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BSc Hons, MSc

UNDERSTANDING CHANGE WITHIN EMOTIONALLY UNSTABLE
PERSONALITY DISORDER

Section A: A critical review of the potential mechanisms of change for
group psychological interventions for Emotionally Unstable Personality
Disorder

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Section B: The service user and staff perspective on change within the
context of Emotionally Unstable Personality Disorder: A Grounded Theory
investigation

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Project Summary

Section A: This literature review focuses on research surrounding the potential mechanisms of change within the context of group interventions for individuals who had received a diagnosis of Emotionally Unstable Personality Disorder (EUPD). The review included quantitative and qualitative studies focusing on change within this setting. This research identified potential unique mechanisms of change for group interventions, but contested that the studies were variable in quality and void of the service user voice. A focus on developing qualitative understandings of change within and beyond the context of psychological therapy and not limited to a particular theoretical lens was noted to be imperative for future research.

Section B: This involves a qualitative investigation, providing a holistic exploration of change that extends beyond psychological therapy. Both individuals with lived experience of EUPD and staff working with this client group were interviewed and a Constructivist Grounded Theory was presented. Clinical and research implications were discussed.

Contents page

SECTION A	1
Abstract	2
1. Introduction	3
1.1. What is EUPD?	4
1.2. Therapeutic Interventions for EUPD	4
1.3. Skills Based Interventions: The Top Down Approach	5
1.4. Personality Integration and Attachment: the Bottom Up Approach	6
1.5. Change Mechanisms	7
1.6. Group Interventions	8
1.7. What is Unique About Group Interventions?	8
1.8. Where is the Service User Voice?	9
1.9. Current Review	10
1.10. Epistemological Position	11
1.11. Research Questions	11
2. Methodology	12
2.1. Inclusion and Exclusion Criteria	13
2.2. Assessment Tools	15
2.3. Structure of the Review	16
3. Literature Review	23
3.1. Overarching Findings	23
3.2. Comparison to Previous Reviews	27
3.3. Do the Studies Really Measure Group Impact?	28
3.4. Qualitative Data	30
3.5. Quality of Studies	31
3.6. Critique of Quality criteria	33
4. Systemic Critique	34
4.1. Application to Clinical Settings	34
4.2. Diagnosis	34
4.3. Gender	35

4.4. Single Symptom Change	36
4.5. Research and Clinical Practice	36
4.6. Changes Over Time	37
4.7. Staff Perspectives	37
4.8. Beyond Therapy	38
5. Summary	39
6. Implications for Research and Practice	40
6.1. Research Implications	40
6.2. Clinical Implications	41
7. Conclusions	43
8. References	45
SECTION B	62
Abstract	63
1. Introduction	65
1.1. What is Emotionally Unstable Personality Disorder?	65
1.2. Challenging Stigma	65
1.3. What Do we Know About the Experience of Change?	66
1.4. Gaps in Current Understanding	68
1.5. Rationale	68
2. Methodology	70
2.1. Design	70
2.2. Epistemological Stance	70
2.3. Interview Schedule	70
2.4. Participants	71
2.5. Procedure	73
2.6. Data Analysis	73
2.7. Quality Assurance	75
2.8. Ethics	76
3. Results	78
3.1. Model Summary	79

3.2. Feeling Stuck	80
3.3. Developing the Foundations for Change	81
3.4. Shifting Positions	83
3.5. Embracing the Changing Self	89
3.6. Model Processes	91
4. Discussion	96
4.1. Summary	96
4.2. Links to Previous Research	96
4.3. Study Quality	98
4.4. Study Limitations	98
4.5. Clinical and Research Implications	99
5. Conclusion	101
6. References	102

List of Tables and Figures

Part A

Table 1 Search Terms	12
Table 2 Inclusion and Exclusion Criteria	13
Table 3 Kazdin's Quality Criteria	15
Table 4 Summary of Included Studies	17
Figure 1 Prisma Flow Diagram Explaining the Literature Search Process	14

Part B

Table 1 Demographic Information	72
Table 2 Developed Categories and Subcategories	78
Figure 1 Preliminary Model Representing the Change Process	83
Figure 2 'Shifting Positions' Category Detail	95

List of Appendices

Appendix A: EUPD Diagnosis Definition	110
Appendix B: Additional Information About Included Studies	111
Appendix C: Quality Assessment of Qualitative Studies	112
Appendix D: Quality Assessment of Case Study	113
Appendix E: Quality of Quantitative Intervention Studies	114
Appendix F: Quality of Observational Cohort and Cross-sectional Studies	115
Appendix G: Quality Assessment of Studies Using Kazdin's Criteria	116
Appendix H: Research Diary Excerpts	120
Appendix I: Interview Schedule for Lived Experience Group	128
Appendix J: Interview Schedule for Staff Group	130
Appendix K: Study Poster for Lived Experience Group	132
Appendix L: Study Poster for Staff Group	133
Appendix M: Information Sheet for Staff Group	134
Appendix N: Information Sheet for Lived Experience Group	138
Appendix O: Consent Form for Lived Experience Group	142
Appendix P: Consent Form for Staff Group	144
Appendix Q: Coded Transcript	146
Appendix R: Focused Codes	147
Appendix S: Examples of Analytic Memos	150
Appendix T: Pictures Documenting Theory Development Process	154
Appendix U: List of Codes and Example Quotations	160
Appendix V: Respondent Validation Email and Responses	179
Appendix W: Audit Trail	186
Appendix X: REC Approval	187
Appendix Y: HRA Approval	188
Appendix Z: Author Guidelines for the Journal for Personality Disorders	189
Appendix A1: NRES End of Study Form	191

Appendix B1: Study Summary Form for HRA and REC	193
Appendix C1: Study Summary Form for Participants	196

Major Research Project

Section A

Sarah Jones

Title:

A critical review of the potential mechanisms of change for group psychological interventions for Emotionally Unstable Personality Disorder

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Abstract

Emotionally Unstable Personality Disorder (EUPD) has been historically perceived as untreatable. In more recent years, there has been a shift in perspective leading to the development of psychological interventions which act to challenge stigma and support individuals to make meaningful changes.

Research has begun to evaluate what elements of psychological therapy facilitate change. Due to the increasing provision of therapeutic input using a group element within the National Health Service (NHS) this review focused on interventions with this modality. Furthermore, previous literature has only focused on quantitative studies evaluating influences of change, which limits the service user narrative and reduces the depth of results. A systematic literature review was completed and identified 20 appropriate studies using mixed methodologies.

A range of potential mechanisms were identified, some of which were arguably unique to the group experience. These mechanisms included development and practicing of both interpersonal and emotion focused skills, personal readiness, emotional growth and identity development. However, the review revealed the youth of the data to date. In order to develop a holistic theory of change it would be beneficial to collate qualitative data evaluating the service user perspective of change across and beyond particular therapeutic interventions.

Keywords: Emotionally Unstable Personality Disorder, Change, Mechanisms, Group Intervention, Qualitative.

1. Introduction

Individuals who have received a diagnosis of Emotionally Unstable Personality Disorder (EUPD)¹ currently face huge difficulties in navigating their way to appropriate support and psychological treatment. This challenge is also reflected within Mental Health Services (MHS) who struggle to provide consistent, evidence based and effective treatment for individuals with this diagnosis.

This inaccessibility and inconsistency within service provision for EUPD is arguably correlated to the origins, understanding and discrimination surrounding the diagnosis. Borderline Personality Disorder (BPD), the more common diagnostic label, was founded by Stern (1938) to describe patients who were believed to have fallen between neurosis and psychosis. The diagnosis encapsulates difficulties that overspill across several diagnostic categories and has often been discussed negatively by service users' within the research literature, acting to reinforce views of 'not fitting in' (Horn, Johnstone & Brooke, 2007).

This mirroring of diagnostic ambiguity has extended to service provision. Until 2003 (with the publication of 'personality disorder: no longer a diagnosis of exclusion' (National Institute for Mental Health (NIMH) in England, 2003)) individuals with a diagnosis of EUPD were not perceived to be treatable. Although there have been significant changes in perception and treatment of EUPD, therapeutic pessimism remains rife within MHS today (Lam, Poplavskaya, Salkovskis, Hogg & Panting 2016; Markham & Trower, 2003).

¹ The term 'borderline personality disorder' will only be referred to within the current review when referring to the historical origins and study search terms.

With the historic and current ambiguity in understanding and treating EUPD, it is vital for research to explore what enables individuals with this diagnosis to change.

1.1. What is EUPD?

The current research utilised the term, ‘Emotionally Unstable Personality Disorder’ as opposed to the more common term, ‘Borderline Personality Disorder’. This is in line with the United Kingdom (UK) diagnostic system, the ICD-10 (World Health Organisation (WHO), 2008). Anecdotally, this term has also been found to be preferable for service users’ as some have argued that it more accurately denotes their core difficulties (Mind, 2015).

Emotionally Unstable Personality Disorder (EUPD) is characterised by difficulties in managing affect, impulsivity, interpersonal difficulties and identity confusion (Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004). These characteristics can culminate in multiple suicide attempts and self-harm behaviour. Individuals who are diagnosed with EUPD report higher levels of early life abuse compared with other diagnoses (Zanarini, Frankenberg, Reich, Hennen & Silk, 2005) and a higher prevalence of insecure attachment styles (Agrawal, Gunderson, Holmes & Lyons-Ruth, 2004). Definitions of EUPD as defined by WHO (2008) can be viewed in Appendix A.

1.2. Therapeutic Interventions for EUPD

As noted above, since the NIMH publication (NIMH, 2003) there had been a surge of research, commissioning and service provision for personality disorder. Furthermore, there has been a development in provision of psychological interventions for this diagnosis and the acknowledgement that individuals with this diagnosis could be treated.

Psychological interventions are often the cornerstone of the facilitation of change and so thus a review of the literature base for psychological interventions within EUPD is of paramount importance. The following descriptions of prominent psychological interventions

for EUPD did not aim to be exclusive, but the interventions below were selected due to common implementation within the National Health Service (NHS) (NHS, 2016).

Descriptions of therapeutic interventions were divided into ‘bottom up’ and ‘top down’ therapies, arguably representing the two common intervention strands (present focused skills teaching and explorative, reflective therapies). These two types of interventions may include both overlapping and unique change mechanisms.

1.3. Skills Based Interventions: The Top Down Approach

One of the focuses of treatment for difficulties related to EUPD is the acquisition and application of skills necessary to aid emotional regulation, impulsive urges and chronic negative thoughts. In recent years, skills based psychological therapies have been linked to the concept of ‘top-down processing’, whereby emotional regulation strategies such as distancing are used to help manage intense emotional reactions which may be bottom up in origin (Dixon-Gordon, Peters, Fertuck & Yen, 2016).

Linehan’s (1993) biosocial theory notes both potential biological and social origins which interact, leading to difficulties associated with EUPD. Linehan’s (1993) model proposed that biological vulnerabilities such as the increased sensitivity of the sympathetic nervous system could interact with a difficult social environment such as experiencing an invalidating environment in early life.

Linehan went on to develop Dialectical Behavioural Therapy (DBT), a skill based intervention that focused on enabling the individual to accept and tolerate intense emotions while simultaneously encouraging change and promoting new ways of monitoring and responding to emotional states. The standard DBT procedure (Linehan, 1993) involves group therapy, individual therapy, crisis intervention, telephone calls and team consultation. It is the

most widely evidence based psychological intervention for EUPD as identified by the Cochrane Review (Stoffers et al., 2012).

Another skills-based approach, Systems Training for Emotional Predictability and Problem Solving (STEPPS) (Black & Blum, 2017) uses elements of CBT, utilising behavioural strategies in combination with elements of cognitive restructuring to enable the individual to more effectively manage their emotional intensity. As with the skills element of DBT, STEPPS is a group based intervention.

1.4. Personality Integration and Attachment: The Bottom-up Approach

In the context of therapy, bottom-up processes would aim to identify, expose and learn from early difficult and often traumatic experiences, emotions and beliefs which may maintain current distress. Therefore, therapies involving exposure and tolerance to deeply intense emotional states in combination with interpersonal experiential practice arguably fit this category; processes encompassed by a wide range of psychological therapies.

One of these is Schema Therapy (Young, Klosko & Weishaar, 2003), which draws on elements of cognitive therapy, Gestalt psychotherapy, object relations and psychotherapy to encourage personality change. For EUPD, this change is thought to occur through identification, challenging and decreasing the intensity of maladaptive schemas that trigger states known as ‘modes’. Schema Therapy often involves the experiential practice of dysfunctional mode challenging and improving the strength of healthy adult modes, fundamentally enabling a more coherent sense of self.

Other therapies, such as Transference Focused Psychotherapy (Clarkin, Yeomans & Kernberg, 2006) similarly utilise experiential practice to enable clients to identify and re-enact personality fragments or unhelpful ways of interacting with others within therapy

sessions. Through therapist observation and interpretation the therapy can lead to a more cohesive sense of self.

Mentalisation Based Therapy conceptualises the fragmented self as an inability to mentalise and to view oneself through others eyes (Bateman & Fonagy, 2010). In this therapy, individuals with EUPD are given the opportunity to begin identifying the mental states of others as a way of understanding and challenging their own emotional behavioural response.

1.5. Change Mechanisms

The above therapies aim to evoke change for the individuals that engage, either by using a skills-based intervention that aims to help the individual manage emotional distress, or by an experiential relational therapy which aims to help the individual develop a more coherent sense of self. There has been a vast array of research investigating the most vital ingredients within psychological therapies that help clients to change. Exploring these potential change mechanisms has been recommended as an important avenue for research in order to produce the most effective and meaningful interventions for service users' (Kazdin, 2008). The notion of change mechanisms is arguably even more important to explore within EUPD research, when holding in mind the historic context of EUPD and the relatively recent shift in view of EUPD as being a treatable disorder (NIMH, 2003).

The earlier descriptions of psychological therapies for EUPD appear to identify common strands within their theoretical underpinning and implementation, which may be understood by overlapping change mechanisms. However, there are also subtle differences. It would be useful to establish whether there are particular mechanisms within psychological therapy that help/enable clients to change in order to challenge the notion that individuals with this diagnosis cannot change. Forster, Berthollier and Rawlinson (2014) went some way

in addressing this gap in the research literature and completed a review evaluating research exploring potential mechanisms of change within individual psychotherapeutic interventions for those diagnosed with EUPD.

1.6. Group Interventions

Forster et al. (2014) identified several important potential change mechanisms but mainly focused on individual interventions. This decision seems somewhat at odds with the experience of many service users' accessing MHS as a large proportion of psychological interventions are group based (Lorentzen & Ruud, 2013). Furthermore, the majority of the evidence based interventions for EUPD involve a group element (Bales et al., 2012; Fassbinder, et al., 2016).

Moreover, the current climate within the National Health Service (NHS) means that group based interventions are increasingly used due to their comparative cost effectiveness over individual interventions (Kilmer, 2010). Increasing availability of group interventions also mirrors guidance by the National Institute for Health and Care Excellence (NICE, 2009) for individuals with a diagnosis of EUPD. NICE (2009) guidelines for EUPD recommend that psychological interventions should be offered in at least two modalities (e.g. individual & group).

1.7. What is Unique About Group Interventions?

Consequently, it is an oversight that the potential change mechanisms within group interventions within EUPD have not been investigated. Qualitatively, there have been suggestions within the research literature relating to the possible unique contribution to change for group based psychological therapy, as described below.

Firstly, one of the main difficulties for individuals with a diagnosis of EUPD is a chronic struggle to manage interpersonal difficulties (Lieb et al., 2004). Group based

interventions enable a unique opportunity for individuals to work on relationships, challenge previous ways of communicating with others and practice new skills and interactions within a safe environment (Kilmer, 2010). Farrell, Shaw and Webber (2009) received feedback from group participants following on from completion of a group Schema Therapy intervention which identified that meeting others with the same diagnosis was very helpful for service users' in relation to accepting themselves and feeling a sense of belonging.

Furthermore, research has shown that individuals with EUPD may find it more comfortable and at times more powerful to hear feedback or be challenged by a peer as opposed to a therapist (American Psychological Association (APA), 2001). Hummelen, Wilberg and Karterud (2007) noted that another advantage of group therapy for EUPD was that it could help to reduce the intensity of transference towards the therapist and could simultaneously increase different levels of transference in various group members. These interpersonal complexities could subsequently be explored safely within the group setting.

1.8. Where is the Service User Voice?

The vast majority of the studies described here ascertained their positive feedback about group interventions through qualitative means. This suggests that qualitative research may play an important role in understanding the potential unique advantages of group interventions for EUPD.

Qualitative research has been postulated to be of benefit when exploring phenomena with limited understanding or which is deeply rooted within human understanding (Ritchie & Lewis, 2003). To the author's knowledge, the Forster et al. (2014) study was the first of its kind to complete a review exploring potential mechanisms of change within EUPD, again highlighting the recency of the literature base. Furthermore, the concept of change and the influence of psychological therapy for individuals with EUPD is a very complex one. A

qualitative research methodology aligns with the subject matter discussed within the review by Forster et al. (2014) and was an important oversight of the study.

Moreover, whilst bearing in mind the historical context outlined earlier in this review, there is a real need for service user grounded research for EUPD. The review by Forster et al. (2014) was void of the service user voice, arguably missing an opportunity to elucidate service users' perceptions of what changed for them and why. Subsequently, the current study aims to incorporate the voice of the service user within available research.

1.9. Current Review

As discussed, group interventions play an important role in the treatment provision for many service users' who have been diagnosed with EUPD. Therefore, it is important for research to investigate mechanisms of change within the context of group based interventions. The review aims to include qualitative studies exploring service users' perspective of change within the context of therapy to add an additional richness to the review.

Differences lie between a change mechanism and other concepts such as a change mediator or moderator for example. Kazdin (2007) identifies a mediator as a variable that accounts for the relationship between two other variables, whereas a moderator or influencer is a factor that impacts the direction and strength of a relationship between two variables. Finally, Kazdin describes a mechanism of change as, "the processes or events that are responsible for the change" (Kazdin, 2007, p.3) and highlighted that moderators and mediators can help to illuminate potential change mechanisms. For the purpose of the current review, studies were included if they investigated and alluded to change mechanisms (which may have been explored through researching mediators and/or moderators).

1.10. Epistemological Position

A critical realist social constructionist stance (Harper & Thompson, 2012) was taken in evaluation of selected research. EUPD is a problematic diagnosis due to its heterogenic nature (Tyrer, 2009) and this was held in mind throughout the review. This diagnostic instability and subsequently highly varied client group impacts on the ability to apply often rigid and narrow focused academic research to the complexity of clinical practice. Subsequently the constructs, treatments and findings of the included studies were interpreted tentatively whilst holding in mind the systemic context surrounding the research.

1.11. Research Questions

To the author's knowledge no review focusing on mechanisms of change within group psychological interventions currently exists and therefore the current review aimed to fill this gap and to provide an answer to the following research questions:

- 1) What are the proposed factors that influence change within interventions with a group element?
- 2) Do identified mechanisms differ to those found for individual interventions in the review by Forster et al. (2014)?
- 3) How can the research findings be understood within the systemic context surrounding EUPD?
- 4) What are service users' perspectives of therapeutic change within group based interventions?

