make sense to discuss findings by reflecting on the changes participants made along the timeline of their experience:

Pre-group

As indicated by Theme 1 'Finding life hard',when participants reflected on their experience before starting a group they described feeling alone, chronically stuck in rigid patterns of thinking and relating to other people, and talked about using disconnection to cope with this. Disconnection as a coping strategy reduces emotion in the short term but maintains the belief that emotion is something to be feared (Linehan, 1993). The result of this seemed to be an avoidance of any unfamiliar contact with people, an avoidance of relationships unless they were clearly delineated with prescribed rules and ultimately a '*dread* (of) *any kind of social interaction'*. There is then potential for this lack of social interaction to be misinterpreted as *'I'm on my own'* because *'I'm not too great a person'*. Participants talked about struggling with over-focusing on the self, not in any positive way but to mitigate this sense of self-loathing, isolation, and rejection. This is important because social interaction has been found to be a protective factor in maintaining good physical and mental health (Cacioppo et al., 2015; Gabarrell-Pascuet et al., 2023; Keller et al., 2023; Lim et al., 2016; Sirois & Owens, 2023; Steptoe, 2023).

Attachment theory is often used as a framework for thinking about the development of identity (Bowlby, 1988; Kerpelman & Pittman, 2018)). Bowlby argued that children whose needs are not met by their caregivers in a consistent and sensitive manner grow up with a lack of trust towards others and tend to be sensitive to rejection. There are many studies that provide evidence to support the idea that anxious attachment early in life is a predictor of poor self-esteem (Bartholomew & Horowitz, 1991; Brennan & Bosson, 1998; Brennan & Morris, 1997; Kerpelman & Pittman, 2018; set, 2019; Wu, 2009). The data from this study seems to support earlier findings.

There is some evidence that DBT can help to reduce shame (Rizvi & Linehan, 2005). The early pilot study by Rizvi and Linehan (2005) had some limitations: participants attended individual therapy as well as DBT skills training which made it more difficult to isolate what was impacting on shame reduction; and participant numbers were very small (only 5). A more recent study comparing a 16-week transdiagnostic DBT skills group with an activities group found that both groups reduced shame (Neacsiu et al., 2014). The authors comment that more research is needed if we want to understand precisely what mechanisms are involved in reducing shame.

In her article on Shame Resilience Theory (Brown, 2006), Brene Brown discusses the importance of building shame resilience into psychoeducational groupwork. Brown defines shame as 'an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging'. She suggests that this occurs at the intersection of three concepts 'feeling trapped, powerless, and isolated'. These are concepts that are prominent in the data when participants talk about their experience of life before the emotional skills group.

Participants talked about their developmental experiences and described relationships where they did not feel safe and parents who could be angry and unpredictable. They described a sense of ‘finding life hard’ and talked about experiencing an ’overwhelming [sense of] desperation and chaos’, whilst feeling alone and unsupported. For some this led to the conclusion that they were *‘not too great a person’*. Theme 1 and associated sub-themes highlight data that suggests people who experience disconnection early in life through poor attachment relationships, take this pattern of disconnection with them into adult life (Flett et al., 2002; Mikulincer, 1995). The idea that social and emotional disconnection is a risk factor for poor mental and physical health is well established (House, 2001; Klussman et al., 2021; Parent et al., 2021). Moreover, Klussman et al. (Klussman et al., 2020) found that not only was increased connection to others associated with better mental health but increased self-connection improved life satisfaction. Findings from this research project support this.

The way that participants described their experience of being oversensitive, overwhelmed by their emotions, and taking a long time to calm down once they experience intense emotion, all seems very much in line with Linehan’s Bio-social model (Jones et al., 2023; Reddy & Vijay, 2017). Therefore, to all intents and purposes the bio-social model was experienced by participants as a good fit with their internal world and provided them with an explanation that made sense.

Mid-group

There is a growing interest in the use of different theories, frameworks, and models used in psychotherapy to gain insight into the mechanisms that need to change for treatment to be successful. This often leaves clinicians with considerable difficulty deciding what works and for whom. Wampold (Wampold, 2015; Wampold & Imel, 2015) argues for a transdiagnostic approach to psychotherapy that takes account of common factors between these different models. His paper (Wampold, 2015 p. 270) identifies areas of importance that are common to all psychotherapy: that the model used makes sense to the client and provides a believable explanation of their difficulty; that there is a genuine relationship between therapist and client that provides a 'human connection with an empathic and caring individual' (or in other words a secure attachment relationship); and a sense of optimism or expectation that the treatment will be helpful.

The data from participants in this study seems to support these ideas and shows how all four of the common factors (Wampold, 2015; Wampold & Imel, 2015) can be found by the mid-stage of the group. For example, if you look at the subthemes from the data under theme 2, the first subtheme *'Maybe this group will make a difference'* shows an emerging sense of optimism. Then subthemes *'Trust and safety' and 'Belonging: this group feels like family'* indicate the way in which participants start to experience a more secure attachment relationship within the group, and the final subtheme *'Learning and understanding'* discusses how the model used (DBT) is beginning to make sense to the participant.

The therapeutic relationship is equally important to groupwork as it is to individual therapy (Alldredge et al., 2021) and has been shown to have a consistently positive effect on outcomes irrespective of the therapeutic model (Bedics et al., 2012; Lo Coco et al., 2022). Findings from this research show how powerful it was for participants to experience feeling safe and supported in their relationship with the group facilitators as well as with other group members. Given the strong association between therapeutic alliance and outcomes it is important for group facilitators to repair ruptures as they occur. However, there may be other factors that impact on outcomes, for example the recent study looking at pain management groups by Alldredge et al. (Alldredge et al., 2023) who found that the gender composition of groups had an effect. Outcomes for female only pain management groups were better than those for mixed groups. It is possible that in female only groups, participants felt an increased sense of safety and as a result were able to show more empathy and honesty, something that could increase alliance and improve validation within the group.

Post-group

Maslow's hierarchy of needs (Maslow et al., 1987) sets out a model that highlights the importance of love and connection. Social interactions and how important they are for us has been a topic that many researchers have been interested in exploring. More recently the impact of Covid-19 and the way that this period of imposed social disconnection may have impacted on our mental Covid-19 provided us with a unique environment to study the relationship between connection with others, health, and psychological resilience (Dettmann et al., 2022; Holt-Lunstad, 2022, 2023; Khan et al., 2023; Nitschke et al., 2021).

The central organising concept '*My journey from disconnection towards connection'* captures the personal change that took place as participants worked through the emotional skills group. As they began to feel more able to connect with their emotions and with other people in the group, this seemed to impact on their wider social systems. Participants talked about being more able to cope with complex social interactions and repair ruptures in relationships. Taking part in the group seemed to give participants a new set of skills, they acquired a language which meant they could articulate things they would not have been able to before the group.

The group environment where participants were supported to connect with their own emotions in an emotionally charged social setting seemed to reduce shame. Consequently, they were able to *'Re-evaluate the importance of connection'* and learn that they felt better when they connected with themselves and with others rather than using avoidance or disconnection. This created a virtuous cycle where improved self-connection and increased self-compassion created a safe space where they could recognise their own emotional needs. An increase in their ability to tolerate connection with others tended to improve the likelihood of getting their emotional needs met, whilst feeling cared for and more connected promoted an improved sense of self and reduced shame and this in turn made it easier to connect with others. This is in line with findings from research looking at the link between shame, social connection, and social anxiety (Oren-Yagoda et al., 2022; Swee et al., 2021) and finds support for the idea that emotional skills groups can reduce self-stigma and shame (Smith et al., 2023; Stynes et al., 2022).

Online delivery

Most participants agreed that there were advantages and disadvantages to meeting as a group online. What was perhaps surprising was the ease with which they all managed the technical aspect of online groups, and they reported very little difficulty connecting to Microsoft Teams. For some participants the online nature of the group provided them with the ability to fine tune their level of engagement. Participants talked about how helpful it felt to be able to adjust their level of emotional arousal by switching off the camera or the microphone, something that would not be possible in a face-to-face setting. Having the ability to control this was also commented on and valued in the context of pre-group experiences where emotion often felt overwhelming and out of control.