2. Methodology

The current review utilised four databases including PsychINFO, MEDLINE, Web of Science and ASSIA using the search terms noted below in Table 1. A Google Scholar search was also completed, using the same search terms. This enabled identification of additional articles (both quantitative & qualitative) and reference lists of review papers were scanned to check for additional articles. Searches took place between October and December 2016.

Table 1.

Search Terms

Search Engine	Terms
PsychINFO, MEDLINE, Web of Science and ASSIA	Borderline Personality Disorder OR Emotion* Unstable Personality Disorder AND change* OR change mechanism* OR change process* OR change over time OR stages of change OR change cycle OR readiness to change OR treatment outcomes OR behaviour change AND therapy OR treatment OR intervention AND group
Google Scholar	Dialectical Behavioural Therapy OR Mentalization OR Schema OR Cognitive Behavioural Therapy OR STEPPS AND Change AND Borderline Personality Disorder OR Emotionally Unstable Personality Disorder

The identified range of studies were then screened and selected based upon inclusion and exclusion criteria, details of which can be seen below in Table 2.

2.1. Inclusion and Exclusion Criteria

Table 2.

Inclusion and Exclusion criteria

Inclusion Criteria	Exclusion Criteria
Studies were required to be written in English.	Review studies were excluded as they tended to focus on general effectiveness as opposed to change mechanisms. However, some review studies were used to inform the rationale for the current research (Binks, Fenton, McCarthy, Lee, Adams & Duggan, 2006; Sempertegui, Karreman, Artz & Bekker, 2013).
Studies were included if they were published between 2003 to the present date (After the publication of ‘Personality Disorder: No Longer a Diagnosis of Exclusion’) (NIMH, 2003).	Studies were excluded if participants were described as having ‘traits’ of EUPD, in order to reduce heterogeneity within an arguably already variable diagnostic presentation.
Included studies involved research participants that had been given a formal diagnosis of EUPD or were deemed to meet criteria for EUPD.	Studies only evaluating therapy effectiveness without focusing on potential change mechanisms were excluded.
Studies were required to include an element of group work within the target intervention.	Studies were excluded if the intervention that was being targeted focused on co-morbid mental health difficulties within the intervention, e.g. a schema group for BPD and PTSD. This was to decrease heterogeneity within the dataset.
Studies were only included if they were observed to demonstrate an association/relationship between the intervention, a mediator/influence of change and some form of therapeutic change.	Studies were excluded if they focused on only individual interventions or it was unclear whether the intervention was individual or group based.

Studies that met inclusion and exclusion criteria were taken forward for full review. Figure 1 notes the literature search process taken to reach the final selected studies.

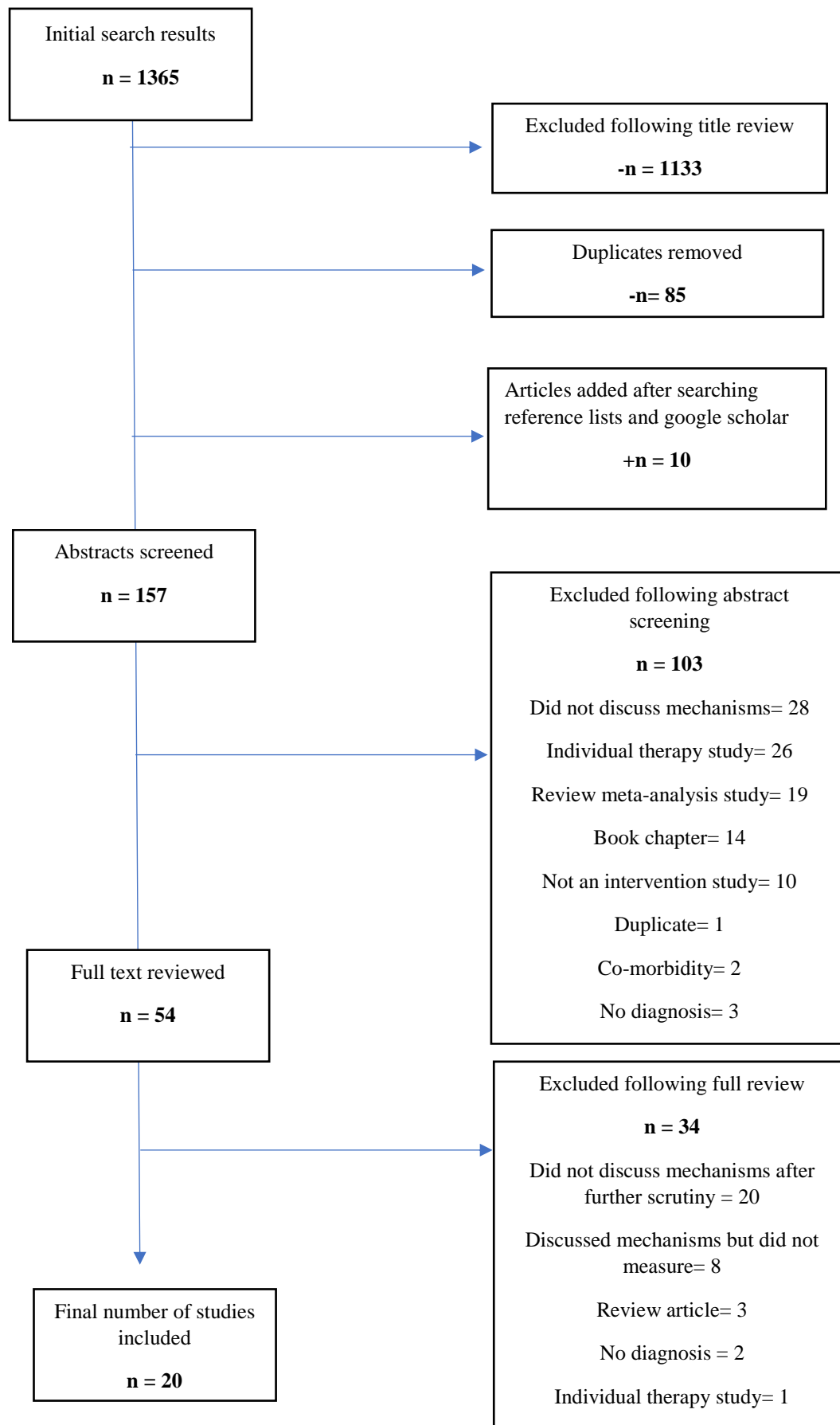


Figure 1. Prisma flow diagram explaining the literature search process. Adapted from 'Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement,' by D. Moher, A. Liberati, J. Tetzlaff, and D. G. Altman, 2009, PLoS Medicine, 6, P1-6. Copyright 2009 by Moher et al. Adapted with permission.

2.2. Assessment Tools

Because the included studies focused on a wide variety of methodologies several types of quality assessment tools were used. For quantitative experimental designs, the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project (EPHPP), 1998) was utilised. Qualitative research was assessed using Mays and Pope (2000) guidance. Correlational studies were reviewed using the Observational Cohort and Cross-sectional Studies tool (National Heart, Lung & Blood Institute, 2014). For case study designs, Yins (2009) quality criteria was used when evaluating applicable studies. Finally, all quantitative studies were reviewed in line with Kazdin's (2007) criteria (see below) for identifying potential mechanisms of change. A copy of all quality assessment tool assessments can be found in Appendix C, D, E, F and G.

Table 3. Kazdin's quality criteria

Criteria	Definition
Strong association	Is there a strong association between intervention and mediator of change? Is there a strong association between the mediator and therapeutic change?
Specificity	The proposed association between the intervention, mediator and outcome is specific and unlikely to be due to another mediator.
Consistency	Observed results can be viewed across studies, samples and conditions.
Experimental Manipulation	Direct experimental manipulation can strengthen belief that mediator effect is due to qualities of a particular intervention.

Timeline	A timeline between causes and mediators must be established to confirm that mediators precede outcome.
Gradient	Greater activation of the proposed mediator is associated with greater change.

2.3. Structure of the Review

The final article search resulted in 20 articles which were taken forward for a full review. Studies were summarised in regard to potential mechanisms of change, and compared and contrasted to findings from the review by Forster et al. (2014). Several forms of quality criteria were utilised to review study quality and studies were then evaluated within a wider systemic context. A full list of included studies can be seen in Table 4, below. For additional information about diagnostic criterion utilised and chosen outcome measures for each of the included studies, please see Appendix B.

Table 4.

Summary of included studies

Study	Participants	Age	Design & intervention	Country	Study length & follow up	Analysis used to assess potential change mechanism	Proposed change mechanism	Findings
Bedics, Atkins, Comtois & Linehan (2012)	101 women meeting DSM-IV criteria for BPD ²	29.3	Randomised Control Trial (RCT) (DBT vs CTBE)	United States (USA)	Data collected at four time points	Mixed effects modelling	Therapeutic Alliance: Therapist affirmation and protection	Clients view of total alliance increased regardless of treatment condition. Increased client rating of therapist affirmation and protection was linked to less self-harm, and increased self love and care in DBT group only
Bedics, Atkins, Harned & Linehan (2015)	101 women meeting DSM-IV criteria for BPD	29.3	Randomised Control Trial (RCT) (DBT vs CTBE)	USA	Data collected at four time points	Mixed effects modelling	Therapeutic Alliance: Client commitment and therapist understanding	Subtleties within therapeutic relationship (client rated commitment and therapist understanding and alliance) reduced self harm in DBT group only
Cunningham, Wolbert & Lillie (2004)	14 women with a diagnosis of EUPD	38.7	Qualitative DBT	United Kingdom (UK)	N/A	Did not specify	Skills teaching	Development of skills was identified as an important influence of change. Participants also discussed

² BPD terminology used in line with diagnostic manual

							Individual responsibility for change	the importance of the group for support
Dammann et al. (2016)	30 inpatients with EUPD (25 female, 5 male)	26.4	Single intervention experimental design (psychodynamic transference focused therapy (TFT) & DBT skill training)	Switzerland	12 week intervention. Measures completed pre and post intervention	Correlation: Pearson or Spearman	Interpersonal skills	There was a significant improvement in the severity of interpersonal skills after the intervention and the severity of interpersonal problems at baseline was positively correlated with EUPD symptomology
Feliu-Soler et al. (2014)	35 participants with EUPD (DBT= 16 females, 2 males; GPM= 15= females, 2 males)	DBT= 30.11 GPM=30.29	Non-Randomised Control Trial Sequential assignment to two intervention groups (DBT-mindfulness vs GPM)	Spain	Completed across two days	Correlation: Bi-variate	Mindfulness practice	The intervention group enabled participants to gain new insights and coping strategies and mindfulness practice was positively correlated with lower emotional reactivity
Geyer (2013)	8 individuals with a EUPD diagnosis who had previously or were currently engaging in a group based programme (3 females, 4 males, 1 gender ambivalent)	47.5	Qualitative (MBT and group psychoanalytic therapy)	UK	N/A	Grounded Theory	Finding new ways of being within an interpersonal space	The author noted that group interventions enabled an interactive relational context which was safe and subsequently enabled conflict and learning
Goodman et al. (2014)	11 participants with EUPD vs 11 Healthy Controls (HC) (9 females, 2 males in both groups)	30.4	Non-Randomised Control Trial 11 participants with EUPD (engaging with DBT intervention) vs 11 HC's	USA	12 month intervention. Data collated at baseline, six months and at 12 months.	Correlation: Pearson	Amygdala activity	Participants with EUPD showed decreased amygdala activation during treatment and subsequent improved emotional regulation

Gratz, Levy & Tull (2012)	Two trials. Trial one: 22 women who met criteria for EUPD Trial two: 19 women who reported dangerous self harm (subthreshold EUPD)	Trial one: 33 years Trial two: 33.3years	Trial one: RCT (Acceptance-based Emotion Regulation Group Therapy (ERGT) + TAU vs TAU) Trial two: Open trial (no control group)	USA	Data collated over three timepoints (baseline, mid treatment, post treatment)	Latent Growth Analysis	Emotional dysregulation	Emotional regulation mediated effect of reductions in dangerous self harm within ERGT
Hodgetts, Wright & Gough (2007)	5 participants with a EUPD diagnosis (2 male, 3 female)	35.2	Qualitative (DBT)	UK	N/A	Interpretive Phenomenological Analysis	Uncertainty: self or group?	The study alluded to many positive benefits and effects of the DBT group, but did not reflect on potential influences of change, except for uncertainty around group or the self as a facilitator of change
Kramer et al. (2016)	41 patients with EUPD (Skills group= 20 female, 1 male; TAU group= 16 female, 4 male)	Skills group= 35.14 Intervention group= 33.6	RCT (DBT informed skills training vs TAU)	Switzerland	Measure distributed pre, post and during a three month follow-up	Mediation Analysis	Assertive anger	DBT skills training increased levels of assertive anger, and mediated symptom reduction, particularly in the context of participant's social roles
Linehan, et al. (2015)	99 women with an EUPD diagnosis	30.3	Single-blind RCT (DBT vs DBT-Skills vs DBT-I)	USA	Baseline and quarterly over one year of treatment. One	Mixed effects modelling	Skills use	Interventions with a skills training component were more effective than those without and resulted in

					year follow up also completed			greater improvements in self-harm and depression scores than individual DBT therapy
McMain, et al. (2013)	80 individuals who met criteria for EUPD (Subset of participants from a wider RCT) (67 females, 13 males)	32.6	RCT (DBT vs General Psychiatric Management (GPM))	Canada	Dependent Measures: Baseline and every four months over one year of treatment	Correlation: Pearson	Emotion and cognitive problem solving	Improvements in cognitive and emotion processes (affect balance and problem solving) associated with more positive treatment outcomes (reduction in symptom distress and improvements in interpersonal functioning)
McSherry, O'Connor, Hevey & Gibbons (2012)	8 participants who met criteria for EUPD (6 females, 2 males)	Age range between 32-55	Qualitative (Adapted DBT)	UK	N/A	Thematic analysis	Group environment and skills application: mindfulness	Developing coping skills and valuing the group environment were seen as potential facilitators of managing emotions and increasing confidence and sense of identity
Neacsiu, Rizvi & Linehan (2010)	108 women with EUPD (63 recurrently suicidal women with EUPD, 45 women with EUPD and drug dependence)	31.44	RCT (DBT vs Community treatment by experts (CTBE) vs Treatment as usual (TAU))	USA	16 months. Measures collected at pre-treatment and then every four months	Mediation analysis	Skill use	Skill use is a potential mechanism for change for suicidal behaviour, depression and anger control
Nee & Farman (2007)	Three women with EUPD currently in prison	19, 29 & 26 years of age	Case studies following on from completion of DBT programme. Both staff and service user perspective included.	UK	N/A	Case Study	Mindfulness, tolerance of distress	Case studies highlighted the differential skills needed at different points of therapy and progress was dependent on individual circumstance

O'toole, Diddy & Kent (2012)	165 women with a EUPD diagnosis	37.10	Correlational (DBT)	5 different states in USA	Interventions ranged from 1-180 weeks	Correlation: Pearson	Mindfulness	Mindfulness and social support were found to be predictors of emotional wellbeing. Mindfulness practice was also associated with less frequent healthcare usage
Perroud, Nicaastro, Jermann & Huguelet (2012)	52 females who met criteria for EUPD	30.7	Single Intervention Experimental Design (Follow up to a DBT intervention)	Switzerland	Baseline measure and at six intervals (at end of each DBT module)	Regression analysis	Mindfulness : Accepting without judgement	Accepting without judgement, a particular aspect of mindfulness training was found to correlate with improvements in EUPD symptoms and viewed as a potential mechanism of change
Perseius, Ojehagen, Ekdahl, Asberg & Samuelsson (2003)	Patient group: 10 women with EUPD diagnosis Therapist group: 4 therapists	Patient group: 27	Qualitative (DBT)	Sweden	N/A	No methodology described	Patient group: Skills And being ready to change Therapist: Manual and being ready to change	Development of a skills tool box and respect and collaboration key components
Sandage et al., (2015)	40 adults who met criteria for EUPD (35 females, 5 males)	40.2	Single Intervention Experimental Design (forgiveness module within DBT intervention)	USA	Four week intervention. Measures completed at 4 time points including 6-week follow-up	Mediation analysis	Reductions in anxious attachment	Decreases in anxious attachment scores mediated effect of motivations to forgive on general EUPD symptomology
Soler et al. (2012)	60 participants who were diagnosed with EUPD	DBT-M=29.33	Non-Randomised Control Trial (DBT- M + GPM vs GPM alone)	Spain	Pre-intervention	Correlation: Pearson	Mindfulness Practice	Minutes of mindfulness practice correlated with improvements to

(DBT= 36 female, 4
males; GPM= 15
females, 4 males) GPM=
31.78

and at end of
intervention

psychiatric symptoms
(attention and impulsivity)

3. Literature Review

3.1. Overarching Findings

A vast array of proposed mechanisms of change were identified within interventions with a group element for EUPD. This diversity in potential change mechanisms is perhaps reflective of the complexity of difficulties individuals with an EUPD diagnosis face. A summary of the possible mechanisms has been listed below.

3.1.1. Skill application.

Some potential change mechanisms focused on application of skills learnt within the therapy. Neascsciu, Rizvi and Linehan (2010) explored whether the emotional regulation skills teaching within DBT was treatment mediator for 108 women with EUPD. The authors found that skills use fully mediated a decrease in suicide attempts, depression and improvements in managing anger.

Linehan et al. (2015) completed the component analysis for DBT, comparing standard DBT (group & individual) to the skills group and to the individual sessions in order to understand the most effective components of the intervention. Linehan et al. (2015) found that interventions with a skills element showed greater improvements in frequency of non-suicidal self injury and depression. This provides further evidence for the benefit of skills teaching in facilitating change.

Many of the qualitative studies also supported the above findings. Participants within Cunningham, Wolbert and Lillie's (2004) ethnographic study reflected on their experience of a DBT group and reasons for its success. Skill use such as distancing and self-soothing were identified as powerful in helping reduce self harm. This was also confirmed within Perseius,

Ojehagen, Ekdahl, Asberg and Samuelsson's (2003) qualitative investigation of individuals experience of receiving DBT. Participants noted that skills training was important in reducing self harm and suicidal behaviours.

Research has also begun to explore the potential value of more specific skills. For example, Feliu- Soler et al. (2014) explored the impact of DBT mindfulness training on emotional reactivity. Participants were assigned to General Psychiatric Management (GPM) or GPM with mindfulness training. The authors found that increased mindfulness practice was correlated with lower emotional reactivity and depression.

Soler et al. (2012) corroborated the above findings, whilst carrying out a non-randomised control trial exploring the impact of a DBT-mindfulness module on several measures of attention and other clinical variables. The authors found that minutes of mindfulness correlated with reductions in depression and confusion symptoms. O'toole, Diddy and Kent (2012) mirrored these findings in their study which investigated the predictors of emotional wellbeing for 165 women involved in DBT. Higher use of mindfulness skills was reflected in reduced healthcare usage.