A scoping review looking at online delivery of DBT since Covid-19 (Lakeman, King et al., 2022) found that although there was limited research available that looks at how the main elements of DBT are taught in an online environment, of the studies looked at programmes tended to be very similar to those delivered face-to-face. This was certainly the case within Talking Therapies. Results from Lakeman et al. suggest that not only is online adaptation of DBT feasible, but it may be more accessible and more acceptable. Indeed, in this review attendance was found to be higher for online groups than for face-to-face. The authors point out that their results need to be interpreted with caution given that there are no large-scale trials that compare face-to-face DBT with online. However, they are very much in line with this study which also found that many participants experienced the group as more accessible and more acceptable because it was online.

Lakeman et al. (Lakeman, Hurley et al., 2022) completed a qualitative study looking at therapist experiences of delivering DBT online and observed that both the therapists and group members needed some additional training and support to work online successfully. They pointed out that the confidence and competence of therapists to deliver online groups varied considerably. By contrast, this study looking at client experiences of emotional skills groups found both clients and participants to have very little technical difficulty. It is possible that this reflects the young age of many therapists in Talking Therapies services (NHS England, 2015), however participants in the study by Lakeman et al. were also young (aged between 23-49). Research on age and technology resistance reveals a mixed picture and there seems no clear support for the idea that young people are better than older people at using technology (Hauk et al., 2018).

Participants in this study experienced the way that group facilitators set up managing the online nature of the group as a dialectic very helpful. Being online enabled them to practise switching the camera off when they felt overwhelmed with intense emotion whilst at the same time trying to stay as present as possible and connect with the group and remain on camera. This flexible approach provided a non-threatening environment in which they could learn to increase their connection with emotion. The most important aspect of the emotional skills group, the ability to learn to tolerate emotion rather than avoid it, did not seem to be diminished by online delivery. At this point in time there seems very little research comparing online adaptations of DBT with face-to-face groups. Existing studies look at feasibility and accessibility rather than a comparison between methods of delivery in relation to outcomes (van Leeuwen et al., 2021; Walton et al., 2023).

Writing from within the culture of the Talking Therapies system.

It has been argued that the Talking Therapies culture is influenced by one research paradigm only (Williams, 2015). Promoted as an evidence-based service that is effective both clinically and economically (NHS England, 2023), Talking Therapies is both praised (Clark et al., 2018) and criticised for its use of numerical outcome data as ‘recovery’ truth (Williams, 2015). Incorporating a wider view could improve the way in which services are shaped and evaluated. This study, written from within the culture of NHS Talking Therapies, acknowledges the positivist lens whilst simultaneously attempting to step outside it, reflect on it and think more deeply about client experiences. The emphasis in this research has been to highlight the language used by participants to generate a rich and complex narrative and gain a deeper understanding of the lived experiences of people who participated in emotional skills groups. In choosing to write from within the culture of Talking Therapies, this research can achieve one of the secondary aims of this research: to ensure that client experiences influence service development.

One of the Key Performance Indicators used to evaluate NHS Talking Therapies services is the recovery rate. This has been operationally defined as someone who moves from 'caseness' at pre-treatment to 'below-caseness' at post treatment as indicated by specific symptom measures for depression and anxiety (Goddard et al., 2015). BPD tends to have a high co-morbidity with other mental health conditions which means that people with significant difficulties with emotional regulation, impulsivity, instability of identity and relational problems often refer into Talking Therapies requesting treatment for anxiety and/or depression. In a study by Hepgul et al. (Hepgul et al., 2016) it was found that 67% of this Talking Therapies population sample reported at least one form of childhood trauma, 16% met criteria for borderline personality disorder and 69% were at high risk of personality disorder. These findings suggest that there are many people who present to Talking Therapies who have complex underlying issues which mean standard Talking Therapies treatments are unlikely to be effective. From a service perspective, the high numbers involved are likely to skew the outcome data in terms of the number of people who will reach 'below-caseness'. Therefore, being able to offer emotional skills groups is not only clinically more helpful but may have a beneficial impact on service evaluation.

Limitations and considerations for future research

Limitations

The choice of purposive sampling reflects the intentional choice of the researcher to provide a sample that is representative of what is being studied. Future research might want to broaden this and include interviews with clients who stopped attending their group to understand more about what was difficult for them or felt unhelpful.

There was a lack of diversity in the study sample. To some extent this reflects the population in rural Somerset and not necessarily a limitation, but it might be worth thinking about how emotional skills groups in the future could be set up to reach a more diverse, multicultural audience and address their needs.

Braun and Clark state that 'RTA can be 'softly' generalisable' in that findings from a study can have relevance beyond the context in which it is studied. However, they go on to explain that the sample size and resulting lack of statistical generalisation in RTA should not be framed as a limitation but instead it can be seen to be more theoretically consistent with the philosophical assumptions that underpin this approach (Braun & Clarke, 2022c). Therefore, although the sample for this study was small, it could be argued that this was not a limitation.

Strengths

The use of RTA as a method of analysis was appropriate, and reflexivity was used to acknowledge the impact of the researcher's experience and beliefs on the analysis of the data (Johnson et al., 2020). This research incorporates a high level of reflexivity which aligns well with RTA and provides a depth and a willingness to engage with the complexity of the data. The qualitative design has facilitated important insights into the beliefs, thoughts, and attitudes of participants about their experience of emotional skills groups that would not be evident from the quantitative outcome measures data that is routinely gathered in Talking Therapies evaluations.

Future research

Participants varied in the changes they made, but in general terms attending the emotional skills group can be seen to create a virtuous cycle, a chain of positive events in which one desirable change promotes another resulting in an ongoing cycle of improvement. It would be interesting to discover more about whether the improved sense of trust that participants developed in themselves, a sense that they could cope with adversity, could be sustained over time. Further research into this area would help to justify any cost associated with training and supporting therapists to deliver online emotional skills groups within Talking Therapies.

There is a gap in the literature when it comes to comparing online adaptations of DBT with face-to-face groups (van Leeuwen et al., 2021; Walton et al., 2023). Research that looks at client experiences and outcomes is important given that it is likely many groups will continue to be delivered online in the future. More research into training and support for therapists would also be helpful if we want to develop a better understanding of what is required to improve therapist confidence in delivering these groups online and to understand what makes for a successful therapeutic relationship from both client and therapist perspectives.

Data that fits into the theme 'Trust and safety' suggests that most participants experienced the group as safe enough to be able to discuss their emotional experiences. Online delivery was generally perceived as helpful because it allowed participants to control their exposure to vulnerability. It might have been interesting to include participants who dropped out of groups and explore the extent to which their sense of safety within the group impacted on their disengagement. However, these clients are not always easy to contact.

Research looking at the impact of social disconnection during Covid found that not only did isolation and loneliness have a negative impact on mental health but also that minority ethnic groups were particularly vulnerable (Holt-Lunstad, 2022, 2023; Khan et al., 2023). Participants in this study were not ethnically diverse and reflected the demographics of the area. If emotional skills groups could be targeted to reach minority groups, they might provide a means to reach out to those disproportionately affected during Covid, improve their ability to increase social connection and increase psychological resilience should we experience another pandemic in the future.

However, psychological resilience is complex. Loneliness, vulnerability, attachment, gender and ethnicity are just some of the many factors that intersect to improve our ability to cope with adversity. For some people, an emotional skills group may be particularly helpful, others may prefer faith groups or choose individual therapy. More research is needed to identify what works best for whom.

This research is possibly the first to explore client experiences of online emotional skills groups in adult NHS Talking Therapies. As such it provides a rare insight into these groups. Findings highlight how positive the online group emotional skills experience can be. Given the scarcity of these groups in primary care, the ongoing debate around the adaptation of DBT (Koerner et al., 2021) and the emphasis on using research to inform service decisions about what treatments to offer (NHS England, 2023; NICE, 2023), this study provides new evidence to support the delivery of online emotional skills groups as part of the range of Talking Therapies treatments on offer and enables the client's voice to be heard in shaping service delivery.

Implications for counselling psychology

The growing evidence base in support of transdiagnostic adaptations of DBT (Barrow et al., 2023; Bharmal et al., 2022; Childs-Fegredo & Fellin, 2018; Cludius et al., 2020; Gillespie et al., 2022; Lamph et al., 2019; Malivoire, 2020; Marwaha et al., 2013; Ritschel et al., 2015; Wilks & Ward-Ciesielski, 2020; Wittkamp et al., 2023) as standalone emotional skills groups opens an opportunity to offer this therapeutic experience to a much wider group of people. There may be limited opportunity for counselling psychologists to work directly within Talking Therapies services as group facilitators, but counselling psychologists taking on management roles or moving into research may be able to increase the availability of emotional skills groups being offered within Talking Therapies and other settings.