Perroud, Nicastro, Jermann and Huguelet (2012) developed the above research further and explored particular elements of mindfulness practice that might influence change. Perroud et al. (2012) assessed mindfulness skills at six intervals during a one year DBT intervention. Specifically, increased ability to accept without judgment correlated with improvements in EUPD symptoms (depression and hopelessness).

The acknowledgement of mindfulness practice as a potential mechanism of change has also been highlighted within the qualitative literature. Within their case study design, Nee and Farman (2007) reported that Ms A found mindfulness practice as valuable in enabling

therapeutic change, whilst discussing her experiences of receiving DBT whilst in prison (Nee & Farman, 2007).

One study evaluated a different element of the emotion regulation system: emotional and cognitive problem-solving processes. McMain et al. (2013) completed a Randomised Control Trial (RCT) comparing DBT to GPM for 80 individuals with a EUPD diagnosis. The authors found that improvements in affect balance and problem solving following on from the intervention were correlated with reductions in symptom distress and improvements in interpersonal functioning.

3.1.2. Tolerating and managing emotions.

Several studies demonstrated the importance of communicating and managing emotions. Gratz, Levy and Tull (2012) developed an emotion regulation group therapy for women with EUPD and found that reductions in emotion dysregulation mediated reductions in self harm. Goodman et al. (2014) supported these findings and identified that reduced amygdala activation correlated with reduced emotional dysregulation, highlighting the potential neurological impact of therapy. The value of becoming more able to manage emotions in facilitating change was also confirmed within the qualitative literature (Nee & Farman, 2007).

More recently, Kramer et al. (2016) evaluated the processes of change within an RCT comparing a DBT skills group verses treatment as usual. The authors found that increases in assertive anger mediated symptom reduction in the DBT skills group. This suggests that subtle emotional processes may influence therapeutic change.

3.1.3. Therapeutic alliance.

Bedics, Atkins, Comtois and Linehan (2012) explored differences in the therapeutic relationship and introject whilst completing a two-year RCT comparing DBT verses

Community Treatment by Experts. Bedics et al. (2012) found that participants within the DBT condition who perceived their therapist as warm, affirmative, protective and loving reported less incidences of self harm and greater self love and care. Bedic, Atkins, Harned and Linehan (2015) extended these findings and found that participants with higher client rated commitment and therapist understanding experienced reduced self harm. These findings reflected in the wider literature base regarding the importance of the therapeutic relationship for all types of mental health problems (Lambert & Barley, 2001).

3.1.4. Interpersonal skills and shifts in identity.

Another potential change mechanism identified within the included studies was the role of a developing a sense of self. McSherry, O'Conner, Hevey and Gibbons (2012) completed a thematic analysis of service user experience of adapted DBT. Participants identified the value of the group setting on increasing confidence and regaining and renewing a sense of identity. Geyer (2013) completed a grounded theory investigation of the experience of change within group interventions for EUPD. Geyer (2013) acknowledged the importance of group therapy in enabling participants to try out new ways of being within a safe space.

Dammann et al. (2016) used a quantitative research design which also highlighted the importance of interpersonal development. The authors evaluated changes in interpersonal problems after a 12-week Transference Focused Therapy combined with DBT skills training. Improvements in interpersonal problems were observed and interpersonal problems at baseline correlated with most interpersonal problem scores at the end of the intervention, as well as several measures of EUPD symptomology (e.g. anxiety). This research suggests that interpersonal difficulties could be a potential mechanism of change.

Research completed by Sandage et al. (2015) also explored elements of interpersonal difficulties. The authors evaluated a group forgiveness module within a DBT intervention

over four time points. The authors found an increase in measures of forgiveness, attachment insecurity and psychiatric symptoms. The authors then completed a mediation analysis and concluded that reductions in anxious attachment mediated the relationship between increases in motivations to forgive to reductions in psychiatric symptoms such as depression.

3.1.5. Personal readiness.

Finally, several of the qualitative studies (Cunningham et al., 2004; Perseius et al., 2003) and one quantitative study (Bedics et al., 2015) alluded to the importance of personal readiness, taking responsibility and help seeking as important facilitators of change. This was identified by participants within Hodgetts, Wright and Gough's (2007) qualitative investigation of experience of DBT. Participants found it hard to identify whether change came from the therapy model or from within themselves.

3.2. Comparison to Previous Reviews

The proposed mechanisms or influences of change within group interventions appear similar to those identified for individual interventions within previous reviews. Skill use, experiential avoidance, emotional regulation and cognitive change were all noted as potential change mechanisms within the review (Forster et al., 2014).

However, of particular interest were the additional possible influences of change that were identified within the current review. These skills included interpersonal skill development, developing emotional balance, the increased ability to problem-solve, expressing assertive anger, learning and practicing mindfulness skills, reconnection with and evolution of identity as well as increased tolerance of distress and personal readiness. It is theorised that many of the skills listed above are those that are more readily utilised and appropriate within group settings. For example, interpersonal skill practice is a relational skill, one that requires a group setting in order for individuals to express, challenge and be

challenged within a safe environment. Therefore, it is possible that the proposed change mechanisms identified in the current review were reflective of an additional, unique influence of group based interventions. However, these results need to be interpreted tentatively, for reasons discussed below.

The finding that personal readiness and commitment to change (Bedics et al., 2015; Cunningham et al., 2004; Hodgetts et al., 2007; Perseius et al., 2003) are potential mechanisms of change is a new finding. This finding was not observed within most quantitative studies and the results highlight the value of qualitative service user research in understanding internal drivers of change. The potential importance of readiness to change requires further investigation.

3.3. Do the Studies Really Measure Group Impact?

Although numerous studies noted some potential change mechanisms, many of the included study designs and methodologies made it difficult to meaningfully disentangle the influence of group intervention elements in comparison to individual intervention components. This made it difficult to identify particular mechanisms of change for group based interventions.

For example, only one study (Linehan et al. 2015) completed a component analysis of a DBT intervention. DBT is the most widely researched group element psychological therapy for EUPD (Droscher, Startup, Petfield & Cartwright-Hatton, in press) and so this finding is surprising. In Kazdin's (2007) paper regarding mechanisms of change, he recommended component analysis as an effective way of deciphering potential mediators and subsequent potential change mechanisms within psychological therapy. The current review has highlighted a paucity of this type of analysis within the literature base surrounding group interventions, which future research should aim to address.

An alternative perspective for the findings of the current review is that group interventions did not produce unique change mechanisms when compared to individual interventions and that the additional proposed influences of change identified in the current review were due to some other factor, such as evolution of the literature base. This is supported by the finding of several of the included studies (Bedics, Atkins, Harned & Linehan, 2015; Neasciu et al. 2010) who noted that both the intervention condition and control condition had a positive impact on included outcome measures and often resulted in a reduction in EUPD symptomology. This suggests that psychological interventions may include generalised influences of change that are not always restricted to a particular type of intervention. This was noted within the review by Forster et al. (2014) and has been alluded to within the research literature (Connolly Gibbons et al., 2009).

However, some of the included qualitative studies went some way to identify the possible unique contribution of group intervention utilising a qualitative grounded theory methodology. Geyer's (2013) overarching theory identified "discovering new ways of being in an interpersonal space" (p.46) as the core process relating to change for eight individuals who had engaged in group therapy. This finding suggests that group therapy may offer a unique way in evolving interpersonal skills and sense of self.

Furthermore, in the qualitative research by Perseius et al. (2003), participants identified the group skills focus of DBT as key in enabling them to reduce suicidality and self-harm behaviours. Cunningham et al. (2004) noted that participants found the group support vital in their progression and development, stating that group members learnt from each other.

These findings support and expand on some of the quantitative study findings (Linehan et al., 2015; Neasciu et al., 2010) identified within the review and illuminate some

of the subtle processes within group therapy which may enable change. Furthermore, the studies effectively identified and communicated the voices of those with an EUPD diagnosis about what their perception of change was, a stark contrast to the majority of papers in this review.

3.4. Qualitative Data

The current review identified six qualitative studies exploring change for individuals with EUPD which started to include the service user voice. However, there was an absence of studies which asked individuals with lived experience of EUPD directly about their views of change and it appears disjointed that the voices of those with this diagnosis are not more prevalent within the research literature.

Only Geyer's (2013) research focused specifically on understanding change within group therapy, as opposed to through another lens such as 'recovery' or within a service evaluation. The recovery concept has been noted to jar with many service users' experiences of their struggles with EUPD who stated that the concept of recovery did not always denote the complexity and long term nature of their difficulties (Katsakou et al., 2013).

Unfortunately, the majority of included qualitative studies utilised the recovery concept when exploring change and this may have restricted researchers' questions and subsequently influenced participant's responses.

With the evolution of the service user led movement (Thornicroft & Tansella, 2005) which has developed within the last decade and has influenced both MHS provision and research, it is argued that the voices of those with an EUPD diagnosis is not equally and transparently represented within the literature base.

3.5. Quality of Studies

Alongside evaluation of study findings, included studies were evaluated for quality. Because of the variety of study designs and methodologies employed, it was difficult to gain an overall assessment of study quality and subsequently studies were evaluated based upon their methodological orientation using corresponding quality assessment tools as appropriate.

3.5.1. Qualitative studies.

The qualitative studies within the current review were reviewed against Mays and Pope's (2000) criteria and varied considerably in their quality (as seen in Appendix C). Only two of the seven studies utilised some form of triangulation within the analysis of their studies (Geyer, 2013; Perseus et al., 2003). None of the included studies included respondent validation and only one study (Geyer, 2013) included any reflections about the researcher's influence on the dataset. This lack of participant verification and evaluation of researcher reflexivity arguably left the authors open to biased results, further reinforcing the silencing nature of a large proportion of the research literature for individuals with EUPD.

Furthermore, the overall quality of the written analysis varied considerably between studies, with fluctuating quality of methodology description and adherence and at times with limited information about the ways in which the researchers acknowledged negative cases (McSherry et al., 2012). These findings suggest that the literature base needs to enhance the quality of qualitative research focusing on change within the context of EUPD.

Appendix D noted that the case study by Nee and Farman (2003) gave sufficient detail regarding participant's backgrounds and presentation during their experience of the DBT group. However, of the three case studies reported only one was included within the current review as it was the only case study to express the service users' views of what

helped within the group and why. Again, the inconsistency between case studies and the omission of the service user voice is a notable oversight.

3.5.2. Quantitative studies.

As with the included qualitative studies, the quantitative studies also varied in quality. Please see Appendix F and G for further information. Using the EPHPP (1998) criteria to assess study quality, it was noted that the majority of included studies provided adequate descriptions of their methodology and were able to control for individual differences between intervention groups prior to analysis. However, studies varied in their ability to adequately describe outcome measures utilised with regard to validity and reliability, with some poorly describing the rational and overall validity of their outcome measures (Feliu-Soler et al. 2014; Kramer et al. 2016).

Some of the correlational study designs failed to observe their proposed mechanism of change regularly over several time frames, making it difficult to ascertain the strength of the relationship between the study variables and proposed mechanisms of change (Dammann et al., 2016; Feliu-Soler et al., 2014). For example, O’toole et al. (2012) completed a cross correlational study collecting measures at a single time point. This study, and many others included in this review, would have benefited from a longitudinal measurement of change by completing outcome measures at several points throughout treatment and at follow-up. This would have enabled the studies to truly ascertain the strength of the relationship between variables.

3.5.3. Kazdin’s criteria.

When reviewing quantitative studies in relation to Kazdin’s (2007) criteria for identifying mechanisms of change, it was noted that only three of the 13 appropriate studies were able to imply some direction of the cause and effect of potential change mechanisms.

The vast majority of appropriate studies were correlational in nature. This meant that criteria such as identifying a strong association, timeline and experimental manipulation were unable to be met. The specificity and consistency of hypothesised change mechanisms varied considerably, with many studies being the first of their kind to investigate a particular phenomenon (McMain, et al. 2013) reducing the ability to apply the above criteria.

However, three studies (Gratz et al., 2012; Kramer et al., 2016; Feliu-Soler et al., 2014) were more able to meet Kazdin's (2007) criteria, arguably largely due to their between-group design and robust mediation analyses. The studies acknowledged a strong association, specificity, experimental manipulation, timeline and plausibility of proposed mechanisms. One study (Gratz et al., 2012) also generalised their findings to a second trial, strongly increasing the consistency of the proposed change mechanism.

3.6. Critique of Quality Criteria

As noted above, the collection of studies included within the current review varied considerably in their quality. However, it is also important to note that the above quality criteria frameworks are just one way of interpreting the data. It is potentially reductionist to apply one form of quality criteria for a wide variety of study methodologies. For example, Geyer (2013) deliberately chose not to complete respondent validation as this conflicted with the epistemological position of the study. This subtlety was missed when applying generalised quality criteria, highlighting the limitation of quality assessment criteria, as noted by Hammersley (2007).

4. Systemic Critique

EUPD research focusing on change is arguably in its infancy which is perhaps reflective of some of the observed variations of study quality noted above. The wider systemic context surrounding EUPD needs to be held in mind when reviewing studies of this nature. Some pertinent contexts have been identified and used to critically evaluate the included studies.

4.1. Application to Clinical Settings

When evaluating the diversity of group interventions, 17 out of the 20 studies evaluated a DBT intervention. It is a limitation of the current literature base that the interventions evaluated within EUPD research are not representative of the interventions utilised in clinical practice (Avon & Wiltshire NHS Mental Health Partnership Trust, 2013; Camden & Islington NHS Foundation Trust, 2015). Furthermore, only five of the 20 included studies were located within UK, NHS contexts, reducing the generalisability of findings to clinical settings.

4.2. Diagnosis

The included studies varied with regards to the diagnostic tools used when assessing EUPD diagnosis, highlighting the variation across classification use within clinical work and in research (The British Psychological Society & The Royal College of Psychiatrists, 2009). A study by Zimmerman (1994) found that less than a third of 52 outpatients were diagnosed with the EUPD diagnosis when utilising both the ICD-10 and DSM-IV. The relative inconsistency across diagnostic systems is arguably reflective of ambiguity surrounding the underlying construct of EUPD.

As noted earlier, EUPD, or Borderline Personality Disorder as it is also known, is a diagnosis rife with controversy. This ambiguity continued after the publication of the DSM-

III (American Psychiatric Association, 1980) and subsequent publications which looked to increasingly categorise EUPD symptomology, a route which many healthcare professionals stated was a rather arbitrary process with little clinical meaning (Silk, 2002). Tyrer (2009) completed a critical analysis of the concept of Borderline Personality Disorder and concluded that it represents discrete symptoms rather than personality traits and should be re-classified as a mood disorder.

It appeared that the articles included in the current review were also prone to this difficulty. Five different diagnostic classification systems were used to identify appropriate participants in the current review. It is difficult to conclude with great certainty that participants included in the review studies were presenting with comparative and similar difficulties and symptomology, particularly when holding in mind the historical ambiguity around the EUPD diagnosis itself.

4.3. Gender

Women represented a large proportion of samples included in the present review with 10 of the 20 studies including only female participants and with the remaining study samples being predominantly female. This echoes a pattern observed more widely within society, where women are more commonly diagnosed with EUPD than men (Skodol & Bender, 2003). This could correlate with the increased incidence of abuse that women experience comparatively to men (Office for National Statistics, 2016) and the societal response to withdraw and label. Ussher (2011) reflected on this societal process “are these expressions of intense anger symptoms of a disorder, such as BPD, as many women are told? Or rather, are they another aspect of women’s ‘reasonable response’ to childhood sexual abuse?” (p. 138) It appears that this societal discourse is still rife within academic research.

4.4. Single Symptom Change

A large portion of the quantitative review studies included very few outcome measure tools to capture EUPD symptomology. Perroud et al. (2012) included the Beck Depression Inventory (Beck, Steer & Brown, 1996) and the Beck Hopelessness Scale (Beck & Steer, 1988) as their measures of general EUPD symptomology and Gratz et al. (2012) used the Deliberate Self-Harm Inventory (Gratz, 2001) as their dependent variable measure.

It is unlikely that the complexity of EUPD symptomology could be effectively measured using one or minimal forms of outcome measures. This was noted by Madan and Fowler (2014) who aimed to reduce the inconsistency in use of outcome measures across research studies for EUPD by identifying a battery of tests for researchers to utilise. This battery included eight measures and highlights the complexities of the EUPD experience, one that single symptom measures cannot encapsulate.

Furthermore, a significant number of the included studies identified potential mechanisms of change for a precise relationship between a specific intervention and a particular element of EUPD symptomology (Kramer et al. 2016). It is contended that sparsity of outcome measures used, as well as the rather restrictive relationships between mediator and particular EUPD symptoms identified, reduces the generalisation and meaningfulness of research findings to individuals who struggle with EUPD.

4.5. Research and Clinical Practice

After reviewing the meaning and validity of the findings and methodology of the included studies, a noticeable disparity was identified between the findings of the studies and the meaningful application to clinical practice. Kazdin (2008) reflected on this tension, noting that the arguable neatness of client issues included within research trials is often not reflective of the “loose and fuzzy” (p.148) outcomes of clinical practice. Kazdin (2008) went on to note

that qualitative research can help bridge the gap between research and practice, being utilised as a way of testing and generating clinically grounded research hypotheses, a form of analysis which was sparsely used within the current review.

Many of the studies in the current review attempted to identify specific outcomes and elements of the EUPD diagnosis to evaluate whilst subsequently failing to capture the intricacies of difficulties experienced by someone with this diagnosis (Tyrer, 2009). Exploring service users' perspectives on meaningful outcome measures, would be a useful step in bridging the gap between clinical experience and academic research, whilst simultaneously incorporating the service user voice.

4.6. Change Over Time

The studies included varying use of follow-ups, with some studies including a brief follow-up time (Kramer et al., 2016), whilst the majority of other studies did not include a follow-up at all (Feliu- Soler et al., 2014; Goodman et al., 2014). This was an important omission when holding in the mind the notion that therapeutic interventions should evoke change that occurs beyond therapy (Beck, 2011; Linehan, 1993; Young, 1999) and the long-term nature of difficulties experienced by individuals with EUPD. To really explore mechanisms of change and the subsequent impact that they have on participants lives, future research studies should aim to monitor change over a longer period of time using extended follow ups, as recommended by Levy (2008).

4.7. Staff Perspectives

Only one study in the current review included staff perspective of changes for clients and subsequent potential mechanisms of change (Nee & Farman, 2007). This appears to be a significant oversight within the research literature to date, as staff members who work

intensely with individuals with a EUPD diagnosis are likely to have unique and valuable contributions about what instigates change for the service users' that they work with.

Furthermore, a large degree of the research literature highlights stigma within MHS, particularly within individual interactions between service users' and staff members (King, 2014; Weight, 2013). Including staff members' perspectives about their experiences of working with service users' may enable a new narrative to be incorporated into the research literature, one that promotes a thoughtful, caring and valuable relationship between staff and service users'.