Findings from this study suggest that counselling psychologists should not shy away from getting involved in the process of running adaptations of DBT in a much wider range of settings. Counselling psychologists have an opportunity to combat the longstanding stigma and discrimination based on the association between DBT and the diagnostic label of BPD. They can influence the culture within the NHS and encourage colleagues to step forward and use adaptations of DBT in their clinical practice.

Final Reflections

Completing this piece of qualitative research has had a powerful impact on my clinical practice. I have observed that learning to take an inductive approach to research and trying not to push my views onto people when I'm interviewing them, in addition to being more aware of reflexivity and how my own ideas might be impacting on data analysis, has translated into a change in my clinical practice. Before I started this project, my approach was heavily influenced by CBT training which promotes making an early decision about which diagnosis specific formulation should be used. I would then lead my client through this, albeit in a collaborative style. Therefore, in the past I would have had my own ideas about the structure and direction of therapy and taken a lead role in the direction of each session. Although I was certainly aware of trying to minimise the power differential, this approach positioned me as the 'expert' (Edwards, 2013; Levitt & Whelton, 2023; Wilmots et al., 2020). More recently, I have noticed a shift away from the medical model towards using a bio-psycho-social model as the starting point for my clinical work (Boyle & Johnstone, 2020).

The process of engaging in research has taught me to allow more space for people to explore their own experiences and come to their own conclusions. This change in my clinical style means that the power balance is more equal (Fitzgibbon & Winter, 2023). I allow more space for reflection, and it feels as if I am working relationally at more depth. The experience of completing a research project and the amount of reading, writing, and reflection involved has been invaluable in shaping who I am personally and who I want to become as a professional counselling psychologist.

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Appendices

Appendix A Patient Information Sheet (PIS)

University of the West of England
BRISTOL

Experiences of attending an emotional skills group: a qualitative study.

Patient Information Sheet

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please read the following information and discuss it with friends and relatives if you wish. Ask us if anything is not clear or if you would like more information. Contact details are on page 3.

What is the purpose of the study?

The purpose is to understand clients' experiences of attending an emotional skills group with Somerset NHS Talking Therapies. We are interested in hearing what happened from when you had your first discussion about the group until you completed it. This will help us to understand more about how these groups are experienced and whether there are ways to improve them.

Why have I been chosen?

You have been invited to take part because you have completed an emotional skills group within the last 6 months. We are inviting 8-12 clients to take part from several different groups that have been run online across Somerset.

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

You will be invited to take part in a video or telephone interview. You will be asked about your experiences of the emotional skills group by a post graduate research student Emma Bonnin who is also a member of the clinical team. Video interviews will be audio-recorded and typed up. Everything that you say will be confidential. The interview will last for around one hour.

Do I have to take part?

No, taking part is voluntary. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form and given a copy to keep. If you take part you are still free to withdraw at any time, and provided the research has not been written up your data will not be included in the study. If you decide not to take part you do not have to give a reason, nobody will be upset and the care you receive will not be affected.

What are the possible risks of taking part?

We do not anticipate any risk or discomfort in discussing your experiences of attending the emotional skills group. However, if the interview makes you feel particularly worried about your experience in the group, the researcher will arrange for you to see a therapist from Somerset Talking Therapies for additional support. There is a risk to participants that confidentiality may have to be broken if they disclose information that suggests risk to them or to others.

What are the possible benefits of taking part?

We do not anticipate any direct benefits of taking part, but the information we get from the study will help to improve our understanding of client experiences which might influence health service practices.

What are my responsibilities?

We would be grateful if you could attend an online or phone interview if you agree to take part. We would also like you to complete a brief demographic questionnaire before the interview.

How will we use information about you?

We will need to use information from you and your medical records for this research project. This information will include your NHS number, name and contact details. People will use this information to do the research or check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure. Once we have finished the study we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What data will be collected and who will it be shared with?
This study will collect data about your experience in the Emotional skills group run by Somerset NHS Foundation Trust Talking Therapies (IAPT) service. You will be asked about the referral process, your expectations of the treatment, how you felt when attending the group, what was helpful/unhelpful and your reflections after completing the group. This data (anonymised) will be shared with the study team and other members of UWE teaching staff.

Will my taking part in this study be kept confidential?
Yes. When the interview is typed up it will be made anonymous because we will take out all names of people and places. Our reports will not contain the names of people or places. The audio-recordings will be deleted as soon as we have typed up the interview. Some direct quotes (anonymised) may be published in academic journals and reports.

What are my choices about how my information is used?
You can stop being part of the study at any time, without giving a reason, but once the research paper has been written up we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won’t be able to let you see or change the data we hold about you.

What will happen to my data if I lose capacity to consent?
If you lose consent during the study all identifiable data would be withdrawn. Data which is not identifiable to the research team may be retained.

What will happen to my data once the study is completed?

Participant data (anonymised) will be used to produce a doctoral thesis. An electronic copy of this will be retained by the University of the West of England in their library. Encrypted recordings of interviews and electronic copies of participant data stored on NHS encrypted laptop will be deleted once the study has been written up.

What will happen to the results of the research study?

The findings will be reported in a post graduate dissertation stored at the University of the West of England and may also be shared via professional publications, journals and conferences. Findings will include direct quotes from the interviews but these will be anonymised. In addition, a summary of the results will be sent to everyone who takes part in the study.

Who is funding the study and who has reviewed the research?

This research study is part of a taught doctorate programme in Counselling Psychology at the University of the West of England. It has been approved by the Health Research Authority (REC reference: 22/PR/0030 ; project ID IRAS 307917) and the University of the West of England (UWE) ethics committee.

What do I do now?

If you are interested in taking part in an interview, please complete and return the email form or post back the reply slip in the reply-paid envelope. The researcher will then contact you with further information.

Where can you find out more about how your information is used?

You can find out more about how we use your information by either writing or sending an email to:

Central study contact details:

Study Team:

Postgraduate Research Student (UWE Bristol)
Associate Professor in Rheumatology and Self-Management, UWE
Senior Lecturer in Counselling Psychology, UWE

If you have any concerns about participating in this study and would like to receive free independent advice please contact PALS (Patient Advice and Liaison Service) on pals@somersetft.nhs.uk or 01823343536.

Appendix B Emotional Skills NHS Patient Information Leaflet

INTRODUCTION TO EMOTIONAL REGULATION SKILLS COURSE

This course may be for you if:

- You often feel overwhelmed by your emotions
- You often feel intensely frustrated, or anxious, or low, or a mixture of all three
- Your emotions seem too painful to cope with
- Your feelings get in the way when you're interacting with other people
- You struggle with assertiveness

If you would like to find ways of managing your feelings rather than fighting them then the Emotion Regulation group/course may be of use to you.

12 weekly sessions

The focus is on learning new skills, not talking about past events or painful times.

Just like learning any new skill it involves a willingness to try out new approaches and a readiness to practise them at home between the sessions.

The course covers;

- naming and understanding different emotions
- responding to emotions differently
- increasing more positive emotions

- Mindfulness: which helps you to calm physiological symptoms and move the focus of your attention away from your emotional thoughts
- assertiveness skills

Session structure
Each session is in 2 parts:
50 minutes: feedback from skills practice
10 Minute tea/coffee break
60 minutes: skills training and preparation for practice at home.

Appendix C Health Research Authority (HRA) ethical approval letter

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email:
approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

17 February 2022

Dear

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	Emotional skills groups: a qualitative study exploring client experiences of online group work in an Improving Access to Psychological Therapies Service.
IRAS project ID:	307917
Protocol number:	N/A
REC reference:	22/PR/0030
Sponsor	University of the West of England (UWE), Bristol

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 307917. Please quote this on all correspondence.

Yours sincerely,
Approvals
Specialist
Email: approvals@hra.nhs.uk

Cc DOS

Appendix D Health and Applied Sciences (HAS) ethical approval letter

UWE Bristol University of the West of England

Faculty of Health & Applied
Sciences Glenside Campus
Blackberry Hill
Stapleton
Bristol   BS16 1DD

Tel:

Our ref:
JW/lt 15th
March
2022

Dear

Application Number: HAS.22.03.083
Application title: Emotional skills groups: a qualitative study exploring client experiences of online group work in an Improving Access to Psychological Therapies Service
REC reference:
22/PR/0030 IRAS
project ID: 307917

Your NHS ethics application and approval conditions have been considered by the Faculty Research Ethics Committee on behalf of the University. It has been given ethical approval to proceed with the following conditions:

- You comply with the conditions of the NHS ethics approval.
- You notify the Faculty Research Ethics Committee of any further correspondence

with the NHS Ethics Committee.

- You must notify the Faculty Research Ethics Committee in advance if you wish to make any significant amendments to the original application.
- If you have to terminate your research before completion, please inform the Faculty Research Ethics Committee within 14 days, indicating the reasons.
- Please notify the Faculty Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.
- Any changes to the study protocol, which have an ethical dimension, will need to be approved by the Faculty Research Ethics Committee. You should send details of any such amendments to the committee with an explanation of the reason for the proposed changes. Any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee.
- Please note that the Research Ethics Sub-Committee (RESC) is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the RESC and its committees.

Please note that your study should not commence at any NHS site until you have obtained final management approval from the R&D department for the relevant NHS care organisation. A copy of the approval letter(s) must be forwarded to Leigh Taylor in line with Research Governance requirements Please note that despite the easing of lockdown in England and across the devolved nations, you must continue to follow guidance as set by the UK Government and the relevant devolved administrations. If you have any questions about how this may affect starting your research project or for further information, please contact res.admin@uwe.ac.uk.

In the UK, face-to-face research and fieldwork can be undertaken but there should still be consideration of whether the activities could be delivered in an alternative way. There must still be appropriate mitigations related to Covid-19 risks included within risk assessments, including account taken of requirements from stakeholders.

From Tuesday 1 March, the moratorium on UWE Bristol international travel has been lifted and travellers are now able to request permission to travel through a new online approval process. All applications for international travel must follow the new process with bookings to be made in liaison with the Finance Services team through the University's designated travel management company.
Please see the guidance at https://intranet.uwe.ac.uk/tasks-guides/Guide/travelling-on-university- business.

Please ensure that before proceeding with your research:

- you have sought contractual advice from the UWE Contracts Team xxx if your research involves external funding and/or contracts with partner organisations;
- You have sought advice from the UWE Data Protection Team (dataprotection@uwe.ac.uk) if, in relation to collecting and/or sharing personal data, a third party (i.e. any person or institution extraneous to UWE) is involved in the research project.

The Faculty and Research Ethics Sub-Committees (FRECs and RESC) are here to advise researchers on the ethical conduct of research projects and to approve projects that meet UWE's ethical standards. Please note that we are unable to give advice in relation to legal issues, including health and safety, privacy or data protection (including GDPR) compliance Whilst we will use our best endeavours to identify and notify you of any obvious legal issues that arise in an application, the lead researcher remains responsible for ensuring that the project complies with UWE's policies, and with relevant legislation https://intranet.uwe.ac.uk/whats-happening/sites/gdpr/updates/pages/research-and-gdpr- compliance-update-08-may-2019.aspx. If you need help with legal issues please contact safety@uwe.ac.uk (for Health and Safety advice), data.protection@uwe.ac.uk (for data protection, GDPR and privacy advice).

We wish you well with your research.

Yours sincerely
Chair Faculty Research Ethics Committee c.c. Director of Studies

Appendix E Consent Form

University of the
West of England
BRISTOL

CONSENT FORM

Experiences of attending an emotional skills group: a qualitative study.

Please tick box

I confirm that I have read and understand the information sheet version 3 dated 16/02/2022 for the above study and have had the opportunity to ask questions. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐

I agree to the interview being recorded and understand that names will be removed from the typed transcript. ☐

I agree that some anonymised quotes from the interview will be used in academic journal publications and reports ☐

I understand that relevant sections of my medical records and data collected during the study may be looked at by responsible individuals from the NHS Trust or from regulatory authorities, where it is relevant to my taking part in this research. ☐

I give permission for these individuals to have access to my records ☐

I agree to take part in the above study ☐

Name of Participant	Date	Signature
Researcher	Date	Signature

1 for participant; 1 for researcher

Appendix F Interview Schedule

University of the West of England
BRISTOL

Experiences of attending an emotional skills group:
a qualitative study.

Interview schedule

This interview schedule is a guide to the interview topics. The researcher might also ask additional questions to clarify information following each answer from the client.

Prior to the start of the interview:
Explain the aim of this study: to understand clients' experiences of attending an online emotional skills group. Explain that this research forms part of a doctoral course in counselling psychology at the University of the West of England. The researcher is interested in examining whether there are any ways of improving these groups and in the longer term whether they should remain online or return to face-to-face delivery.

Explain that clinicians will not be told which clients are taking part in the research and participants will not be able to be identified from any findings.

Discussion of how the interview will be audio-recorded, issues of confidentiality and anonymisation, and informed consent, will be carried out.

Request client to complete questionnaire to provide demographic and condition-related information.

Part A: Initial referral to the emotional skills group

- How did a member of the clinical team discuss the possibility of attending the emotional skills group?
- What did you think the group might offer, if anything?
    - How did you react to the idea of being part of an online group?
    - Did you have any concerns about the group before it started?
    - Was there anything you were looking forward to?
- What might have prevented you from attending the group?

Part B: Attending the emotional skills group

- Can you describe how you felt when you attended the group?
- How did you experience the skills teaching?
    - What was your experience of mindfulness during the sessions?
    - What was it like for you talking about using emotional skills?
    - What was it like for you listening to other people in the group talk about their use of emotional skills?
- What was helpful or unhelpful about the sessions?
    - What did you think about the handouts?
    - What was your experience of mindfulness during the group?
- How did you react when someone in the group became upset?
    - How did the group facilitators respond to people if they became upset?
- If you had a difficult session or missed a session, what helped you to come back to the group, if anything?

Part C: Reflections after completing the group

- How do you feel now after completing the emotional skills group?
- Has the group and its treatment affected you in your day-to-day life?
- Were there any advantages or disadvantages to attending online rather than face-to-face?
- How did you experience the online nature of this group?
- What are your views on the care you received whilst participating in this group?

Part D: Close

- Are there any issues that we have not talked about that you would like to raise?
- Thank you very much for your time and valuable contribution to the study.

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West of England

Appendix G Demographic Information

Experiences of attending an emotional skills group: a qualitative study.

You do not have to answer these questions but doing so will help us ensure that this research project takes into account any differences in participant demographics. You are welcome to answer as many or as few questions as you like.”

About you

1. What is your sex?

○ Male
○ Female
○ Prefer to self-describe/Other ____________________

2. What is your age?

○ Under 25
○ 25-44
○ 45-64
○ 65-84
○ 85 years or older

3. Do you have any children aged from 0 to 17 living at home with you, or who you have a regular caring responsibility for?

○ Yes
○ No
○ Prefer not to say

4. Do you look after, or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age?

- ○ Yes
- ○ No
- ○ Prefer not to say

5. Do you consider that you have a disability?

- ○ Yes
- ○ No
- ○ I don't know
- ○ Prefer not to say

6. If yes, how would you describe your disability?

- ○ Sensory
- ○ Learning
- ○ Mental Health
- ○ Physical
- ○ Other ___________________________

7. What is your ethnic background?

White

- ○ White English / Welsh / Scottish / Northern Irish / British
- ○ Irish
- ○ Gypsy or Irish Traveller
- ○ Any other white background

Asian/Asian British

- ○ Indian
- ○ Pakistani
- ○ Bangladeshi
- ○ Chinese
- ○ Any other Asian background

Black/African/Caribbean/Black British

○ African

○ Caribbean

○ Any other Black / African / Caribbean background

Mixed/Multiple ethnic background

○ White and Black Caribbean

○ White and Black African

○ White and Asian

○ Any other Mixed / Multiple ethnic background

Other ethnic group

○ Arab

○ Other: ----------

8. Which of the following best describes how you think of yourself?

○ Heterosexual or Straight

○ Gay or Lesbian

○ Other

○ I would prefer not to say

9. What is your religion?

○ No religion

○ Hindu

○ Sikh

○ Christian

○ Jewish

○ Buddhist

○ Muslim

○ Prefer not to say

○ Any other religion (please specify)

10. Do you consider yourself trans/transgender? (Or is your current gender different from that you were assigned at birth?)

- ○ Yes
- ○ No
- ○ Prefer not to say

Appendix H Example of Coded Transcript

Participant

But I don't know how to put it succinctly. I wanted to be challenged. I didn't want to feel 'yay carry on. Yeah. Yeah, yeah, yeah. Yeah. Get on with it'. Yeah. Yeah, that's what I didn't want.