4.8. Beyond Therapy

Individuals with EUPD do not always have access to or remain in therapy (Kroger, Harbeck, Armbrust & Kliem, 2013; NICE, 2009) but do often have contact with community mental health teams, are part of the Care Programme Approach, may have a care-coordinator or be part of a therapeutic community or specialist day service. This was a neglected aspect of client care within the current review. It is essential that research begins to explore potential change mechanisms within more indirect therapeutic work to support the notion of more generalised change mechanisms.

5. Summary

A review was undertaken to explore the potential mechanisms of change within psychological interventions with a group element for individuals with a diagnosis of EUPD.

The findings of the review correlated with many of the potential change mechanisms identified by Forster et al. (2014) regarding individual interventions for EUPD. However, the current review identified some potential additional benefits of group based interventions that facilitated change. These, for example, included the value of group settings in enabling new ways of being (Geyer, 2013), increasing assertive anger (Kramer et al. 2016) or practicing mindfulness (Feliu- Soler et al. 2014; Nee & Farman, 2007). Therefore, individual and unique qualities of both 'top down' and 'bottom up' therapeutic interventions may enable change for individuals with an EUPD diagnosis. There are also commonalities which transcend intervention type (e.g. enabling new ways of being or readiness to change) which facilitate change.

However, this review contested that both the quantitative and qualitative studies included varied in quality and results should be taken with caution. For example, the quantitative study designs struggled to isolate the unique influence of the group component of interventions. Furthermore, the study designs, outcome measures and samples were often inconsistent and blinkered. Varying diagnostic tools also highlighted the underlying instability of the EUPD diagnosis itself.

The qualitative studies included in the current review enabled a richer understanding of service user experiences and went some way to identify potential unique influences of change within group based interventions. A large proportion of qualitative research also highlighted the importance of personal readiness to change which is an interesting and new research finding. However, only one study (Geyer, 2013) directly asked participants about

their perspective of change, as opposed to exploring change within a different context (e.g. via service evaluation or through the lens of ‘recovery’). This observation is possibly reflective of a wider systemic issue within psychological research and the service user involvement movement for EUPD. It appears that the service user voice is still restricted within qualitative data.

A qualitative grounding in patient experience of change is argued to be an important missing link between current research findings and the desired goal of understanding mechanisms of change within EUPD for group based interventions, and beyond. Bearing in mind the wider historical context surrounding EUPD as well as the current stigma still prevalent within society towards this diagnosis (Horn, Johnstone & Brooke, 2007), a need for a service user grounded understanding of change is imperative.

6. Implications for Research and Practice

This review has highlighted several areas for potential future research.

6.1. Research Implications

6.1.1. Quantitative research focusing on change within group based interventions.

It would be beneficial for future research to explicitly explore potential influences of change within group interventions. This could involve completing further component analyses and using RCT’s as opposed to correlational designs in order specifically investigate the potential additional value of group based interventions for EUPD, whilst following Kazdin’s (2007) criteria for rigorously assessing mechanisms of change.

6.1.2. Qualitative research focusing on service users’ experiences of change within psychological therapy.

There is a need for further research to explore service users' experience of change within group based interventions, across a broader spectrum of psychological therapies in order to more effectively encapsulate the experiences and complexities noted for individuals who struggle with EUPD.

6.1.3. Qualitative research focusing on service users' experiences of change outside of psychological therapy.

As noted earlier in the review, many individuals do not access 'traditional' psychological therapy. Consequently, further research should aim to develop a more holistic, service-user grounded understanding of change, across a wider range of service provision and personal life contexts. This is supported by the findings within the current review that identified the role of the service user in making meaningful changes. This suggests that change extends beyond therapy and is more of a complex interaction than previous reviews have suggested.

6.1.4. Qualitative research focusing on staff experience of change.

The current review has highlighted a lack of qualitative research exploring staff's experience of effective support and changes noted for the individuals who they have worked with, an avenue which future qualitative research should aim to explore.

6.2. Clinical Implications

As well as having important implications for academic research, the current review has highlighted several important clinical implications.

6.2.1. Use of group interventions for EUPD.

The above review has highlighted that group interventions for individuals diagnosed with EUPD may enable unique therapeutic change for clients. This includes the development of identity through interaction with other group members, by testing out different ways of

‘being’ in relation to others. Subsequently, group interventions may offer a suitable alternative to individual therapy for some clients. Furthermore, when holding in mind current levels of austerity (Cromarty, 2017), group interventions are likely to be increasingly preferential for NHS services, in order to provide more cost-effective therapy.

6.2.2. NHS group intervention evaluation.

There is a rich variation of group based research interventions prevalent within NHS MHS which are currently less evident within the research literature. Hence, there is a need for further service led evaluations of group interventions that extend beyond that of DBT. This may add clarity around whether there are in fact differences in change mechanisms between group and individual interventions, or whether more general therapeutic change mechanisms are at play. Furthermore, this may add increased generalisability of research findings to clinical settings based in NHS settings, which was a minority within the current review.

6.2.3. Development of meaningful service user driven outcome measures.

There is a need to voice service users’ views about what elements of change would be beneficial to measure when delivering a therapeutic intervention. This would enable development of new outcome measures grounded in the values of service users’ and this could be completed by Clinical Psychologists and other mental health professionals within clinical settings. Furthermore, exploration with service users’ and staff about length of time for meaningful follow-ups would be a meaningful avenue to explore.

7. Conclusions

The current review aimed to explore potential mechanisms of change within group based interventions for EUPD and to explore whether these differed from those identified for individual interventions. An array of potential mechanisms of change were identified. Some correlated with those identified within the review by Forster et al. (2014), such as experiential avoidance, emotional regulation and skill use for example.

The unique role of interpersonal skill development through exploration of testing out new ways of being as well as the use of mindfulness skills were just two examples of potentially unique mechanisms of change for group interventions.

The qualitative studies highlighted the value of skill learning and application (e.g. distancing from emotions) as well as the importance of personal readiness to change. However, the qualitative studies explored the experience of change within a particular context (e.g. whilst evaluating a therapeutic evaluation or within the context of recovery) which may have restricted results and subsequent possible interpretations.

Included studies varied in quality and it was difficult to differentiate the potentially unique contribution of group interventions within many of the study designs. Furthermore, findings were limited by varying outcome measures, short follow-up times and a narrow intervention focus.

Finally, the review noted many studies were void of the service user voice. This was demonstrated by both the sparsity of qualitative studies as well as the lack of grounding of the qualitative studies in the service user experience or perspective. This echoes a wider societal silencing of EUPD which future research should aim to rectify.

This review has identified more questions than answers and results should be interpreted with caution. More rigorous qualitative based research regarding the service user

experience of change is warranted to enhance the depth and quality of a literature base still largely in its infancy.

8. References

Agrawal, H. R., Gunderson, J., Holmes B. M., & Lyons-Ruth, K. (2004). Attachment studies with borderline patients: A review, *Harvard Review of Psychiatry*, 12, 94-104. Doi: 10.1080/10673220490447218.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (2001). *Work group on Borderline Personality Disorder: Practice guideline for the treatment of patients with borderline personality disorder*. Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Avon & Wiltshire NHS Mental Health Partnership Trust. (2013). *South gloucestershire psychological therapies service (PTS)*. N.P.: Author.

Bales, D., van Beek, N., Smits, M., Willemsen, S., Busschbach, J. J. V., Verheul, R., & Andrea, H. (2012). Treatment outcome of 18-month, day hospital mentalization-based treatment (MBT) in patients with severe borderline personality disorder in the Netherlands, *Journal of Personality Disorders*, 26, 568-582. Doi: 10.1002/cpp.1914.

- Bateman, A., & Fonagy, P. (2010). Psychotherapy for borderline personality disorder: Mentalization-based treatment for borderline personality disorder, *World Psychiatry*, 9 (1), 11-15. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2816926/pdf/wpa010011.pdf>
- Beck, A. T., & Steer, R. A. (1988). *Manual for the Beck Hopelessness Scale*. San Antonio, TX: Psychological Corporation.
- Beck, A.T., Steer, R.A., & Brown, G.K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.
- Beck, J. S. (2011). *Cognitive behavioural therapy: basics and beyond* (2nd ed.). New York, NY: The Guilford Press. Retrieved from <http://file.zums.ac.ir/ebook/082Cognitive%20Behavior%20Therapy,%20Second%20Edition%20%20Basics%20and%20BeyondJudith%20S.%20Beck%20Phd%20Aaron%20T.%20Be.pdf>
- Bedics, J. D., Atkins, D. C., Comtois, K. A., & Linehan, M. M. (2012). Treatment differences in the therapeutic relationship and introject during a 2-year randomised control trial of dialectical behaviour therapy versus non-behavioural psychotherapy experts for borderline personality disorder, *Journal of Consulting and Clinical Psychology*, 80(1), 66-77. Doi: 10.1037/a0026113.

Bedic, J. D., Atkins, D. C., Harned, M. S., & Linehan, M. M. (2015). The therapeutic alliance as a predictor of outcome in dialectical behaviour therapy versus non-behavioural psychotherapy by experts for borderline personality disorder, *Psychotherapy Theory Research Practice Training*, 52, 67-77. Retrieved from https://www.researchgate.net/profile/David_Atkins2/publication/273323493_The_the_rapeutic_alliance_as_a_predictor_of_outcome_in_dialectical_behavior_therapy_versus_nonbehavioral_psychotherapy_by_experts_for_borderline_personality_disorder/links/550303bb0cf2d60c0e64c5ac/The-therapeutic-alliance-as-a-predictor-of-outcome-in-dialectical-behavior-therapy-versus-nonbehavioral-psychotherapy-by-experts-for-borderline-personality-disorder.pdf

Binks, C. A., Fenton, M., McCarthy, L., Lee, T., Adams, C. E., & Duggan, C. (2006). Psychological therapies for people with borderline personality disorder, *The Cochrane Database of Systematic Reviews*, 2012(1). Doi: 10.1002/14651858.CD005652.

Camden & Islington NHS Foundation Trust. (2017). Camden and Islington personality disorder service. Retrieved from <http://www.candi.nhs.uk/services/camden-and-islington-personality-disorder-service>

Clarkin, J. F., Yeomans, F. E., & Kernberg, O.F. (2006). *Psychotherapy for Borderline Personality: Focusing on object relations*. New York, NY: John Wiley & Sons Inc.

Connolly Gibbons, M. B., Crits-Christoph, P., Barber, J. P., Stirman, S.W., Gallop, R., Goldstein, L., & Ring Kurtz, S. (2009). Unique and common mechanisms of change across cognitive and dynamic psychotherapies, *Journal of Consulting and Clinical Psychology*, 77, 801–813. Doi: 10.1037/a0016596.

Cromarty, H. (2017, February). Adult social care funding (England). Retrieved from http://cdn.basw.co.uk/upload/basw_61912-4.pdf

Cunningham, K., Wolbert, R., & Lillie, R. (2004). It's about me solving my problems: Clients assessments of dialectical behaviour therapy, *Cognitive and Behavioural Practice*, 11, 248-256. Doi: 10.1108/JIDOB-09-2015-0027.

Dammann, G., Riemenschneider, A., Walter, M., Sollberger, D., Kuchenhoff, J., Gundel, H.,...Gremaud-Heitz, D. J. (2016). Impact of interpersonal problems in borderline personality disorder inpatients on treatment outcome and psychopathology, *Psychopathology*, 49, 172-180. Doi: 10.1159/000446661.

Dixon-Gordon, K. L., Peters, J. R., Fertuck, E. A., & Yen, S. (2016, June). Emotional processes in borderline personality disorder: An update for clinical practice, *Journal of Psychotherapy Integration*. Doi: 10.1037/int0000044.

Droscher, H. K., Startup, H., Petfield, L. S., & Cartwright-Hatton, S. (in press). Psychological therapies with a group component for people experiencing borderline personality disorder: a systematic review and meta-analysis, *Psychopathology Review*.

Effective Public Health Practice Project. (1998). Quality assessment tool for quantitative studies. Hamilton, ON: Author. Retrieved from http://www.ehpp.ca/PDF/Quality%20Assessment%20Tool_2010_2.pdf

Farrell, J. M., Shaw, I. A., & Webber, M. A. (2009). A schema-focused approach to group psychotherapy for ourpatients with borderline personality disorder: a randomized controlled trial. *Journal of Behavior Therapy and Experimental Psychiatry*, 40, 317-328. Doi: 10.1016/j.jbtep.2009.01.002.

Fassbinder, E., Schuetze, M., Kranich, A., Sipos, V., Hohagen, F., Shaw, I.,...Schweiger, U. (2016). Feasibility of group schema therapy for outpatients with severe borderline personality disorder in germany: A pilot study with three year follow-up, *Frontiers in Psychology*, 7(1851), 1-9. Doi: 10.3389/fpsyg.2016.01851.

Feliu-Soler, A., Pascual, J. C., Borrás, X., Portella, M. J., Martín-Blanco, A., Armario...Soler, J. (2014). Effects of dialectical behavioural therapy- Mindfulness training on emotional reactivity in borderline personality disorder: Preliminary results, *Clinical Psychology and Psychotherapy*, 21, 363-370. Doi: 10.1002/cpp.1837.

Forster, C., Berthollier, N., & Rawlinson, D. (2014). A systematic review of potential mechanisms of change in psychotherapeutic interventions for personality disorder, *Psychology & Psychotherapy*, 4(1), 1-14. Doi: 10.4172/2161-0487.1000133.

Geyer, C. (2013). *Discovering 'new ways of being' in interpersonal space: a grounded theory of experiences of change in people diagnosed with BPD* (Unpublished doctoral dissertation). Canterbury Christ Church University, Canterbury, UK.

Goodman, M., Carpenter, D., Tang, C. Y., Goldstein, K. E., Avedon, J., Fernandez, N.,...Hazlett, E. A. (2014). Dialectical behavioural therapy alters emotion regulation and amygdala activity in patients with borderline personality disorder, *Journal of Psychiatry Research*, 57, 108-116. Doi: 10.1016/j.jpsychires.2014.06.020.

Gratz, K. L. (2001). Measurement of deliberate self-harm: preliminary data on the deliberate self-harm inventory, *Journal of Psychopathology and Behavioural Assessment*, 23, 253-263. Doi: 10.1023/A:1012779403943.

Gratz, K. L., Levy, R., & Tull, M. T. (2012). Emotion regulation as a mechanism of change in an acceptance-based emotion regulation group therapy for deliberate self-harm among women with borderline personality disorder pathology, *Journal of Cognitive Psychotherapy*, 26, 365-380. Doi: 10.1891/0889-8391.26.4.365.

Hammersley, M. (2007). The issue of quality in qualitative research, *International Journal of Research & Method in Education*, 30, 287-305. Doi: 10.1080/17437270701614782.

Harper, D., & Thompson, A. R. (2012). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. Chichester, UK: John Wiley & Sons Ltd.

Hazlett, E. A. (2014). Dialectical behaviour therapy alters emotion regulation and amygdala activity in patients with borderline personality disorder, *Journal of Psychiatric Research*, 57, 108-116. Doi: 10.1016/j.jpsychires.2014.06.020.

Hodgetts, A., Wright, J., & Gough. (2007). Clients with borderline personality disorder: Exploring their experiences of dialectical behaviour therapy, *Counselling and Psychotherapy Research*, 7, 172-177. Doi: 10.1080/14733140701575036.

Horn, N., Johnstone, L., & Brooke, S. (2007). Some service user perspectives on the diagnosis of Borderline Personality Disorder, *Journal of Mental Health*, 16, 255-269. Doi: 10.1080/09638230601056371.

Hummelen, B., Wilberg, T., & Karterud, S. (2007). Interviews of female patients with borderline personality disorder who dropped out of group psychotherapy,

International Journal of Group Psychotherapy, 57(1), 67-91. Doi:
10.1521/ijgp.2007.57.1.67.

Katsakou, C., Marougka, S., Barnicot, K., Savill, M., White, H., Lockwood, K., & Priebe, S.
(2013). Recovery in borderline personality disorder (BPD): A qualitative study of
service user' perspectives, Plos one, 7(5), 1-8. Doi:10.1371/journal.pone.0036517.

Kazdin, A. E. (2007). Mediators and mechanism of change in psychotherapy research, The
Annual Review of Clinical Psychology, 3, 1-27. Doi:
10.1146/annurev.clinpsy.3.022806.091432.

Kazdin, A. E. (2008). Evidence-based treatment and practice, American Psychological
Association, 63, 146-159. Doi: 10.1037/0003-066X.63.3.146.

Kilmer, K. (2010). A review of group intervention with personality disorders (Doctoral
dissertation). Pacific University, Oregon. Retrieved from
<http://commons.pacificu.edu/cgi/viewcontent.cgi?article=1954&context=spp>

King, G. (2014). Staff attitudes towards people with borderline personality disorder, Mental
Health Practice, 19, 31-35. Doi: 10.7748/mhp2014.02.17.5.30.e803.

- Kramer, U., Pascual- Leone, A., Berthoud, L., de Roten, Y., Marguet, P., Kolly, S.,...Page, D. (2016). Assertive anger mediates effects of dialectical behaviour- informed skills training for borderline personality disorder: A randomised controlled trail, *Clinical Psychology & Psychotherapy*, 23, 189-202. Doi: 10.1002/cpp.1956.
- Kroger, C., Harbeck, S., Armbrust, M., & Kliem, S. (2013). Effectiveness, response, and dropout of dialectical behaviour therapy for borderline personality disorder in an inpatient setting, *Behaviour Research and Therapy*, 51, 411- 416. Doi: 10.1016/j.brat.2013.04.008.
- Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome, *Psychotherapy: Theory, Research, Practice, Training*, 38, 357-361. Doi: 10.1037/0033-3204.38.4.357.
- Lam, D. C., Poplavskaya, E. V., Salkovskis, P. M., Hogg, L. I., & Panting, H. (2016). An experimental investigation of the impact of personality disorder diagnosis on clinicians: Can we see past the borderline? *Behavioural and Cognitive Psychotherapy*, 44, 361-373. Doi: 10.1017/S1352465815000351.
- Levy, K. N. (2008). Psychotherapies and lasting change, *American Journal of Psychiatry*, 165, 556–559. Doi:10.1176/appi.ajp.2008. 08020299.

Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder, *Lancet*, 364, 453-461. Doi: 10.1016/S0140-6736(04)16770-6.

Linehan, M. M. (1993). *The Skills Training Manual for Treating Borderline Personality Disorder*. New York, NY: Guildford.

Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsiu, A. D.,...Murray- Gregory, A. M. (2015). Dialectical behaviour therapy for high suicide risk in individuals with borderline personality disorder: A randomised clinical trial and component analysis, *JAMA Psychiatry*, 72, 475- 482. Doi: 10.1001/jamapsychiatry.2014.3039.

Lorentzen, S., & Ruud, T. (2013). Group therapy in public mental health services: approaches, patients and group therapists, *Journal of psychiatric and mental health nursing*, 21, 219-225. Doi: 10.1111/jpm.12072.

Madan, A., & Fowler, J. F. (2014). Consistency and coherence in treatment outcome measures in borderline personality disorder, *Borderline Personality Disorder and Emotional Regulation*, 2(1), 1-4. Doi: 10.1186/s40479-014-0022-5.