Commented [AU1]: Expectations of course

Commented [AU2]: Sessions lacking authenticity

Does that make sense?

Researcher

Yes it does.

And how did you react to the idea of it being an online group?

Participant

Brilliantly, well actually, because unfortunately the last two years have been crazy. So I'll be as brief as I can. I used to be an out there go rule the world kind of woman and I moved to this house. I have medical issues. When lockdown happened, I had in the space of one week, three calls from the hospital, two calls from my GP surgery, saying you're at risk. Stay in. Stay in. Stay in. Stay in. And so for two years, I didn't leave the house and I've now become a bit agoraphobic. So when I heard it was an online course and like that, yay. Because I don't get in the car anymore. I don't go out.

Commented [AU3]: Travel

Commented [AU4]: Agoraphobic

Commented [AU5]: Advantages online sessions

Researcher

OK.

Participant

So it was good for me, but not in a great way.

Commented [AU6]: Perceptions group potential

Researcher

Yeah, I get that.

Umm.

And was there anything that you were looking forward to - before the group started?

Participant

Yeah, absolutely. I was looking forward to knowing what the content was. I'm an avid note taker. I've got all my notes here from all the sessions that we had and I really wanted to be getting something out of it. So yeah, I was really interested and really up for it. Hopefully there's new content in there, or even if it's not new content that I've heard of or seen somewhere in the past or something, perhaps they can put a spin on it and make me go. Ah, actually. Do you know what, Yeah, I can do something with that. So yeah, I was really looking forward to it.

Commented [AU7]: Techniques emotional skills

Commented [AU8]: Expectations of course

Commented [AU9]: Own notes

Commented [AU10]: Expectations of course

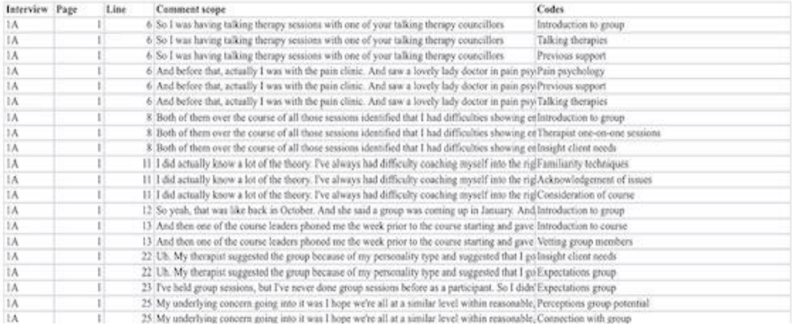
Commented [AU11]: Familiarity with techniques

Commented [AU12]: Techniques emotional skills

Researcher

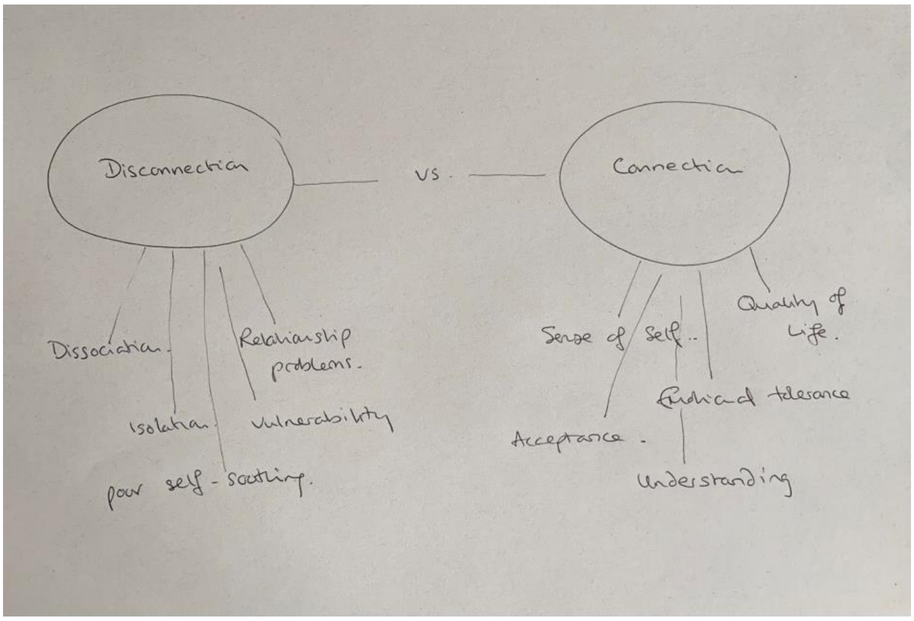
What might have prevented you from attending?

Appendix I Example of Excel Spreadsheet with Codes



Interview	Page	Line	Comment scope	Codes
1A	1	6	So I was having talking therapy sessions with one of your talking therapy councillors	Introduction to group
1A	1	6	So I was having talking therapy sessions with one of your talking therapy councillors	Talking therapies
1A	1	6	So I was having talking therapy sessions with one of your talking therapy councillors	Previous support
1A	1	6	And before that, actually I was with the pain clinic. And saw a lovely lady doctor in pain psy	Pain psychology
1A	1	6	And before that, actually I was with the pain clinic. And saw a lovely lady doctor in pain psy	Previous support
1A	1	6	And before that, actually I was with the pain clinic. And saw a lovely lady doctor in pain psy	Talking therapies
1A	1	8	Both of them over the course of all those sessions identified that I had difficulties showing en	Introduction to group
1A	1	8	Both of them over the course of all those sessions identified that I had difficulties showing en	Therapist one-on-one sessions
1A	1	8	Both of them over the course of all those sessions identified that I had difficulties showing en	Insight client needs
1A	1	11	I did actually know a lot of the theory. I've always had difficulty coaching myself into the rig	Familiarity techniques
1A	1	11	I did actually know a lot of the theory. I've always had difficulty coaching myself into the rig	Acknowledgement of issues
1A	1	11	I did actually know a lot of the theory. I've always had difficulty coaching myself into the rig	Consideration of course
1A	1	12	So yeah, that was like back in October. And she said a group was coming up in January. And	Introduction to group
1A	1	13	And then one of the course leaders phoned me the week prior to the course starting and gave	Introduction to course
1A	1	13	And then one of the course leaders phoned me the week prior to the course starting and gave	Vetting group members
1A	1	22	Uh. My therapist suggested the group because of my personality type and suggested that I go	Insight client needs
1A	1	22	Uh. My therapist suggested the group because of my personality type and suggested that I go	Expectations group
1A	1	23	I've held group sessions, but I've never done group sessions before as a participant. So I didn'	Expectations group
1A	1	25	My underlying concern going into it was I hope we're all at a similar level within reasonable,	Perceptions group potential
1A	1	25	My underlying concern going into it was I hope we're all at a similar level within reasonable,	Connection with group

Appendix J Diagram of Early Themes



Appendix K Journal Length Summary

Emotional Skills Groups: A qualitative study exploring client experiences of online group work in an Improving Access to Psychological Therapies Service.

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Abstract:

Background: Many people treated in National Health Service (NHS) Talking Therapies services have highly complex needs which are not always met by the length and type of treatment offered. Some services have offered emotional skills groups to meet complex needs, but little is known about client experiences of these. The evidence base for transdiagnostic applications of Dialectical Behavioural Therapy (DBT) is growing but further research is required.

Aims: To gain insight into client experiences of online emotional skills groups in NHS Talking Therapies.

Methods: 12 participants were recruited from a Talking Therapies service who had attended an emotional skills group. Semi-structured interviews focused on client experiences and were analysed using Reflexive Thematic Analysis (RTA).

Results: Participants found the emotional skills group to be a positive experience. The central organising concept, ‘My journey from disconnection towards connection’ is split into three main themes: 1) Finding life hard; 2) Maybe this group will make a difference; and 3) Re-evaluating the importance of connection. These themes are broken down into sub-themes allowing for a more in-depth analysis which revealed the importance of the therapeutic relationship as a mechanism for change.

Originality: There is little known about client experience of online emotional skills groups in adult NHS Talking Therapies services.

Findings: This research finds support for the idea that the emotional skills component of DBT may be beneficial as a stand-alone transdiagnostic group. Increased access to online emotional skills groups in Talking Therapies services should be considered to better meet the mental health needs of more complex clients. Transdiagnostic adaptations of DBT may be of value in a wide range of different settings but more research is needed.

Keywords: online emotional skills groups, client experience, NHS Talking Therapies, dialectical behavioural therapy, DBT, Improving Access to Psychological Therapies, IAPT.

Article Classification: Research paper

Introduction

In 2023, Improving Access to Psychological Therapies (IAPT) changed names to NHS Talking Therapies but the service structure remained the same (NHS England, 2023b). Talking Therapies is a National Health Service (NHS) initiative in England that provides psychotherapy in primary care (NCCMH, 2020). It was developed to deliver evidence-based psychological therapy in a highly structured and systematic manner. It uses a stepped care model (NHS England, 2023a), where the least intrusive interventions are offered first and specific types of therapy are matched to the client's primary diagnosis based on recommendations from the National Institute for Health and Care Excellence (NICE, 2023).

The National Institute for Health and Care Excellence guidelines (NICE, 2023) currently recommend Dialectical Behavioural Therapy (DBT) as a treatment for people with Borderline Personality Disorder (BPD) (American Psychiatric Association, 2013) which means that emotional skills groups based on an adaptation of DBT are rarely offered in primary care (NHS England, 2023a). Despite this, one or two Talking Therapies services do offer emotional skills, possibly when someone in management has a personal interest in DBT (Southern Health NHS FT, 2023).

DBT was initially developed by Marsha Linehan (Linehan, 1993) for chronically suicidal patients diagnosed with BPD. In its original conceptualisation, DBT is an integrative treatment that combines behavioural theory, dialectics, and principles from Zen Buddhism. It is based on a biosocial theory which proposes that biological vulnerability (e.g., high emotional sensitivity to internal and external stimuli, poor impulse control, slow return to emotional baseline) combined with an invalidating environment can create difficulties with emotional regulation and cause problems in interpersonal interactions.

Although historically DBT has been associated with treating personality disorders, it is now generally accepted that it can also be used to treat a much wider range of mental health problems (Koerner et al., 2021). There is increasing evidence to suggest that many psychological problems can be understood as an inability to modulate painful negative emotions without engaging in unhelpful coping strategies (Berking & Wupperman, 2012; Gratz et al., 2015; Hallion et al., 2018; Kraiss et al., 2020; Miola et al., 2022). This has led to a growth in research into the transdiagnostic application of DBT in the form of stand-alone emotional skills groups for eating disorders, substance use disorders, psychosis, post-traumatic stress disorder and bipolar disorder as well as anxiety, depression and working with neurodiversity (Holmqvist Larsson et al., 2023; Howells et al., 2020; Linehan & Wilks, 2015; Ritschel et al., 2015). Transdiagnostic psychotherapeutic interventions target the core underlying processes that are thought to lead to the development and maintenance of emotional and psychological problems across a range of disorders (Koerner et al., 2021).

Despite growing support for adaptations of DBT used as a transdiagnostic intervention (Ben-Porath et al., 2020; Childs-Fegredo & Fellin, 2018; Delaquis et al., 2022; Dimeff et al., 2021; Gupta et al., 2023; Koerner et al., 2021; Linehan & Wilks, 2015; Moore et al., 2022b; Ritschel et al., 2015; Schaeuffele et al., 2021; Wilks et al., 2017), this model continues to be strongly associated with the client group it was originally designed to treat (Childs-Fegredo & Fellin, 2018; Dimeff et al., 2021; Schaeuffele et al., 2021). This research explores the experiences of a group of people who attended a transdiagnostic online emotional skills group in Talking Therapies. It is hoped that a greater understanding of their experiences will reveal new knowledge and insight into the use of online groups that offer adaptations of DBT.

Aims: There is less known about the way in which clients experience DBT influenced groups as opposed to the full DBT programme (Childs-Fegredo & Fellin, 2018; Flynn et al., 2019; Lakeman et al., 2022; Swales, 2018; Valentine et al., 2020) and little known about adaptations of DBT as stand-alone emotional skills groups in primary care (Kelly et al., 2022; Lamph et al., 2019). This research project addresses a gap in the literature by considering the question *'How do clients experience online emotional skills groups in Talking Therapies?* It seeks to provide a voice for clients who participate in these groups and contribute to a growing body of knowledge about adaptations of the DBT model.

Method: 12 participants were recruited from a Talking Therapies service who had attended an emotional skills group. Semi-structured interviews focused on client experiences and were analysed using RTA (Braun & Clarke, 2013, 2022a, 2022b). Qualitative analysis provides an opportunity to capture the complexity and nuance of individual and group experiences (Holleman et al., 2020).

Participants: Nine women and three men who had completed an emotional skills group were recruited from a Talking Therapies service. The sampling for this project was purposive which is common within qualitative research (Braun & Clarke, 2013).

Ethics: This project received approval from the NHS Health Research Authority and the University of the West of England Faculty Research Ethics Committee and adheres to the British Psychological Society's (BPS) Code of Human Research Ethics (BPS, 2023). Potential participants were given a copy of the Patient Information Sheet which provided detailed information about the purpose of the study and what participation entailed before taking part.

Risk management: Potential participants thought to have high levels of risk or high vulnerability were excluded from this study.

Procedure: Data was collected via semi structured interviews through secure NHS video conferencing and transcribed by the researcher prior to coding and analysis (Braun & Clarke, 2006). Data was anonymised and stored securely on a password protected NHS laptop. Analysis involved a six-stage process which involved familiarisation with the dataset, coding, generating initial themes, developing and reviewing themes, refining, defining and naming themes and writing up (Braun & Clarke, 2006, 2013, 2022a, 2022b).

Results: The central organising concept 'My journey from disconnection towards connection' sits as an umbrella over the three main themes, and three sets of subthemes. It explores the experience of participants as they move away from a general pattern of disconnection towards connection in a multitude of ways, highlighting their observations in relation to the impact this journey has on their emotional regulation and sense of self.

Central organising concept: 'My journey from disconnection towards connection'

There was considerable difference in the emotional intensity across the interviews. Some participants expressed high emotion and talked in detail about their inner experiences whereas others seemed to express more concrete thinking and responded in a brief, factual, less emotional manner. The overarching theme that ran across all interviews was the way in which participants talked about their experience of disconnection: how they disconnected from themselves; from their feelings; from their body; from the group; and from other people and what changed when they started to connect.

Theme 1 Finding life hard: Without exception participants shared a common experience of life before the group, it was not easy. People who experience intense and unstable emotions often struggle to cope with life, themselves, and relationships with other people (Kulacaoglu and Kose, 2018). This pre-group experience of Finding life hard was explored in more detail using subthemes: Overwhelming desperation and chaos; I'm on my own; and Identity – 'I'm not too great a person'.

1:1 Overwhelming desperation and chaos: This theme arose from the way in which many participants talked about experiencing feelings of desperation prior to starting the emotional skills course. Jane was clear that before she was referred to the group she would have accepted any offer of help, irrespective of whether it was likely to be effective, *'I mean, when you're desperate, you don't really investigate that so closely'* and Lisa described feeling desperate for a treatment that offered some hope: *'I don't know, I was at my last port of call for trying to get the appropriate help. I had seen a number of people in London and wasn't happy with the offers they had given me so I was pretty ready to go [to the group] because I wanted any help I could get'.*

Ben's comment, *'it's just that, you know I roller coaster through life'* allows us to glimpse the instability and constant fluctuation in his patterns. Without going into detail, Liz also hints at the chaos and desperation she experienced prior to starting the group when she says, '*I had a bit of a meltdown in January. That's what sort of led me to this course'.* This is echoed by Mike when he says *'at the time I was going through crisis'.*

Instability of emotion was something that all participants struggled with and for many this seemed to have been a lifelong problem. Jane explained, '*life for me is so much about running to keep up. With everything I need to keep up with and then crashing and then running and then crashing and running'.*

1.2 I'm on my own: This theme arose because many participants reported experiences of being on their own or feeling that they didn't fit in with peers or family groups. Lesley encapsulated this when she said, '*at the time I thought I've just got [to have] someone I can talk to. Just someone to contact because I don't talk to anyone from one week to the next'.*

Cacioppo's evolutionary theory (Cacioppo et al., 2014) proposed that loneliness is adaptive and that the uncomfortable emotion we feel when socially isolated motivates us to stay in groups which increases our chance of survival. In a recent study (Eres et al., 2021) found that difficulties with emotional regulation were 'uniquely associated with loneliness' and loneliness was found to be associated with poor mental health. Subsequent research supports this (Hayes et al., 2022; Laslo-Roth et al., 2023; Preece et al., 2021; Tan et al., 2022) but loneliness is a complex construct and the link between loneliness and emotional regulation is not well understood.