Markham, D., & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for

challenging behaviour, *British Journal of Clinical Psychology*, 42, 248-256. Doi: 10.1348/01446650360703366.

Mays, M., & Pope, C. (2000). Qualitative research in health care: assessing quality in qualitative research, *British Medical Journal*, 320, 50-52. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117321/>

McMain, S., Links, P.S., Gulmond, T., Wnuk, S., Eynan, R., Bergmans, Y., & Warwar, S. (2013). An exploratory study of the relationship between changes in emotion and cognitive processes and treatment outcome in borderline personality disorder, *Psychotherapy Research*, 23, 658- 673. Doi: 10.1080/10503307.2013.838653.

McSherry, P., O'Conner, C., Hevey, H., & Gibbons, P. (2012). Service user experience of adapted dialectical behaviour therapy in a community adult mental health setting, *Journal of Mental Health*, 21, 539-547. Doi: 10.3109/09638237.2011.651660.

Mind. (2015, May). Borderline personality disorder: What is BPD? Retrieved from http://www.mind.org.uk/information-support/types-of-mental-health-problems/borderline-personality-disorder-bpd/#.WO3_B4WcHug

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement, *PLOS Medicine*, 6(7), 1-6. Doi: 10.1371/journal.pmed.1000097.

National Health Service. (2016, August 22). Borderline personality disorder- treatment.

Retrieved from

<http://www.nhs.uk/conditions/borderline-personality-disorder/pages/treatment.aspx>

National Heart, Lung and Blood Institute. (2014, March). Systematic evidence reviews and clinical practice guidelines: Quality assessment tool for observational cohort sectional studies. Retrieved from

<https://www.nhlbi.nih.gov/health-pro/guidelines/in-develop/cardiovascular-risk-reduction/tools/cohort>

National Institute for Mental Health in England. (2003). Personality disorder: no longer a diagnosis of exclusion. London, UK: Author. Retrieved from

<http://personalitydisorder.org.uk/wp-content/uploads/2015/04/PD-No-longer-a-diagnosis-of-exclusion.pdf>

National Institute for Health and Care Excellence. (2009). Borderline personality disorder: treatment and management. London, UK: The National Collaborating Centre for Mental Health.

- Neacsiu, A. D., Rizvi, S. L., & Linehan, M. M. (2010). Dialectical behaviour therapy skills use as a mediator and outcome of treatment for borderline personality disorder, *Behaviour Research and Therapy*, 48, 832-839. Doi: 10.1016/j.brat.2010.05.017.
- Nee, C., & Farman, S. (2007). Dialectical behavioural therapy as a treatment for borderline personality disorder in prisons: three illustrative case studies, *Journal of Forensic Psychiatry and Psychology*, 18, 160-180. Doi: 10.1080/14789940601104792.
- Office for National Statistics. (2016, August 4). Abuse during childhood: Findings from the crime survey for England and Wales, year ending March 2016. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/abuse-during-childhood/findings-from-the-year-ending-march-2016-crime-survey-for-england-and-wales>
- O'toole, S. K., Diddy, E., & Kent, M. (2012). Mindfulness and emotional well-being in women with borderline personality disorder, *Mindfulness*, 3, 117-123. Doi: 10.1007/s12671-011-0085-y.
- Perroud, N., Nicastro, R., Jermann, F., & Huguelet, P. (2012). Mindfulness skills in borderline personality disorder patients during dialectical behaviour therapy: preliminary results, *International Journal of Psychiatry in Clinical Practice*, 16, 189-196. Doi: 10.3109/13651501.2012.674531.

- Perseius, K. I., Ojehagen, A., Ekdahl, S., Asberg, M., & Samuelsson, M. (2003). Treatment of suicidal and deliberate self-harming patients with borderline personality disorder using dialectical behavioural therapy: The patients' and the therapists' perceptions, *Archives of Psychiatric Nursing*, 17, 218-227. Doi: [http://dx.doi.org/10.1016/S0883-9417\(03\)00093-1](http://dx.doi.org/10.1016/S0883-9417(03)00093-1).
- Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers*. London, UK: SAGE Publication Ltd.
- Sandage, S. J., Long, B., Moen, R., Jankowski, P. J., Worthington, E. L., Wade, N. G., & Rye, M. S. (2015). Forgiveness in the treatment of borderline personality disorder: A quasi- experimental study, *Journal of Clinical Psychology*, 71, 625-640. Doi: [10.1002/jclp.22185](https://doi.org/10.1002/jclp.22185).
- Sempertegui, G. A., Karreman, A., Artz, A., & Bekker, M. H. (2013). Schema therapy for borderline personality disorder: a comprehensive review of its empirical foundations, effectiveness and implementation possibilities, *Clinical Psychology Review*, 33, 426-447. Doi: [10.1016/j.jbtep](https://doi.org/10.1016/j.jbtep).
- Silk, K. (2002). Borderline personality disorder: the lability of psychiatric diagnosis, *Current Psychiatry*, 1(11), 24-33. Retrieved from

<http://www.mdedge.com/currentpsychiatry/article/66143/personality-disorders/borderline-personality-disorder-lability>

Skodol, A. E., & Bender, D. S. (2003). Why are women diagnosed more than men? *Psychiatric Quarterly*, 74, 349-360. Doi: 10.1023/A:1026087410516.

Soler, J., Valdeperez, A., Feliu-Soler, A, Pascual, J. C., Portella, M. J., Martin- Blanco, A.,...Perez, V. (2012). Effects of dialectical behavioural therapy-mindfulness module on attention in patients with borderline personality disorder, *Behaviour Research and Therapy*, 50, 150-157. Doi: 10.1016/j.brat.2011.12.002.

Stern, A. (1938). Borderline group of neuroses, *The Psychoanalytic Quarterly*, 7, 467- 489.
Retrieved from
<http://psycnet.apa.org/psycinfo/1939-02565-001>.

Stoffers, J. M., Völlm, B. A., Rüker, G., Timmer, A., Huband, N., & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder (Review), *The Cochrane Database of Systematic Reviews*, 2012(2), 1-255. Doi: 10.1002/14651858.CD005652.pub2.

The British Psychological Society & The Royal College of Psychiatrists. (2009). Borderline personality disorder: the nice guideline on treatment and management. Leicester, UK: British Psychological Society. Retrieved from <https://www.nice.org.uk/guidance/cg78/evidence/bpd-full-guideline-242147197>

Thornicroft, G., & Tansella, M. (2005). Growing recognition of the importance of service user involvement in mental health service planning and evaluation, *Epidemiology and Psychiatric Sciences*, 14(1), 1-3. Doi: 10.1017/S1121189X00001858.

Tyrer, P. (2009). Why borderline personality disorder is neither borderline nor a personality disorder, *Personality and Mental Health*, 3, 86-95. Doi: 10.1002/pmh.78.

Ussher, J. M. (2011). *The madness of women: Myth and experience*. Hove, UK: Routledge.

Weight, E. J. (2013). Staff attitudes towards inpatients with borderline personality disorder, *Mental Health Practice*, 17(3), 34-38. Doi: 10.7748/mhp2013.11.17.3.34.e827.

Widiger, T. A., & Spitzer, R. L. (1991). Sex bias in the diagnosis of personality disorders: Conceptual and methodological issues, *Clinical Psychology Review*, 11(1), 1-22. Doi: 10.1016/0272-7358(91)90135-H.

World Health Organisation. (2008). ICD:10: International statistical classification of diseases and related health problems (10th Rev. ed.). New York, NY: Author.

Yins, R. K. (2009). Case study research: Design and methods (4th eds.). California, CA: SAGE Publications, Inc.

Young, J. E. (1999). Cognitive therapy for personality disorders: A schema-focused approach (3rd eds.). Florida, FL: Professional Resource Exchange.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York, NY: The Guildford press.

Zanarini, M. C., Frankenberg, F. R., Reich, D. B., Hennen, J., & Silk, K. R. (2005). Adult experiences of abuse reported by borderline patients and Axis II comparison subjects over six years of prospective follow-up, *Journal of Nervous and Mental Disease*, 193, 412-416. Doi: 10.1111/j.1600-0447.2004.00362.x.

Zimmerman, M. (1994). Diagnosing personality disorders: A review of issues and research methods, *Archives of General Psychiatry*, 51, 225-245. Doi: 10.1001/archpsyc.1994.03950030061006.

Major Research Project

Section B

Sarah Jones

Title:

The service user and staff perspective on change within the context of Emotionally Unstable
Personality Disorder: A Grounded Theory investigation

For submission to: Journal of Personality Disorders

Word Count: 7959 (+254)

Abstract

Introduction:

Qualitative research has begun focussing on the experience of change within psychological therapy for individuals with a diagnosis of Emotionally Unstable Personality Disorder. However, many individuals do not access therapy but instead utilise other forms of support. This study aimed to develop a holistic theory of change, applicable to but extendable beyond the remit of psychological therapy.

Methodology:

Twelve individuals were interviewed using semi-structured format about their experience of change. Five individuals with a diagnosis of EUPD were interviewed alongside seven staff members. A Grounded Theory methodology was used.

Results:

The key change experience was defined as one of 'shifting positions' where the individual began evolving their relationship to themselves, to others and to help. This process was often facilitated by development of safe and trusting relationships and a personal readiness to change. The change process could simultaneously be enhanced and set back by staff and Mental Health Services.

Discussion:

This change process mirrors and expands the findings of previous research and offers a change model applicable across settings. Future research should include the perspective of carers and clinical settings should explore how best to support staff to attune to individuals' needs in order to facilitate change.

Keywords: emotionally unstable personality disorder, borderline personality disorder, change, holistic.

1. Introduction

1.1. What is Emotionally Unstable Personality Disorder?

Individuals who have received a diagnosis of Emotionally Unstable Personality Disorder (EUPD)³ (World Health Organisation (WHO), 2016) often struggle with difficulties in managing intense emotions, acting impulsively and managing interpersonal relationships.

EUPD is the most common personality disorder, equating to roughly 3% of the population (Chen, McCutcheon, Jovev, Jackson & McGorry, 2007), accounting for 50 % of inpatients with a personality disorder and 15% of all inpatients (Widiger & Weissman, 1991). The high prevalence of EUPD combined with the complexity of difficulties that individuals with this diagnosis experience has propelled a great deal of interest in developing and improving treatment, services and the evidence base for this client group.

1.2. Challenging Stigma

However, this interest has not always been positive. Historically, individuals with a diagnosis of EUPD have been viewed as ‘untreatable’ by Mental Health Services (MHS) (Gunderson, 2009). EUPD has been viewed as a diagnosis with less therapeutic optimism comparatively to other mental health difficulties (Markham & Trower, 2003) and is arguably the most stigmatised mental health diagnosis there is (Aviram, Brodsky & Stanley, 2006).

The ‘Personality Disorder, no longer a diagnosis of exclusion’ (National Institute for Mental Health in England, 2003) publication was the first policy to provide recommendations

³ As EUPD is the term utilised by the International Statistical Classification of Diseases and Related Health Problems 10 (ICD-10), the diagnostic tool employed by the National Health Service (NHS) (NHS Digital, 2017) this study will subsequently adopt this term as opposed to the more common term Borderline Personality Disorder.

for service provision and treatment for individuals with this diagnosis and was arguably a catalyst for promoting a change in perception of EUPD. This publication encouraged services, mental health professionals, service users' and society more generally to treat this diagnosis as one with optimism for change and hope for the future. There has since been a growth in service provision, education and policy change for this diagnosis (The British Psychological Society & The Royal College of Psychiatrists, 2009). Research has also mirrored this growth and several pools of research have illuminated the reality of change for individuals with a diagnosis of EUPD.

1.3. What Do We Know About the Experience of Change?

These improvements included a natural decline in unhelpful coping behaviours such as self-harm as well as a reduction in dangerous risk-taking. This implies that a natural change process takes place, one that could be enhanced by service provision, but one that can also be iatrogenic in nature. Insufficient service provision may disrupt the natural change process and reinforcing unhelpful patterns of relating (Fonagy & Bateman, 2006).

The qualitative research literature has also aided understanding of change within EUPD. Katsakou and Pistrang (2017) completed a meta-synthesis of qualitative studies exploring treatment and recovery within EUPD and identified an increase in self-acceptance, managing thoughts and emotions, practicing new ways of relating to others and developing hope as important elements within the change experience.

However, the vast majority of the studies within Katsakou and Pistrang's (2017) review explored change within therapy and, furthermore, within the context of recovery. The recovery framework has been argued to jar with the experience of many service users' with EUPD (Geyer, 2013; Katsakou et al. 2013; Larivière et al., 2015), underplaying the complexity and often long term nature of difficulties associated with this diagnosis (Katsakou et al. 2013). Subsequently, the qualitative literature to date may not be capturing the

intricacies of the change process and understanding the data through a lens which may not fit with many service users' experiences.

There has also been an acceleration of evidence based treatments for EUPD (Stoffers-Winterling et al., 2012) which aim to evoke change. These therapies range from skills focused therapies such as Dialectical Behavioural Therapy to experiential, interpersonal focused therapies with more emphasis on the origins of difficulties, such as Schema Therapy. Although there are often differences in theoretical origin of various psychological interventions for EUPD, these therapies share many commonalities in regard to the delivery, technique and focus of interventions (De Groot, Verheul & Trijsburg, 2008). This similarity has also been reflected in study outcomes. Paris' (2015) review on psychological interventions for EUPD concluded that, "there is no evidence that specific techniques make a difference in treatment outcomes" (p. 16).

Although model specific factors have not been identified for individual effectiveness within the literature base, research has begun to evaluate which therapeutic qualities may enable change for individuals with EUPD. Forster, Berthollier and Rawlinson (2014) evaluated the literature base and identified several potential change mechanisms within individual therapy for EUPD. These included the therapeutic relationship, skill use and mentalising for example. However, Forster et al.'s (2014) review illuminated a sparsity of the voice of those with lived experience within the research literature focusing on change within and beyond psychological therapy.

One study, Geyer (2013) was found to contradict this finding by developing a grounded theory of change. Geyer's (2013) theory identified a core change process of, "discovering new ways of being in an interpersonal space" (p.46). However, the theory was limited to a particular therapeutic context, group therapy.

1.4. Gaps in Current Understanding

The research to date, including Geyer's (2013) study, is arguably misaligned from the reality of service provision offered to individuals with an EUPD diagnosis. This provision does not always include access to psychological therapy (Choi-Kain, Finch, Masland, Jenkins & Unrush, 2017). Many individuals access other forms of support MHS such as being held within Multi-Disciplinary Team's (National Institute of Care Excellence (NICE), 2009).

More recently, Bateman and Fonagy (2009) developed structured clinical management, an evidence based approach which combines risk and medication management, problem solving, developing skills and managing crisis. The approach is being utilised within several NHS trusts (Camden and Islington NHS Foundation Trust, 2017). Bateman and Fonagy (2009) completed structural clinical management to mentalisation-based treatment and concluded that both interventions enabled substantial reductions in self-harm, hospital admission and suicidality.

This research suggests that individuals with a diagnosis of EUPD can change through a diverse range of interventions. Furthermore, as noted previously, many individuals with an EUPD diagnosis experience change naturally over time (Zanarini, Frankenberg, Reich & Fitzmaurice, 2012). This implies that the change process may be complex and suggests that change in the context of MHS may be influenced by several interventions including but not exclusive to psychological therapy. Therefore, the proposed study aims to develop a holistic understanding of the process of change.

1.5. Rationale

The aim of this study was to explore the experience of change for individuals with a diagnosis of EUPD. Experience of change was explored through both the perspective of individuals with lived experience of EUPD who were volunteering or in paid work as well as staff who supported individuals with this diagnosis.

Overall, the research aimed to develop a holistic theory of change for individuals with a diagnosis of EUPD, not limited to psychological therapy. To the author's knowledge, a theory of this nature does not currently exist. It was hoped that this study would be beneficial to the research, implementation and appraisal of service provision for service users' with a diagnosis of EUPD. Research questions included:

- a. What are the experiences of change for individuals with a diagnosis of EUPD?
- b. How do individuals describe change?
- c. To what do individuals attribute change?
- d. How is change described within the context of MHS?

2. Methodology

2.1. Design

This study utilised a Constructivist Grounded Theory Methodology (CGTM) (Charmaz, 2014) as this approach acknowledges the impact of the researcher on the data. Grounded Theory is deemed appropriate when limited understandings of a phenomenon have been researched (Harper & Thompson, 2012; Urquhart, 2013). The process involved completing individual interviews, transcribing and coding the data and through an it-process, developing a model to understand the experience of change.

2.2. Epistemological Stance

The author took a Critical Realist Social Constructionist (CRSC) stance (Harper & Thompson, 2012) to enable understanding of findings to be viewed within the surrounding systemic context, whilst acknowledging the author's role in co-creation of results (Charmaz, 2014). This stance seemed particularly important whilst holding in mind the vast stigma and discrimination surrounding the EUPD diagnosis. A CRSC approach was adopted in the hope that it would enable understanding on the systemic influences of change and empower the service user voice.

To enable transparency of researcher influence, a reflexive approach was adopted throughout the research process and a reflective research diary can be found in Appendix H. Potentially significant values and characteristics of the author are also included at the start of Appendix H.

2.3. Interview Schedule

Two interview schedules were designed in consultation with a service user consultation group to help ensure ease of understanding and openness of questions. The

developing interview schedule was also reviewed regularly using the questions posed by Charmaz (2014) (p.64) to enable flexibility, focus, awareness of implicit assumptions, accessibility and openness. Final interview schedules can be viewed in Appendix I and J.

2.4. Participants

Twelve participants were recruited. Five participants with lived experience of EUPD (n = 5) were recruited, with an average age of 46 (range 26- 55). Seven staff members were interviewed, with an average age of 47.57 (range 33- 54). Please see Table 1 below for full demographic information.

Eligibility criteria for those with lived experience included having received a diagnosis of EUPD, being over 18, not currently using MHS and currently volunteering or in paid employment. This was to encourage recruitment of individuals who were arguably further along in their recovery and to aid a longitudinal and increased depth of understanding about change. Furthermore, it was hoped that this pool of participants would potentially find reflecting on the topic of change more comfortable and subsequently less distressing than individuals currently accessing treatment.

Staff members were required to have worked with individuals with this diagnosis. This sample was chosen to incorporate the perspectives of individuals with a more representative experience of contact with MHS and beyond and to aid theory triangulation (Harper & Thompson, 2012).

Table 1.