Participants didn't discuss their experience of isolation or loneliness directly but hinted at their experience of sadness and isolation prior to starting the group. This quote from Jane reveals the bleakness of her life and how low her expectations were, '*I felt it was better than sitting at home on my own'.*

Although a proportion of the participants were socially isolated, others were very busy with complex family relationships. However, irrespective of the physical presence of others in their lives, there was a shared sense amongst the group members of being alone, of not being understood and not being able to rely on getting any emotional support from the people around them.

1:3 Identity – 'I'm not too great a person': One of the most powerful themes that arose from the data was in relation to identity. Most of the participants talked about experiencing a negative sense of self. They talked about the way that this caused them distress and difficulty, both in the wider context of their life and in their experience of participating in an emotional skills group. Although scoping reviews are not considered as powerful in the hierarchy of evidence as systematic reviews, a recent study by Norder et al. identifies that internalising shame is a predictor of poor treatment outcome (Norder et al., 2023).

In the participant group, Clare explained how struggling with emotional regulation made her think that she was a failure. She talked about her early life experience and recognised that difficulty expressing emotions was an established pattern in her family and something that she had been exposed to from a young age. Clare said that when she suppressed her emotion and subsequently *'exploded'* it felt as if she was a bad mother, this creates a social identity (the bad mum) that in Clare's cultural setting is highly shameful. Clare's struggle with her negative sense of self and her emotional regulation is something she thinks about in a relational way: in her relationship with herself; with her son; and with the wider community. Her difficulty with intense and unstable emotions seems to reinforce her sense of failure and compound the internal image she has of herself as a poor mother.

'it's another reason why I wanted to do the emotional skills group because I don't want to offload how I am on my son. I think, like, nature and nurture, there's always that debate, but definitely nurture, I think has got a lot to do with it. And if you've come from a family that's not used to dealing with emotions and just shows rage, that's something I don't want my son to have'. (Clare)

All participants described themselves as emotional, '*I'm really emotional. It's been so intense recently' (Sally)* and some implied that they thought this was a negative attribute '*I was having [emotional] outbursts and not being too great a human' (Mike).* This sense of their emotions being too strong, too difficult to connect with, too much for other people, too out of control, seems to contribute to the negative sense of self that many people talked about at the start of the group and compound their sense of isolation.

Theme 2 'Maybe this group will make a difference': What the data also showed was the way in which attending the group enabled participants to move away from feeling stuck and develop a sense of optimism. For some clients, this sense of hope began from the moment that they were offered an assessment whereas others were quite cynical at first but started to develop hope as the sessions progressed.

Sylvia described a very positive experience at assessment which drew her into the group and encouraged her but at the same time there was ambivalence and skepticism as identified by Lesley.

'I think in terms of accessing some sort of care this has been one of the nicer pathways I've gone along…… they were very friendly. I kept going'. (Sylvia)

'*well most members of the group, we were all a bit scared because it was a group and we weren't very optimistic about it'. (Lesley)*

2:1 Trust and safety: Many of the participants talked about not feeling safe enough as a child to express their feelings. They also talked about similar difficulties in their adult relationships and reflected on their experience of sharing emotions within the group as well as how this impacted on their sense of trust and safety.

Ben mentioned early on that he thought many of the group participants struggled with trust, '*Yeah, there were a lot of trust issues as well'.* He hinted at attachment problems in his relationship with his mother, '*I have quite a difficult relationship with my mum'* and worried about whether he would be taken advantage of if he began to trust other people in the group:

'Concerns just like am I being taken seriously to begin with, you know, like there was a lot of people and you know, we're all quite vulnerable actually……. And you know there were

sometimes when we all had a cry over the video but it was just like, you know, no one was taking the mick out of one another….. But there was that doubt. I mean, do I trust them enough to tell some of my deepest, darkest secrets kind of thing. But you know, it was helpful just talking'.

In the context of poor attachment relationships where you are always let down by other people (Bowlby, 1988), Lesley talked about fear: '*it was a fear thing. ….. just afraid I suppose'.* Lesley was the only participant to use the word fear, she was the participant who experienced dissociation that was further along towards the abnormal end of the spectrum, she experienced the most difficulty with relationships, and described experiencing the most significant difficulty with trust and was the most socially isolated:

'Like friendships? I've got no friends. What's a friend? I don't even know. I don't trust a soul. I don't trust anybody. I find it very difficult …. Emotional regulation … and everyone is talking about going out with their friends, with their family and I just don't have any of that and I'm thinking what!!?' (Lesley)

On the other hand, Susan talked about the way in which she experienced the group as a safe space. For her and for many other participants, the sense of safety and support in the group allowed them to take the risk and express their emotions:

'And it was a safe environment for people, you know, even for someone like me who has to manage their face. What I got when people were emotional or upset was this is a safe environment. If they can't do it here, where can they do it? …but it was a safe environment and I absolutely support and appreciate that'. (Susan)

2:2 Belonging: 'This group feels like family': Although most participants found their emotional tolerance improved as they moved from disconnection towards connection, some people experienced the opposite whilst at the same time expressing a value in their experience of connection and an improved understanding of why they might dissociate, switch of the computer, or need to disconnect in other ways.

'Towards the end I was so sad when it finished because we all liked it. It felt like a family. Towards the end we had all shared these experiences and like we were all looking after one another, you know, talking, reassuring each other'. (Ben)

Contrasting with this, Sharon said: *'I participated more in the beginning, actually, than the end. I think because I was more enthusiastic at the beginning and then throughout it as it got more intense and more real it I ended up…..No, I engaged less with it because it was more intense I think'.* Sharon's example shows how positive experiences of connection can sometimes be experienced as threatening because the individual is anticipating abandonment (Bowlby, 1969; Mallinckrodt, 2010). Perhaps if the duration of the group had been longer Sharon might have moved through this and developed enough sense of safety to connect.

Overall, this theme reflects the value placed by many participants on the growing sense of connection within the group. Most participants experienced a sense of loss when the group ended and for some this was the catalyst to go out and find other means to connect with other people.

2:3 Learning and understanding: All the participants expressed positive experiences of the learning they achieved during the group. For example, Susan talks about being able to use the skills that she learnt in the group and apply them to her life outside the group, '*actually, if I am starting to feel out of sorts… I will look at the notes and I will do it specially the STOP one'.*

Ben's comment reveals the way that his expectations have changed and become more realistic*, 'I just thought that I would be able to learn how to handle my emotions better and I have learnt, you know, certain ways of coping with different things, you know, certain things better. But yeah, I'm still learning….. you know it doesn't happen overnight'.*

Mike pointed out that some of the handouts were difficult for people with dyslexia because of the heavy use of acronyms '*like the acronyms for me as a dyslexic. Difficult to remember an acronym and especially all the time'.* Other participants also found the use of acronyms in the DBT handouts (Linehan, 2015) difficult to remember or irritating but overall, the participants found the learning from the group helpful.

Theme 3 Re-evaluating the importance of connection: The final theme considers the way in which participants gradually developed an awareness that connecting with other people was important. This change in thinking seemed to occur in response to the lived experience of connection through shared emotion in the group.

3.1 Recognising my own needs: For all participants, the experience of connection in the group led to an increased awareness of their own emotional needs. Emotional validation which was initially modelled by group facilitators began to spread and by the end of the group many participants were validating each other's emotional experiences and looking for opportunities to get their emotional needs met in their wider relationships.

Susan talked about wanting to extend connection with people in the group. In this excerpt she recognizes the value of being able to share her emotional experiences and receive a validating response. Having completed the emotional skills group, she is choosing to connect rather than disconnect from other people ('*I'm a bit agoraphobic'*).

'*Going forward though, you know there are some people who may share certain ideas that may help, you know, is that still a no go or can people stay in touch?... If somebody who's had a particularly difficult week, or somebody who's said something that really resonates with you, you can talk to them afterwards … and say,' do you know what, thanks for sharing – I'm sorry you got upset. I really understand where you are coming from and you are absolutely justified in feeling the way that you feel', you know validating someone. Up close and personal, patting them on the back'. (Susan)*

However, some participants still found it very difficult to recognise their emotional needs which may be indicative of the lack of attachment and care experienced early on in life (Bowlby, 1988). Being cared for, having their emotional needs met and distress validated was perhaps not something they had experienced.

3.2 Growth and Change: This sub-theme picks up on the way that participants began to increase not only their tolerance of emotions but their emotional awareness. Very much in the way that psychodynamic theory sets out the importance of making the unconscious, conscious (Freud, 1915 cited in Akhtar, 2020) participants talk about the way that attending the group enabled them to become more consciously aware of their emotion. This awareness gave them a sense of understanding and control which in turn allowed them to make behavioural and psychological changes.

Sandra commented *'emotions are very much in charge of you. But just knowing that there's actually a system to get back in control. It was very empowering talking about that'.* She describes moving from feeling out of control at the start of the emotional skills group to feeling in control at the end of it. This suggests that addressing 'feeling trapped, powerless, and isolated' may be important in developing a sense of connection (Brown, 2006).

By contrast, Peter said that attending the group had not changed his behaviour but he did notice that he was feeling different, *'I definitely feel better for having gone through the process with the group. I haven't adopted any of the specific skills'. (Peter)*

This sub-theme reveals a virtuous cycle whereby increased awareness and increased tolerance of emotions promotes a sense that ideas from DBT might be helpful, which in turn makes it more likely that participants will attempt to be more consciously aware of their emotions and more willing to tolerate them.

3.3 Feeling more connected: The final sub-theme looks at what the data reveals about the way in which participants experienced connection with others during the group and how this impacted on their sense of self and their wider relationships.

Prior to starting the group, Clare said '*I wouldn't say looking forward to it because I kind of dread any kind of social interaction anyway'* . This contrasts with what she said about the group once it ended:

'I miss it. Right now, I wish I could go back and talk to them again …. I feel like I need something because I don't have a lot of close friends and I'm very, you know, solitary bird. So, it's nice to have it. I like being able to talk to people, but I often have that shut off'. (Clare)

Clare seems to be showing an important change in her behaviour after attending the emotional skills group by seeking out connection with other people rather than avoiding connection. This connection-seeking behaviour has the potential to reduce feelings of loneliness and disconnection. There is good evidence to show that increased social relationships are protective in terms of increased resilience during a mental health crisis (Conversano et al., 2020; Li & Nishikawa, 2012; Magson et al., 2021).

Findings: This study found emotional skills groups were a positive experience. Validation, empathy, safety, and emotional warmth were all seen as important and highly valued by group participants. Sharing emotional experiences was experienced as difficult but helpful and participants talked about moving away from feelings of isolation and loneliness towards a desire to connect with other people. Findings are discussed by reflecting on the changes participants made along the timeline of their experience:

Pre-group

As indicated by Theme 1 'Finding life hard', prior to attending the emotional skills group people talked about feeling alone, chronically stuck in rigid patterns of thinking and relating to other people. They described using disconnection to cope with this. Using disconnection as a coping strategy reduces emotion in the short term but this inadvertently maintains the belief that emotion is something to be feared (Linehan, 1993). The result of this seems to be an avoidance of any unfamiliar contact with people, an avoidance of relationships unless they are clearly delineated with prescribed rules and ultimately a '*dread* (of) *any kind of social interaction'*. There is then potential for this lack of social interaction to be misinterpreted as *'I'm on my own'* because *'I'm not too great a person'*.

Mid-group

There is a growing interest in the use of different theories, frameworks, and models used in psychotherapy to gain insight into the mechanisms that need to change for treatment to be successful. This often leaves clinicians with considerable difficulty deciding what works and for whom. Wampold (Wampold, 2015; Wampold & Imel, 2015) argues for a transdiagnostic approach to psychotherapy that takes account of common factors between these different models. His paper (Wampold, 2015 p. 270) identifies areas of importance that are common to all psychotherapy: that the model used makes sense to the client and provides a believable explanation of their difficulty; that there is a genuine relationship between therapist and client that provides a 'human connection with an empathic and caring individual' and a sense of optimism or expectation that the treatment will be helpful. The data from participants in this study seems to support these ideas and shows how all four of the common factors (Wampold, 2015; Wampold & Imel, 2015) can be found by the mid-stage of the group.

Post-group

The group environment where participants were supported to connect with their own emotions in an emotionally charged social setting seemed to reduce shame. Consequently, they were able to *'Re-evaluate the importance of connection'* and learn that they felt better when they connected with themselves and with others rather than using avoidance or disconnection. This created a virtuous cycle where improved self-connection and increased self-compassion created a safe space where they could recognise their own emotional needs. An increase in their ability to tolerate connection with others tended to improve the likelihood of getting their emotional needs met, whilst feeling cared for and more connected promoted an improved sense of self and reduced shame and this in turn made it easier to connect with others. This is in line with findings from research looking at the link between shame, social connection, and social anxiety (Oren-Yagoda et al., 2022; Swee et al., 2021) and finds support for the idea that emotional skills groups can reduce self-stigma and shame (Smith et al., 2023; Stynes et al., 2022).

Online delivery

Most participants agreed that there were advantages and disadvantages to meeting as a group online. What was perhaps surprising was the ease with which they all managed the technical aspect of online groups, there was very little difficulty connecting to Microsoft Teams. For some participants the online nature of the group provided them with the ability to fine tune their level of engagement. Participants talked about how helpful it felt to be able to adjust their level of emotional arousal by switching off the camera or the microphone, something that would not be possible in a face-to-face setting. Having the ability to control this was also commented on and valued in the context of pre-group experiences where emotion often felt overwhelming and out of control.

Limitations

Purposive sampling was appropriate for this study however future research might want to include interviews with people who stopped attending their group to understand more about what was difficult for them or felt unhelpful.

There was a lack of diversity in the sample. To some extent this is representative of the population in rural Somerset and not necessarily a limitation, but it might be worth thinking about how emotional skills groups in the future could be set up to reach a more diverse, multicultural audience.

Writing from within the culture of the Talking Therapies system

It has been argued that the Talking Therapies culture is influenced by one research paradigm only (Williams, 2015). Promoted as an evidence-based service that is effective both clinically and economically (NHS England, 2023), Talking Therapies is both praised (Clark et al., 2018) and criticised for its use of numerical outcome data as 'recovery' truth (Williams, 2015). Incorporating a wider view could improve the way in which services are shaped and evaluated. This study, written from within the culture of NHS Talking Therapies (the researcher is part of the Talking Therapies team), acknowledges the positivist lens whilst simultaneously attempting to step outside it, reflect on it and think more deeply about client experiences. The emphasis in this research has been to highlight the language used by participants to generate a rich and complex narrative and gain a deeper understanding of the lived experiences of people who participated in emotional skills groups.

Research looking at the impact of social disconnection during Covid found that not only did isolation and loneliness have a negative impact on mental health but also that minority ethnic groups were particularly vulnerable (Holt-Lunstad, 2022, 2023; Khan et al., 2023). Participants in this study were not ethnically diverse and reflected the demographics of the area. If emotional skills groups could be targeted to reach minority groups, they might provide a means to reach out to those disproportionately affected during Covid, improve their ability to increase social connection and increase psychological resilience should we experience another pandemic in the future.

However, psychological resilience is complex. Loneliness, vulnerability, attachment, gender and ethnicity are just some of the many factors that intersect to improve our ability to cope with adversity. For some people, an emotional skills group may be particularly helpful, others may prefer faith groups or choose individual therapy. More research is needed to identify what works best for whom.

This research is some of the first to explore client experiences of online emotional skills groups in adult NHS Talking Therapies. As such it provides a rare insight into these groups. Findings reveal how positive these experiences involving online adaptations of DBT are for people in primary care services. Given the ongoing debate around the adaptation of DBT (Koerner et al., 2021) and the emphasis on using research to inform service decisions about what treatments to offer in Talking Therapies (NHS England, 2023; NICE, 2023), this study provides evidence that supports delivering online emotional skills groups at this level in the NHS and enables the client's voice to be heard in shaping service delivery.

Recommendations

There is a gap in the literature when it comes to comparing online adaptations of DBT with face-to-face groups (van Leeuwen et al., 2021; Walton et al., 2023). Research that looks at client experiences and outcomes is important given that it is likely many groups will continue to be delivered online in the future. More research into training and support for group facilitators would also be helpful if we want to develop a better understanding of what is required to improve confidence in delivering these groups online.

Implications for Counselling Psychology

Counselling psychologists taking on supervisory, management or research roles may be able to increase the availability of emotional skills groups being offered within Talking Therapies and other settings. Psychologists are well placed to influence the culture within the NHS and encourage their colleagues to use adaptations of DBT more frequently in their clinical practice.

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