Demographic Information

Participant	Pseudonym	Role	Gender	Age	Ethnicity
Lived experience participant 1	Christie	Trainer	Female	49	Black British
Lived experience participant 2	Ariel	Trainer	Female	50	White British
Lived experience participant 3	Kelly	Volunteer	Female	55	White European
Lived experience participant 4	Nicola	Self-employed	Female	26	White British
Lived experience participant 5	Sandra	Support worker	Female	50	White British
Clinician 1	Sasquia	Team leader Key worker	Female	52	White Other
Clinician 2	Sally	Mental health nurse	Female	43	White British
Clinician 3	Martha	Occupational therapist	Female	55	Not disclosed
Clinician 4	Chloe	Assistant psychologist	Female	33	White British
Clinician 5	Matthew	Counselling Psychologist	Male	42	White British
Clinician 6	Margaret	Recovery worker	Female	54	White British
Clinician 7	Carol	Mental Health Nurse	Female	54	White British

2.5. Procedure

Two specialist personality disorder NHS services and two voluntary organisations were contacted between June 2016 and December 2016. Participants were approached either through known contact with the project supervisor who gained consent to initiate contact, via posters disseminated which enabled self-referral or via word of mouth. A copy of the recruitment posters can be seen in Appendix K and L. After consent to contact was obtained or self-referral was received, participants were e-mailed about the project to ensure they met eligibility criteria.

Five individuals with lived experience were recruited. Two individuals were recruited via their employment within a specialist personality disorder service, two via voluntary organisations and one through word of mouth. Seven staff members were recruited through their employment within two specialist personality disorder services.

Those who consented to being interviewed were e-mailed the participant information sheet in advance (Appendix M & N). During the interview meeting, participants were asked to read the participant information sheet again. A consent form was then signed, (Appendix O & P). 11 individual interviews took place at a local NHS service, and one took place at the client's home. Interviews followed the interview schedules found in Appendix I and J. Interviews were audio recorded and ranged from 36 minutes to 1 hour, (mean= 47.3 minutes) for staff interviews and from one hour and five minutes to one hour and 32 minutes (mean = 1.26 hours) for the lived experience group. After the interviews were completed, participants were fully debriefed and the interviews transcribed.

2.6. Data Analysis.

A Constructivist Grounded Theory Methodology was undertaken and followed the below steps suggested by Charmaz (2014).

2.6.1. Initial coding.

All transcripts were transcribed verbatim, allocated pseudonyms and fully anonymised. As recommended by Charmaz (2014), six transcripts were coded at a line by line level in order to bring the researcher closer to participants' perspectives whilst reducing the potential for researcher bias to influence interpretation. These transcripts were chosen because they were felt to represent a diversity of participant type. Coding utilised 'gerunds' (e.g. action words such as 'being') argued by Charmaz (2014) to enable application of a process orientated lens to the data. A transcript complete with open codes can be found in Appendix Q.

2.6.2. Focused coding.

Using the code frequency and the constant comparative method (Glaser and Strauss, 1967), initial codes were funnelled into more focused codes and included expansion and refinement of codes which appeared significant to the data set. A list of focused codes can be found in Appendix R.

2.6.3. Theory development.

Focused codes were compared, contrasted, combined and elaborated through utilisation of analytic memos (see Appendix S). This process led onto the development of categories and subcategories. Relationships between categories were explored and theory categories refined until development of the main change model was identified. This was an iterative process whereby focus oscillated between codes, categories and the raw data to ensure the developing theory was grounded in participants' descriptions. Details of model evolution and category development can be seen in Appendix T and U.

Furthermore, respondent validation of initial themes was completed and subsequent responses can be viewed in Appendix V. From this feedback, themes were reviewed to ensure

that the themes captured both participant groups equally. This included a review of raw data to ensure that themes could be evidenced by both pools of participants and some adaptations were made to theme definition and supporting quotations as result of this process.

2.7. Quality Assurance

Quality assurance guidance from Charmaz (2014) which focuses on study credibility, originality, resonance and usefulness was applied throughout the research process.

Furthermore, several research strategies were utilised to increase the overall quality of the data, as detailed below.

2.7.1. Triangulation.

The research design aimed to promote diversity and triangulation of the research phenomenon in question, by inviting both staff and those with lived experience to engage in the research. Furthermore, initial codes were compared against four personal accounts of change (Green, n.d.; Kavanagh, n.d.; Monarch Butterfly, n.d.; National Institute for Health and Care Excellence (NICE), 2009) from two individuals with lived experience and two carers in order to incorporate an additional lens to the experience of change.

2.7.2. Consistency and reflexivity.

One project supervisor and one independent professional co-coded two of the research interviews to enable exploration of similarities and differences between codes. The co-coding process was one that instigated further thoughts and reflections but was not used to evaluate coder consistency, as this conflicted with the epistemological position of the research. This part of the coding process was fundamental in illuminating potential researcher bias.

These researchers also reviewed initial codes for all research interviews to ensure accuracy in connection to the data set. They also provided reflection about emerging

categories at two points during the analysis to enable further discussion about theory transparency and potential researcher bias. Details of the audit trail process can be viewed in Appendix W.

2.7.3. Research diary.

A research diary was also utilised, enabling reflection of researcher bias as well as strengths and challenges of the research process. Excerpts can be found in Appendix H.

2.7.4. Code of conduct.

The study was conducted in line with the British Psychology Society (BPS) code of ethics and conduct (BPS, 2009) and the project was supervised by two Clinical Psychologists competent in conducting high quality research and with experience in undertaking a Grounded Theory Methodology.

2.8. Ethics

The study received ethical approval in March 2016 (Appendix X letter). The project was given Health Research Approval in May 2016 (Appendix Y). Ethical concerns included the emotional impact of completing research interviews, particularly with the lived experience group. In response to this, all participants were fully debriefed and offered additional support if deemed necessary.

It was likely that staff members would use examples of clients that they had worked with whilst answering interview questions. To protect client confidentiality staff members were asked to not discuss individual client names and any potentially identifiable personal information was changed during transcription.

Finally, it was possible that service users' who utilised the specialist personality disorder services where the interviews took place could be disrupted by the research

interviews. To minimise distress, the research supervisor (who worked within the service) informed all service users' and staff prior to interviews taking place and the researcher and interviewee left the premises promptly after completion of the interview.

3. Results

This study aimed to explore how individuals with a diagnosis of EUPD understood and attributed change and how this was understood within the context of MHS. Initial analysis resulted in 113 focused codes. These were developed into four categories with 11 sub categories. The categories included feeling stuck, developing the foundations for change, shifting positions and embracing the changing self. Details can be found in Table 2 below. A list of all categories, sub-categories and focused codes can be found in Appendix U.

Table 2.

Developed categories and subcategories

Major Categories	Sub-categories
Feeling stuck	Existing not living Experiencing the self as defective Maintaining stuckness
Developing the foundations for change	Understanding the diagnosis Developing stability
Shifting positions	Relationship to self: Learning emotional coping Developing insight Becoming more reflective Relationship to others: Learning to say no Not being afraid to talk Relationship to help: Being more able to access help Practicing skills
Embracing the changing self	Exploring new ways of being Letting go Living, not existing
Model processes Destabilisation	How these processes relate to change Loss of a secure base or reduced stability could disrupt and stunt the change process

Having set backs	Being pulled back to feeling stuck through internal drivers (trauma and negative beliefs) and by ongoing stressors with other people in one's life
Mis-attunement	Mis-attunement to needs disables growth and change (in relation to services and others in life)
Attunement	Attunement to someone's needs enables growth and change (in relation to services and others in life)
Time	People change naturally through age and experience
Turning points	Enable a shift in insight
Taking responsibility to change	Being ready to change enables shifting of positions and development of a sense of self

3.1. Model Summary

The experience of change within the current research was understood to be a complex process by which individuals began to move away from a position of 'stuckness' to one which enabled flexibility and the 'shifting of positions', enabling a growing sense of self. This process was not thought to be uni-directional and was promoted and stunted by several systemic influences. A summary of the final model can be viewed below in Figure 1. Details of categories, sub-categories and dynamic between category processes will be discussed below.

The author notes that this is one way of understanding the interview data, and the reflexive diary and discussion with independent others was key throughout analysis in order to assess the influence of the researcher's beliefs on the data.

3.2. Feeling Stuck

The first category encompassed difficulties that individuals with lived experience described having endured for many years of their life. Participants often referred to themselves as being “bad” or “damaged” and appeared stuck in unhelpful cycles. Some participants and staff noted that the diagnostic label and subsequent treatment by services reinforced beliefs and exaggerated stagnancy.

3.2.1. Existing not living.

Many participants described feeling powerless in relation to their experiences:

I just presumed that it was OK for people to do whatever they wanted and that I was just there for them to do whatever they wanted and I think that probably I thought I was there just to please other people, that that was my job. (Sandra, line 197)

Participants often described feeling as though they were stuck in cycles of destructive coping:

Yeah, yeah and then you go through your day, you know cos I never, it was always a routine for me I'd always do my day and once I was in that was it. You know I'd do something to get me through the evening, and to sleep and to work the next day, so it became a ritual, cos it was the only way I knew could work for me you know.

(Christie, line 80)

3.2.2. Experiencing the self as defective.

There was a sense for many participants of feeling bad, damaged and unwanted for a long time, as noted by Christie:

This woman carried me for 9 months not wanting me, so that's ingrained you know, from the minute the cells were formed, that's in there you know, I don't want you, I don't want you growing in me." (Christie, line 600).

These beliefs were often also portrayed by the diagnostic label itself:

I suppose initially people I think they think generally feel like it's a massive judgement and it means that their personality is marred in some way and ...I think in my experience it symbolises that there might be no hope or no movement so quite scary really. (Carol, line 63)

3.2.3. Maintaining stuckness.

The way in which the diagnosis was given and subsequent treatment from NHS services often promoted powerlessness, "I think it's got to be one of the worst, the most, distressing, negative, awful labels to give someone" (Ariel, line 84).

This notion was also supported by staff members, "[the diagnosis was given] without any explanation what so ever and I think that erm can be very difficult to be told there's something disordered with your personality without any explanation or understanding" (Martha, line 56).

3.3. Developing the Foundations for Change

This category involved establishing the foundations necessary to support change. The experience often involved developing understanding about the diagnosis in a way that could enable a shift in relationship with it. Developing some sense of stability was identified as important for many participants and provided security to encourage and enable change. This base often came from MHS, but could also arise from support from family and friends, or the self.

3.3.1. Understanding the diagnosis.

This theme involved developing a differing understanding of the diagnosis, one that could provoke acceptance for some, tolerance or rejection by others. Regardless of position, it appeared that being able to have conversations about the diagnosis was an important process and facilitated engagement and a reduced sense of aloneness and judgement:

Usually it's when we start and explain the graph about the, the arousal level and how, how it differs from other people, it starts making sense and people start to not feel judged by that and, and often that's when they, when they start working with you."

(Sasquia, line 73)

3.3.2. Developing stability.

A key experience for the majority of participants was the development of a sense of stability. This stability could be developed through involvement with services or by being supported by family, friends or the self. Sandra reflected on the importance of a consistent team of people during her hospital treatment, "I was managed by what...a community rehab team, which was a team of people...and they held me" (Sandra, line 60). The importance of building a trusting relationship with service users' to encourage service users' to feel more comfortable to make changes:

Those things are all I suppose about you know relating and building up trust with a worker those things would enable people to start really thinking what is it they need to change naming it or even knowing what it is they need to change. (Carol, line 197)

All staff talked about needing to have their own forms of stability to be able to best support service users', "you absolutely need to work as a team that's the other thing that I think that really is the thing that actually can really help to facilitate change" (Martha, line 280).

3.4. Shifting Positions

Shifting positions was identified as the key change experience for participants. This experience involved establishing new ways of relating to the self, to others and to help. This experience was theorised to be fluid, suggesting that individuals continuously moved closer and further away from perceived stuckness. Furthermore, changes in relation to the self, others and to help/support naturally impacted on each other within a cyclical fashion, as seen in Figure 1, below. Examples of the interplay between the three relationships will be discussed in subsequent sections.

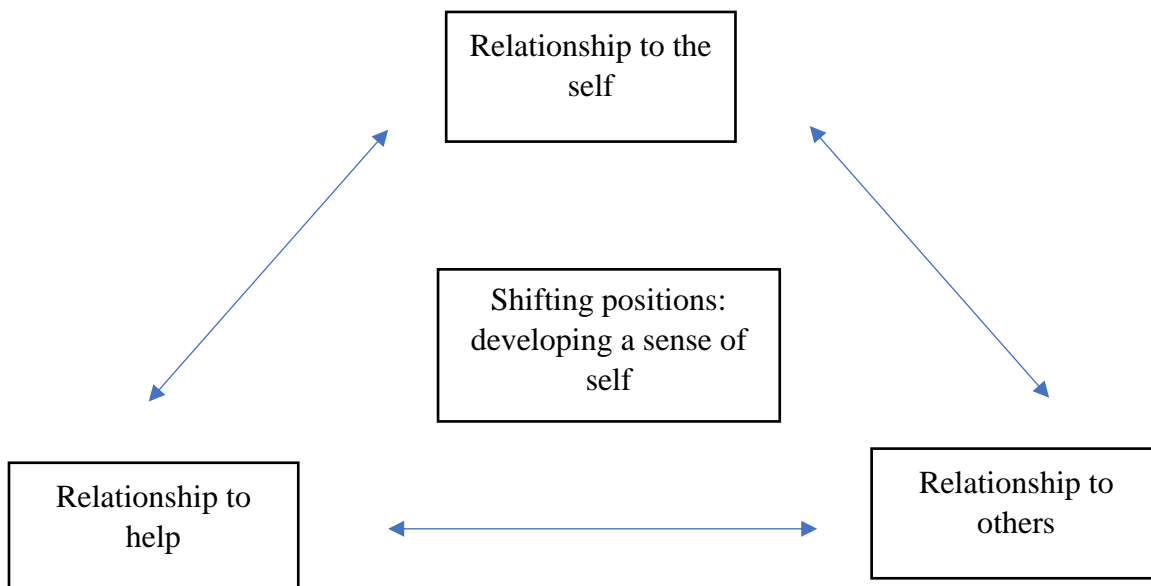


Figure 1. 'Shifting positions' category detail

'Shifting positions' was understood to enable a more cohesive sense of self and identity to develop whereby individuals were more able to narrate their internal world in an integrated way, as demonstrated by Sasquia:

Telling the story was very, very difficult for him and I think yeah that's the change I notice is that he now uses me to reflect on, on experiences and he uses my opinion on

them, on what he's telling me, to form coherent thoughts and they may or may not be according to his beliefs but he can form them. (Sasquia, line 590)

This process could enable an increase in self-confidence and self-compassion, which could increase a sense of self-worth and control over one's life. In relation to becoming pregnant, Nicola noted, "that [pregnancy] kind of opened up other sort of aspects of my personality that have always been there but never really had a chance to flourish" (Nicola, line 406). These processes were facilitated by personal growth as well as through experiences with MHS and within psychological therapy.

3.4.1. Relating to the self.

This sub-category encapsulated changes in relation to one's own internal world. This was naturally impacted through contact with others but was understood to correspond to internalised changes in the self.

Learning emotional coping.

All staff and service users' described the evolution of emotional coping. This coping was often facilitated by the development of skills in naming emotions, developing meta-awareness of emotions, using mindfulness and using distraction for example and these skills often became an ingrained part of the self over time.

Ariel (line 187) noted, "there have been changes, as an overall trend, I've definitely been much more able to manage it [emotional intensity], much more aware of my triggers, and I would become ill or become depressed for less time". Changes in management of emotions often resulted in reduction in harmful behaviours, "I mean I haven't cut myself since 2011 you know and that's a big thing" (Christie, line 221).

These skills were thought to develop through engagement with psychological therapies as well as through personal development. Whilst talking about the value of the STEPPS programme Christie noted that, “being able to track that my emotions are rising is probably the life saver” (Christie, line 294). This highlights the reciprocal nature of the evolution of emotional coping, often facilitated by staff and practiced and honed by service users’.

Developing insight.

Being able to gain new understanding about oneself through telling one’s story was identified as a significant change for many individuals.

Developing an understanding of how past, often traumatic experiences were shaping current difficulties was described by participants, “realising that that was happening that it’s not, that I wasn’t making it up you know and realising that for me it stems from trauma, childhood trauma” (Christie, line 160). Participants noted gaining insight about patterns of behaviour over time:

It then becoming apparent that it was only a short-term thing, it, it was a release, you know I’d be feeling really shitty, I would be hating myself, and the only thing I could

Becoming more reflective.

Participants and staff members noted the experience of developing an increased reflective capacity over time, “I think as we get older, we are able to be more reflective” (Sandra, line 151).

This involved an experience of ‘de-centering’ by becoming less inward focused and more able to take on board the ‘bigger picture’. Increased reflective capacity included

processes such as mentalising and increased theory of mind. Nicola expressed this in relation to her increased ability to help and support others:

Because I've always liked to help people but before I didn't have the, the capacity in me, like I was too introverted is that the right word? I just, I couldn't bring myself to think of other people that much, I thought of other people in the, the context oh of, 'my parents don't want me to kill myself so I better not' and that was about it.

(Nicola, line 388)

As noted in the above quotation, this increased reflective capacity was thought to impact on the way in which individuals related to others, demonstrating the interplay between shifts in relating to the self, others and to help as noted in Figure 2.

3.4.2. Relating to help.

This sub-category denoted changes in relation to the way the individual interacted with help (including individual professionals and services more generally).

Being more able to access help.

It seemed that over time, participants could more able to access help/support in different ways, and this change could sometimes be subtle:

It can be more positive yeah I know we can see from [data recording system] sometimes that people have gone into A&E whereas previously they'd do it erm after and or perhaps struggled to go whereas now they sometimes go to talk to someone.

(Chloe, line 538)

For others, over time they became less dependent on professionals, "and I've been seeing [therapist name] on and off now for, since 2012, and I don't see him regularly now but if I need to I see him" (Christie, line 231). Both quotations demonstrate improvement in

accessing support, which was related to an increased ability to communicate one's emotional needs. Again, this emphasises the interplay between changes in relation to the self and to help.

Practicing skills.

Through engagement with professional help, participants were able to develop skills relating to the self (e.g. emotional coping) and well as to others (e.g. managing social interactions), as noted by Martha when discussing important elements of her role, "skills building definitely, definitely literally talking to people about you know what emotions are you know what you can do to manage your emotions what's the difference between a thought and an emotion real basic basic stuff." (Martha, line 655).

Staff also modelled skills for service users', such as enabling self-compassion and insight into early life experiences through validation of past trauma or through modelling a meta-awareness of change, as noted by Sally:

But you still might you know I might still sit with someone in distress and kind of go you know this is awful you know but you know do you remember when a couple of months ago this was how you felt you know what did you do then to get through that do you know what I mean so you might still loosely be connecting back to progress they've made. (Sally, line 195)

Through these interactions with others, individuals were also encouraged to relate to themselves differently.

3.4.3. Relating to others.

This sub-category encapsulated changes in the interaction with others over time and the development of interpersonal skills.

Learning to say no.

One of the most noticeable shifts when relating to others was the experience of developing healthier relationships, particularly through developing boundaries.

And it's still, that is probably one of the struggles I struggle with still, is, people are still more important than I am, but because I recognise that and because I don't know what I can do about that, I recognise that if I'm tired, I can't do it so I'm learning to say no. (Christie, line 389)

Although this was an area where participants observed changes, as noted by Christie above, interpersonal relationships were still an ongoing struggle for many individuals.

Not being afraid to talk.

Opening up to others was identified as an important change:

I think one of the biggest things that I think is that, was that, I now talk to people, that's, that's quite mammoth, um and that I'm actually not afraid to talk to people, um I think that before, where I thought that if I opened my mouth and said something someone was going to tell me I was being stupid or silly, um I think that, I think that was probably a big thing. (Sandra, line 539)

The subtleties of interacting with others in a new way was communicated by participants, as described by Carol:

And I think again you know the sort of change that...we're able to see that she learnt to negotiate she learnt to communicate more clearly she learnt to step back she learnt to distract erm learnt to take a breath before responding you know. (Carol, line 235)

These quotations highlight the interplay between shifting relationships to the self in regard to being more able to communicate ones needs and the impact this has on interactions with others.

3.5. Embracing the Changing Self

This final category was theorised to involve individuals finding positions or roles that they connected to and could embrace in order to enable continued personal growth. This for example could involve being a paid worker, a volunteer, a mother or a supportive friend. This process often involved letting go of the past and moving towards acceptance of the current self.

3.5.1. Exploring new ways of being.

It seemed that as individuals with EUPD continued evolving, they began developing new passions, interests and roles. Nicola discussed becoming more of a stabiling force for those around her:

I support, yeah, yeah definitely, and also my friends with these problems, I also help them, because I'm in a lot more stable place than they are, most of the time, so I feel like I can" (Nicola, line 380)

Other individuals noted that they used their lived experience to help others and when talking about beginning volunteering, Kelly noted that "I wanted to be you know, in an environment when we weren't on either side of the fence" (Kelly, line 508). This suggests that volunteering enabled her to begin moving away from a position of illness.

This development was often related to an increased acceptance of the diagnosis over time, "I wear my diagnosis like badges or medals of honour now, not that I'm branded or

damaged goods or you know I'm more about being, viewing mental health as an asset rather than a deficit" (Ariel, line 787).

Staff members talked about needing to become more attuned to promoting and enabling new roles:

we have to work harder on this pull, vocational services, offering vocational services, is another thing where we can sort of send an outer signal to say actually when if you want to do that if you're ready to do that, we can help with that and we want to.

(Sasquia, line 447)

3.5.2. Letting go.

For many staff members, observing an increasing self-acceptance was key. Sasquia noted, "It's about the ability to...accept what's happening, I think, it's another factor, which allows people to move on eventually so if they need to" (Sasquia, line 179). This was also true for those with lived experience, some of whom were more able to let go past trauma to move forward with their lives:

I think also I'm able to sit back and think, 'well you know, I will never ever be able to forgive some of the things, the things that, the actions of people but I'm able to let them go because the only person that they hurt is me. (Sandra, line 354)

3.5.3. Living not existing.

Participants talked about a growing sense of enjoyment for living, with an appreciation that going through negative experiences enabled increased enjoyment of life.

Nicola reflected that, "I appreciate things a lot more, like I'll, I love trees, and the flowers, you know like, things in nature, and like when people are kind, they do an act of kindness I really, really appreciate it" (Nicola, line 916). This was encouraged by staff

members, “have fun you know do groups and do things that are fun are some of them can't even remember having fun in their life” (Margaret, line 440).

3.6. Model Processes.

The dynamic process of change for individuals with a diagnosis of EUPD was influenced by the systemic context surrounding an individual. Some of the intricacies of the change model will be discussed below.

3.6.1. Destabilisation.

Instability of one's security and secure base was thought to set some people back. This was demonstrated by several staff members when reflecting on clients that they had worked with, “she has done so much still you know and she is so giving erm you know she could do so much but her life seems to consistently drag her back” (Sally, line 245).

3.6.2. Having setbacks.

The experience of change identified within this model was thought to be a fluid experience and individuals could experience set-backs at multiple points by several factors. These included internal pulls such as negative self beliefs or the impact of past trauma, “trauma is going to hinder change people are consistently you know if people aren't able to move on from the traumatic events that they've kind of been through” (Sally, line 256).

External stressors were also identified as disruptive, “I had a blip when my sister died but again with was more about wanting to sleep because she was taken so suddenly” (Christie, line 224). However, as reframed by Christie, these ‘blips’ were not thought to set someone back completely in their development.

3.6.3. Becoming an active participant.

The movement from feeling stuck to that of developing the conditions for change was often noted to be facilitated by a 'turning point' which instigated a shift in perspective. These turning points included pregnancy, coming close to death, and negotiating a pay-rise for example.

This shift was often in perception of one's own ability to be active participant within their lives, as opposed to a passive recipient:

when I was beginning to get to the point where leaving hospital may have been an option and they were thinking about discharge, they...she [care-coordinator] sat me down and for the first time I think in my entire life, she said 'what is it you want, when you leave?'...it was just like someone was giving me control over how the rest of my life was gonna go. (Sandra, line 64)

This process was also reiterated by staff members, "it's the ability to actually believe that you can have control over your own life" (Martha, line 455).

3.6.4. Taking responsibly for change.

Engaging in the active change experience of 'shifting positions' was found to be influenced by readiness to change. Staff role often involved exploration of fears of change and, "encouraging them [service users] that change wouldn't be so bad" (Chloe, line 414) but all participants noted the importance of personal readiness, "if they're not ready to do it, they won't do it." (Margaret, line 139). This was reiterated by Ariel:

Interviewer: could you describe the most kind of important lessons that you've learnt in your life so far that you'd be willing to share with others?

Ariel: Yes, taking personal responsibly...you should actually realise the power that's inherent within that, that you can control and have your own lived experience and make good of that. (Ariel, line 783)

3.6.5. Attunement.

Being able to shift positions and develop a sense of self was enhanced through attunement of the self and others. The concept of self-attunement is used here to describe a process of identifying and responding to one's own needs. This process could also occur through interaction with others whose role may have been to meet someone else's needs, as described by Sasquia:

It's finding the right carrots at the right time for people to want to move through and get somewhere where they still feel held and they still feel supported but they can actually now play a much bigger role either in [service name] or, or, or outside [service name]. (Sasquia, line 430)

Attunement extended beyond that of individual practitioners, to the level of service provision, "I think, what shifted was not just something in me but was also the policy of the trust about admissions, and the repeated, message from my CPN" (Kelly, line 265).

3.6.6. Mis-attunement.

The backwards arrow between the final two stages in the model reflects the notion of mis-attunement. This describes a disconnect between the individual's needs and what others were able to provide. Others included family and friends as well as health services and professionals. For example, when discussing contact with health services, Sandra reflected, "10 years down the line, yeah I find that really fascinating but I think I've changed but sometimes I think people don't accept that I've changed" (Sandra, line 404). This could lead to individuals feeling stuck or being set back in their change experience.

3.6.7. Time.

An important part of the change experience was the external, uncontrollable factor of time. Time enabled learning through experience, as noted by Sandra:

I think that sometimes you need life [laughter], that sounds terrible but I think you do sometimes, sometimes you need to live a little, before all those terrible things that you think when you're younger, that when you think the sky's falling in, um and sometimes the sky is falling in, but sometimes when you're younger it feels like the sky's falling in, sometimes you need to survive that a bit. (Sandra, line 151)

3.7. Preliminary Model

The predominant change processes (e.g. developing the foundations for change) and influential variables (such as the influence of time and attunement) have been pictorially represented within a model which aims to highlight the continuous, fluctuating change experience. Please see Figure 2 below, for a preliminary model diagram.

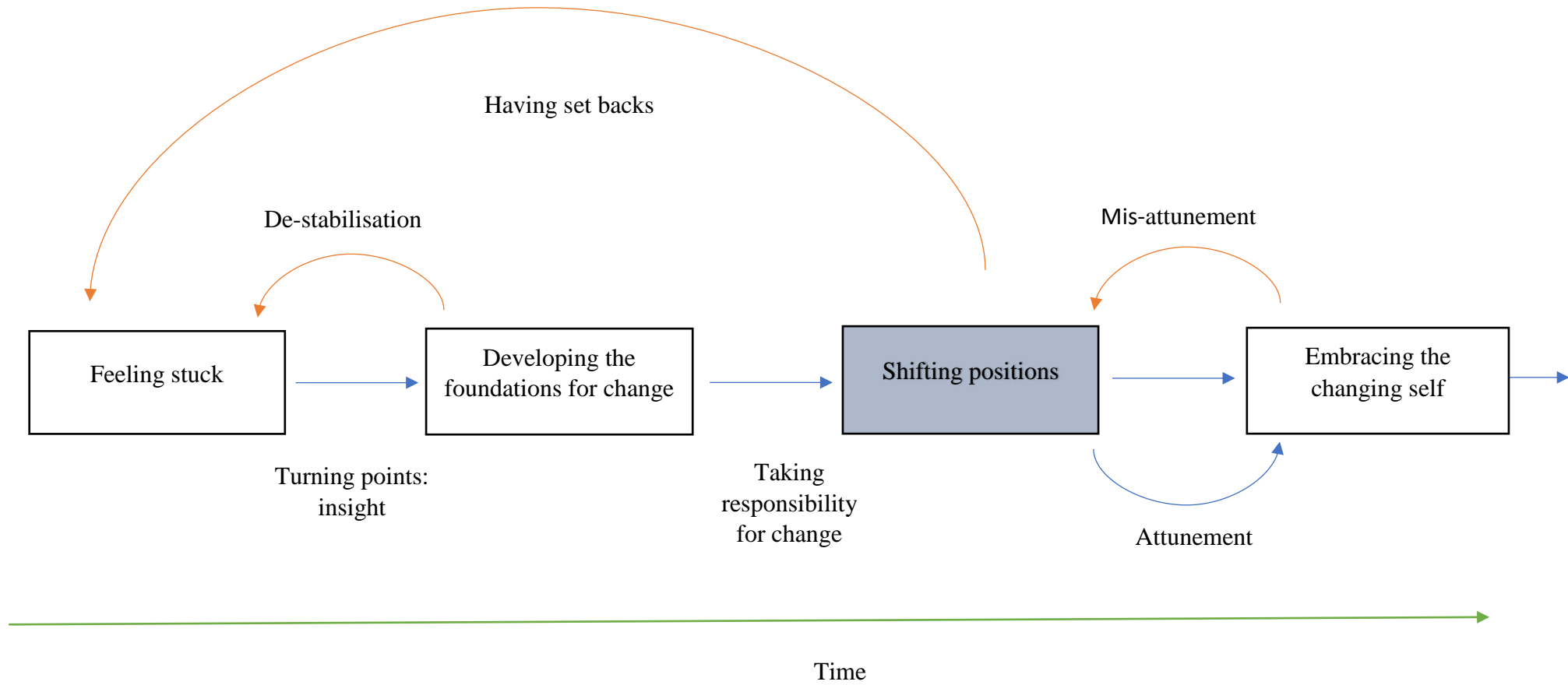


Figure 2. Preliminary model representing the change process

4. Discussion

4.1. Summary

This is the first qualitative study that contextualised the experience of change and the self without looking through a particular lens (e.g. within therapy). The core change experience of ‘shifting positions’ was identified to involve a complex interplay of evolving relationships to the self, to others and to help. These positions all interacted with each other in a way that enhanced the individual’s sense of self. It was suggested that as individuals develop an increased sense of security and understanding of their diagnosis in combination with an internal driver for change then individuals could begin taking risks and exploring different ways of being.

4.2. Links to Previous Research

4.2.1. Identity.

The findings of the current study in which the change process was conceptualised as movement towards a growing sense of self links to past research (Geyer, 2013). Kerr, Finlayson-Dhort, McCutcheon, Beard and Chanen (2015) provided a tentative definition of the self in relation to EUPD. The core self was theorised to involve complex psychological processes (e.g. thinking, planning, remembering) not always in consciousness. These processes were often held in awareness through reflective capacity of the phenotypic self which develops through interaction with the social world.

This reflective capacity of the phenotypic self appears to mirror the ‘shifting positions’ category identified within the final model. In the current model, the change experience was defined as one relating to the multifaceted interaction with the self, others and

to help which facilitated development of insight, mentalising and theory of mind for example. These findings support the notion that EUPD can be understood as a difficulty in coherence of the self and that change over time enables an improved sense of self.

4.2.2. How and to what?

This model explored change throughout individuals lives and enabled a more detailed understanding of change not restricted to a particular context. The model highlighted that individuals change naturally over time, learning through experience, which corresponds to literature focusing on natural changes over time (Zanarini et al., 2012). However, this process could be enhanced through contact with MHS, who, if attuned to the individual's needs, could facilitate change. However, the current model noted that MHS were just as powerful in restricting change. This links to research suggesting that service provision and diagnosis for EUPD is iatrogenic in nature and arguably impedes the individuals' ability to naturally recover (Fonagy & Bateman, 2006).

One of the most consistent messages across all research interviews was the importance of being ready to change. This correlates with findings of past qualitative research (Cunningham, Wolbert & Lillie, 2012; Perseius, Ojehagen, Ekdahl, Asberg & Samuelsson, 2003) as well as the stages of change model (Prochaska & DiClemente, 1982; Soler, 2008) and the movement between the contemplation and actions stages of change. Soler et al. (2008) applied the stages of change model to a DBT group and found that participant progress largely mirrored the stages of the model. The current research suggests that elements of the stages of change model may be applicable across and beyond psychological interventions.

4.3. Study Quality.

When reviewing Charmaz's (2014) quality criteria, the current study was considered to demonstrate sufficient credibility through the detailed and diverse range of interviews included. The study was viewed to meet criteria of originality due to the developing insights raised regarding the experience of change within EUPD, one that extends to all types of MHS provision. The study was perceived to meet resonance and usefulness criteria through positive participant responses and participant triangulation. The study offered a more generalisable understanding of change, one that extends across contexts which it was hoped would be useful for individuals with this diagnosis as well as their surrounding systemic contexts.

4.4. Study Limitations

The opportunistic way in which participants were recruited may have biased the data set. Staff with lived experience who are now working within MHS have arguably taken a particular path in their personal journey. This path may not be the case for many individuals with lived experience of EUPD. Furthermore, the staff recruited work in a particular therapeutic context which further reduces the generalisability of the findings.

The author acknowledged use of psychological terms when describing several processes within the model (e.g. attunement, insight). This may reflect the impact of the researcher on the final model, potentially restricting the depth of analysis. However, the researcher had a desire for the research to be clinically useful and so the terms were argued to encapsulate what the researcher believed was being described, as well as echoing language used by clinicians.

4.5. Clinical and Research Implications.

4.5.1 Clinical implications.

The final model suggests that change can be promoted in several ways. Firstly, as readiness to change was noted to be a key part of the change process, MHS could benefit from assessing an individual's readiness to engage in psychological therapy and specialist services in order to become more attuned to the individual's needs and provide the foundations for change for those deemed not be ready to change.

Furthermore, clinicians would benefit from modelling and promoting the relational skills discussed in the 'shifting positions' category to increase the potential for change. A collaborative focus on noticing and enhancing change would be imperative to encourage service users' to begin embracing change.

This study identified the importance of attunement. Attunement is a fine balance of offering support whilst encouraging independence. This process is a difficult one and services will require specialist supervision and training in order to provide staff with sufficient opportunity to undertake this process. Provision of support to staff teams may be best suited to Clinical Psychologists whose role within Multi Disciplinary Teams often involves providing support for complex clients. Mis-attunement between services and individuals with EUPD is likely to restrict personal growth and perpetuate stigma.

The model identified that change takes time. This was reiterated by Levy (2008) who stated that the development of a sense of self is a complex and difficult process for individuals with EUPD, one which is unlikely to occur suddenly. It is vital that service provision for individuals with this diagnosis is not seen as short term and individuals should be able to access MHS throughout their change experience. MHS should aim to provide ways

for individuals with a diagnosis of EUPD to shift positions e.g. through gaining employment in order to promote personal growth.

Furthermore, the diagnostic process and subsequent treatment by MHS was noted by participants to be poor at times. A conversation and explanation from a professional is essential, and some psychoeducation for individuals to take away would be helpful. This could mirror elements of the psychoeducation module included in STEPPS (Black & Blum, 2017) which may enable the diagnostic process to be more empowering.

4.5.2. Research implications.

Future research could aim to expand the type and diversity of service users recruited. It would have been beneficial to recruit carers and/or family members of those with EUPD about their experience of change, particularly because the current research has identified the complex interplay between the self and other in enhancement and disabling of change. Further research should aim to recruit staff members from a wider variety of clinical backgrounds and settings (e.g. within community mental health teams).

It would be useful for further research to begin exploring the therapeutic benefit of peer support, which was identified as a useful way for individuals to develop a sense of self and personal growth. This is particularly important with the increased provision of 'recovery colleges' and community services promoting peer support based on recommendations by the Department of Health (2011).

5. Conclusion

This was the first qualitative study to directly explore the experience of change for individuals diagnosed with EUPD that was not restricted to the context of psychological therapy.

The model suggested that the experience of change is complex and involves a dynamic interplay between the self, help and to others. The change experience was identified as an experience of 'shifting positions' which enabled individuals to fluidly move between and within relationships to explore different ways of being. It was suggested that this process enabled development of an increased sense of self. Developing a secure base and gaining some understanding of the diagnosis were also important parts of developing the right conditions for change.

Furthermore, the importance of personal readiness to change was identified as a vital element of the change experience. The change process was encapsulated by participants as an experience which occurred naturally over time, but one that could be facilitated by the processes described above. Finally, in regard to the context of MHS, being well attuned to service users' needs at differing points in their experience was found to facilitate change, whereas mis-attunement was found to pull people back to stuck positions and disrupt the change process.

This model extends across therapeutic modalities and settings. Future research would be beneficial in exploring the experience of change across a wider diversity of participants such as the inclusion of carers, family members and individuals with lived experience of EUPD from a wider variety of backgrounds.

6. References

Aviram, R. B., Brodsky, B. S., & Stanley, B. (2006). Borderline personality disorder, stigma, and treatment implications, *Harvard Review of Psychiatry*, 14, 249-256. Doi: 10.1111/j.1447-0349.2009.00594.x.

Bateman, A., & Fonagy, P. (2009). Randomised control trial of outpatient mentalisation-based treatment versus structured clinical management for borderline personality disorder, *American Journal Psychiatry*, 166, 1355-1364. Doi: 10.1176/appi.ajp.2009.09040539.

Black, D. W., & Blum, N. S. (2017). *Systems training for emotional predictability and problem solving for borderline personality disorder*. New York, NY: Oxford University Disorder.

British Psychological Society. (2009). *Code of ethics and conduct: Guidance published by the ethics committee of the British psychological society (ISBN: 978-1-85433-495-4)*. Retrieved from <https://beta.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Code%20of%20Ethics%20and%20Conduct%20%282009%29.pdf>

Camden & Islington NHS Foundation Trust. (2017). *Camden and Islington personality disorder service*. Retrieved from

<http://www.candi.nhs.uk/services/camden-and-islington-personality-disorder-service>

Chen, McCutcheon, Jovev, Jackson, J. A., & McGorry, B. T. (2007). What works in the treatment of borderline personality disorder, *Current Behavioural Neuroscience Reports Journal*, 4, 21-30. Doi: 10.1007/s40473-017-0103-z.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). London, UK: SAGE Publications Ltd.

Choi-Kain, L. W., Finch, E. F., Masland, S. R., Jenkins & Unrush, B. R. (2017). What works in the treatment of borderline personality disorder, *Current Behavioural Neuroscience Reports Journal*, 4, 21-30. Doi: 10.1007/s40473-017-0103-z.

Cunningham, K., Wolbert, R., & Lillie, R. (2004). It's about me solving my problems: Clients assessments of dialectical behaviour therapy, *Cognitive and Behavioural Practice*, 11, 248-256. Doi: 10.1108/JIDOB-09-2015-0027.

De Groot, E. R., Verheul, R., & Trijsburg, R. W. (2008). An integrative perspective on psychotherapeutic treatments, *Journal of Personality Disorders*, 22, 332–352. Doi: 10.1521/pedi.2008.22.4.332.

Department of Health. (2011). No health without mental health: A cross-government mental health outcomes strategy for people of all ages. London, UK: Author. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

Fonagy, P., & Bateman, A. (2006). Progress in the treatment of borderline personality disorder, *British Journal of Psychiatry*, 188, 1-3. Doi: 10.1192/bjp.bp.105.012088.

Forster, C., Berthollier, N., & Rawlinson, D. (2014). A systematic review of potential mechanisms of change in psychotherapeutic interventions for personality disorder, *Psychology & Psychotherapy*, 4(1), 1-14. Doi: 10.4172/2161-0487.1000133.

Fraser K., & Gallop, R. (1993). Nurses' confirming/disconfirming responses to patients diagnosed with borderline personality disorder, *Archives of Psychiatric Nursing*, 7, 336–341. Doi: 10.1016/0883-9417(93)90051-W.

Geyer, C. (2013). *Discovering 'new ways of being' in interpersonal space: a grounded theory of experiences of change in people diagnosed with BPD* (Unpublished doctoral dissertation). Canterbury Christ Church University, Canterbury, UK.

Glaser, B.G., & Strauss, A. (1967). *The discovery of grounded theory*. Hawthorne, NY: Aldine Publishing Company.

Green (n.d.). My borderline personality disorder story. Retrieved from

<http://www.emergenceplus.org.uk/service-user-stories/383-my-borderline-personality-disorder-story-amanda-green.html>

Gunderson, J. G. (2009). Borderline personality disorder: ontogeny of a diagnosis, *American Journal of Psychiatry*, 166, 530-539. Doi: 10.1176/appi.ajp.2009.08121825.

Harper, D., & Thompson, A. R. (2012). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. Chichester, UK: John Wiley & Sons Ltd.

Katsakou, C., Marougka, S., Barnicot, K., Savill, M., White, H., Lockwood, K., & Priebe, S. (2013). Recovery in borderline personality disorder (BPD): A qualitative study of service user' perspectives, *Plos one*, 7(5), 1-8. Doi:10.1371/journal.pone.0036517.

Katsakou, C., & Pistrang, N. (2017, January). Clients' experiences of treatment and recovery in borderline personality disorder: a meta-synthesis of qualitative studies, *Psychotherapy Research*, 1-18. Doi: 10.1080/10503307.2016.1277040.

Kavanagh (n.d.). Kayla's story: Living with borderline personality disorder. Retrieved from <https://www.mentalhealth.org.uk/stories/kaylas-story-living-borderline-personality-disorder>

Kerr, I. B., Finlayson-Short, L., McCutcheon, L. K., Beard, H., & Chanen, A. M. (2015). The 'self' and borderline personality disorder: Conceptual and clinical considerations, *Psychopathology*, 48, 339-348. Doi: 10.1159/000438827.

Larivière, N., Couture, E., Blackburn, C., Carbonneau, M., Lacombe, C., Schinck, S. A., Tribble, D. (2015). Recovery, as experienced by women with borderline personality disorder, *Psychiatry Quarterly*, 86, 555-568. Doi: 10.1007/s11126-015-9350-x.

Levy, K. N. (2008). Psychotherapies and lasting change, *American Journal of Psychiatry*, 165, 556–559. Doi:10.1176/appi.ajp.2008. 08020299.

Markham, D., & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviour, *British Journal of Clinical Psychology*, 42, 248- 256. Doi: 10.1348/01446650360703366.

Monarch Butterfly. (n.d.). BPD from a carer perspective. Retrieved from <http://monarchbutterfly.co.uk/bpd-from-a-carer-perspective/>

National Institute for Health and Care Excellence. (2009). *Borderline personality disorder: treatment and management*. London, UK: The National Collaborating Centre for Mental Health.

National Institute for Mental Health in England. (2003). Personality disorder: no longer a diagnosis of exclusion. London, UK: Author. Retrieved from

<http://personalitydisorder.org.uk/wp-content/uploads/2015/04/PD-No-longer-a-diagnosis-of-exclusion.pdf>

NHS Digital. (2017). Clinical classifications. Retrieved from

<https://digital.nhs.uk/article/1117/Clinical-Classifications>

Paris, J., & Zweig- Frank, H. (2001). A 27-year follow-up of patients with borderline personality disorder, *Comprehensive Psychiatry*, 42, 482-487. Doi:

10.1053/comp.2001.26271.

Paris, J. (2015). Applying the principles of psychotherapy integration to the treatment of borderline personality disorder, *Journal of Psychotherapy Integration*, 25(1), 13-19.

Doi: 1053-0479/15/\$12.00.

Perseus, K. I., Ojehagen, A., Ekdahl, S., Asberg, M., & Samuelsson, M. (2003). Treatment of suicidal and deliberate self-harming patients with borderline personality disorder

using dialectical behavioural therapy: The patients' and the therapists' perceptions,

Archives of Psychiatric Nursing, 17, 218-227. Doi: [http://dx.doi.org/10.1016/S0883-9417\(03\)00093-1](http://dx.doi.org/10.1016/S0883-9417(03)00093-1).

Prochaska, J. O., & DiClemente, C. C. (1982). Stages and processes of self-change of smoking: toward an integrative model of change, *Journal of Consulting and Clinical Psychology*, 51, 390-395. Doi: 10.1037/0022-006X.51.3.390.

Soler, J., Trujols, J., Pascual, C., Portella, M. J., Barrachina, J., Campins, J.,...Perez, V. (2008). Stages of change in dialectical behaviour therapy for borderline personality disorder, *British Journal of Clinical Psychology*, 47, 417-426. Doi: 10.1348/014466508X314882.

Stoffers-Winterling, J. M., Völlm, B. A., Rükler, G., Timmer, A., Huband, N., & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder (Review), *The Cochrane Database of Systematic Reviews*, 2012(2), 1-255. Doi: 10.1002/14651858.CD005652.pub2.

The British Psychological Society & The Royal College of Psychiatrists. (2009). *Borderline personality disorder: the nice guideline on treatment and management*. Leicester, UK: British Psychological Society. Retrieved from <https://www.nice.org.uk/guidance/cg78/evidence/bpd-full-guideline-242147197>

Urquhart, C. (2013). *Grounded theory for qualitative research: A practical guide*. London, UK: SAGE Publications Ltd.

Widiger, T. A., & Weissman, M. M. (1991). Epidemiology of borderline personality disorder, *Hospital & Community Psychiatry*, 42, 1015-1021. Doi: 10.1176/ps.42.10.1015.

World Health Organisation (WHO). (2016). *International statistical classification of diseases and health related problems (10th Revision)*. Geneva: Author.

Zanarini, M. C., Frankenberg, F. R., Bradford-Reich, D., & Fitzmaurice, G. (2010). The 10-year course of psychosocial functioning among patients with borderline personality disorder and axis II comparison subjects, *Acta Psychiatrica Scandinavica*, 122, 103-109. Doi: 10.1111/j.1600-0447.2010.01543.x

Zanarini, M. C., Frankenberg, F. R., Reich, D. B., & Fitzmaurice, G. (2012). Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder and axis II comparison subjects: a 16- year prospective follow- up study, *American Journal of Psychiatry*, 169, 476- 483. Doi: 10.1176/appi.ajp.2011.11101550.

Appendix A

EUPD Diagnosis Definition

The ICD-10, released by the World Health Organisation (WHO) (WHO, 2015) defined EUPD as,

“A personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal and outbursts of intense anger may often lead to violence or "behavioural explosions". These are easily precipitated when impulsive acts are criticized or thwarted by others” (p. 159).

Furthermore, the ICD-10 included two subtypes including the impulsive subtype, characterised by difficulty with impulse control and emotional instability. The second, the borderline subtype, was defined by several forms of emotional instability including chronic feelings of emptiness, unstable relationships, fear of abandonment and confusion in self-identity.

This contrasts with the DSM-IV (American Psychiatric Association, 2013) diagnostic criteria, employing the more commonly known term ‘borderline personality disorder’. The DSM-IV criteria largely mirror that of the ICD-10 but does not differentiate between impulsivity and borderline and identifies dissociation or paranoid ideation as criterion, which is not included within the current ICD-10 criterion.

Appendix B

Quality Assessment of Qualitative studies based on Mays and Pope (2000)

Study	Triangulation	Respondent Validation	Clear exposition of methods of data collection and analysis	Reflexivity	Attention to negative cases	Fair dealing
McSherry, O'Conner, Hevey & Gibbons (2012)	X	X	✓	X	X	✓
Geyer (2013)	✓	X	✓	✓	✓	✓
Cunningham, Wolbert & Lillie (2012)	X	X	X	X	✓	X
Hodgetts, Wright & Cough (2007)	X	X	✓	X	✓	✓
Perseius, Ojehagen, Ekdahl, Asberg & Samuelsson (2003)	✓	X	✓	X	✓	X
Perseius, Ekdahl, Asberg & Samualsson (2005)	X	X	X	X	X	X

Appendix C

Quality Assessment of Case Study based on Yin (2009) criteria

Study	Significant	Unique	Relevant to a wider audience	Complete	Clear research question	Collect and report enough data to address question	Reported clearly	No bias in any single case	Reflections on limitations and potential bias
Nee & Farman (2007)	✓	✓	✓	✓	X	X	✓	✓	X

Appendix D

Quality of Quantitative Intervention Studies based on Effective Public Health Practice Project (EPHPP) (1998).

Study	Selection Bias	Study Design	Confounders	Blinding	Data Collection Methods	Withdrawals and drop-outs	Global Rating
Neacsu, Rizvi & Linehan (2010)	2	2	3	2	1	3	2
Kramer et al. (2015)	2	2	1	2	3	2	2
Sandage (2015)	3	2	N/A	N/A	2	1	2
Feliu-Soler et al. (2014)	2	2	1	2	3	2	2
Bedics, Atkins, Harned & Linehan (2015)	2	1	2	3	2	3	2
Goodman et al. (2014)	2	2	3	2	3	2	2
Gratz, Levy & Tull (2012)	2	1	3	3	2	3	3
Linehan et al (2015)	2	1	1	2	3	2	2
Mcmain et al. (2013)	2	3	1	2	2	3	2
Soler et al. (2012)	2	2	1	2	1	2	2

1= Strong

2= Moderate

3= Weak

Appendix E

Quality of Observational Cohort and Cross-sectional Studies based on National Heart, Lung and Blood Institute (NIH) (2014)

Study	Research question	Specified population	Participation rate above 50%	Participants recruited from similar populations? Uniform eligibility criteria?	Sample size justification?	Exposure of interest measured before outcome being measured?	Sufficient timeframe?	Different levels of exposure?	Iv clearly defined and implemented?	Exposure assessed more than once?	Outcome measures	Blinding of outcome assessors	Follow up rate	Statistical analyses
O'toole, Diddy & Kent (2012)	G	F	G	G	G	G	P	P	F	P	F	N/A	P	F
Perroud, Nicastro, Jermann & Huguélet (2012)	F	F	G	G	P (No justification)	G	F	G	G	G	G	N/A	P	F
Dammann et al. (2016)	G	F	G	G	p	F	P	P	F	G	G	N/A	P	F

G= good

F= fair

P= poor

Appendix F

Quality Assessment of Studies Using Kazdin's Criteria

Study	Strong association	Specificity	Consistency	Experimental Manipulation	Timeline	Gradient	Plausibility/ Coherence
Neacsiu, Rizvi & Linehan (2010)	✓	✓	✓	✓	✓	X	P
Kramer et al. (2016)	✓	✓	P	✓	✓	X	P
Sandage (2015)	P	✓	P	X	X	X	P
Feliu-Soler et al. (2014)	P	P	X	P	x	X	P
Bedics, Atkins, Comtois & Linehan (2012)	P	P	P	✓	X	X	✓
Bedics, Atkins, Harned & Linehan (2015)	P	P	P	✓	X	X	✓
Goodman et al. (2014)	P	P	X	P	X	X	P
Gratz, Levy & Tull (2012)	✓	✓	✓	✓	✓	X	✓
Linehan et al (2015)	X	X	X	✓	X	X	P
Mcmains et al. (2013)	P	P	X	X	X	X	P
Soler et al. (2012)	P	P	X	✓	X	P	P
O'toole, Diddy & Kent (2012)	X	X	X	X	X	X	P
Perroud, Nicastro, Jermann & Huguelet (2012)	P	P	X	X	X	X	P
Dammann et al. (2016)	P	P	X	X	X	X	P

P= Part

Appendix G

Additional Information About Included Studies

Study name	Diagnostic measure	Outcome measure
Bedics, Atkins, Comtois & Linehan (2012)		Structural analysis of social behaviour (SASB)
		The suicide attempt self-injury questionnaire (SASII)
Bedics, Atkins, Harned & Linehan (2015)	DSM-IV	The California Psychotherapy Alliance Scales (CALPAS)
	SCID-11	Hamilton Rating Scale for Depression (HRSD)
		Structural analysis of social behaviour (SASB)
		The suicide attempt self-injury questionnaire (SASII)
Cunningham, Wolbert & Lillie (2012)	DSM-IV	N/A
Damman et al. (2016)	DSM-IV	Hamilton Rating Scale- Depression, Brief Psychiatric Scale (BPRS)
		Profile of mood states
		Five Facet Mindfulness Questionnaire (FFMQ)
		Experiences Questionnaire (EQ)
		Daily Mindfulness Practice Times
		CPT-II (computerised neuropsychological attention test)
		Inventory of Personality Organisation (IPO)
		Symptom checklist (SCL-90)

		Beck depression inventory (BDI),
		Spielberger state and trait inventory (STAI),
		Spielberger state and trait anger inventory (STAXI)
Feliu-Soler et al. (2014)	SCID-II (Spanish version)	HDRS,
	Diagnostic Interview for Borderlines-Revised (Spanish Version)	Brief Psychiatric Rating Scale (BPRS)
		Self-assessment manikin questionnaire (SAM)
		salivary cortisol (Scort)
Geyer (2013)	No information given.	N/A
Goodman et al. (2014)	DSM-IV	Difficulties in Emotional Regulation Scale (DERS)
		amygdala activation measured by Functional magnetic resonance imaging fMRI)
Gratz, Levy & Tull (2012)	Revised Diagnostic Interview for Borderlines	Deliberate self-harm Inventory (DSHI)
	Structured Clinical Interview for DSM-IV	Difficulties in Emotional Regulation Scale (DERS)
Hodgetts, Wright & Cough (2007)	2) History of self harm DSM-IV (American Psychiatric Association, 1994)	N/A
Kramer et al. (2016)	DSM-IV (American Psychiatric Association, 1994)	Outcome Questionnaire: 45.2
Linehan, et al. (2015)	International Personality Disorders Examination	Suicide attempt Self-Injury Interview,
	SCID-11	Suicidal Behaviours Questionnaire
		Reasons for living Inventory
		Hamilton Rating Scale for Depression
		Hamilton Rating Scale for Anxiety
Mcmain, et al. (2013)	International Personality Disorders Examination	symptom Checklist-90- Revised (SCL-90R)

Inventory of Interpersonal Problems (IIP)		
McSherry, O'Connor, Hevey & Gibbons (2012)	DSM-IV diagnostic criteria	N/A
Neacsiu, Rizvi & Linehan (2010)	Structured Clinical Interview for DSM-IV Axis II Personality Disorder (SCID-11)	DBT ways of coping checklist (DBT-WCCL)
	International Personality Disorders Examination	Suicide attempt and self-injury interview (SASII)
		Hamilton Depression Scale (HRSD)
		State-trait expression inventory
Nee & Farman (2007)	SCID-11	N/A
O'toole, Diddy & Kent (2012)	No information given	Five Facet Mindfulness Questionnaire (FFMQ) Multidimensional Scale of Perceived Social Support (MSPSS)
		Survey of physical and emotional well-being (MOS-36)
		Alcohol Use Disorders Identification Test, Office visits for health concerns
Perroud, Nicaastro, Jermann & Huguelet (2012)	International Personality Disorders Examination	
	SCID-11	
Perseius, Ojehagen, Ekdahl, Asberg & Samuelsson (2003)	DSM-IV	N/A
Perseius, Ekdahl,	DSM-IV	N/A

Asberg & Samuelsson (2005)		
Sandage (2015)	McLean Screening Instrument for Borderline Personality Disorder	<p>Transgression-related interpersonal motivations inventory (TRIM)</p> <p>Decisional forgiveness scale (DFS)</p> <p>Emotional forgiveness scale (EFS)</p> <p>Trait forgiveness scale (TFS)</p> <p>Experiences in close relationships scale-short form</p> <p>Psychiatric symptoms checklist</p>
Soler et al. (2012)	<p>SCID-II (Spanish version)</p> <p>Diagnostic Interview for Borderlines-Revised (Spanish Version)</p>	<p>Hamilton Rating Scale- Depression, Brief Psychiatric Scale (BPRS)</p> <p>Profile of mood states</p> <p>Five Facet Mindfulness Questionnaire (FFMQ)</p> <p>Experiences Questionnaire (EQ)</p> <p>CPT-II (computerised neuropsychological attention test)</p>

Appendix H

Research_Diary Excerpts

I am a 27 year old white woman with experience of working in a Specialist Personality Disorder service prior to training. As a result of these experiences, I identify a desire to challenge stigma as well as an affiliation to working with this client group. I was mindful throughout the research process of the potential impact that my position and ideas might have on the research process and reflected on this throughout the diary. Examples of my reflections can be found in this appendix.

05/06/2016

I've been doing lots of research on EUPD for Part A. I also know that identifying and reflecting on my beliefs and perceptions around personality disorder is an important part of the research process. I thought I'd begin this today. I dislike the term personality disorder. I think it is demeaning to those who receive it and sends a message that at the core of your personality, you are disordered, or damaged. But from past clinical experience, the term has often made sense to people, eventually. It seems that for some people, having some sort of answers as to why they are suffering the way that they are must be empowering.

I know from experience that this client group are sometimes personally challenging to work with. The work is complicated and messy and draining. But working with these individuals, I saw change. I want this research to empower those with the diagnosis and surrounding services to challenge stigma and to give hope for change.

These personal beliefs and values are within me, but acknowledging them will hopefully allow me to become more aware of if they seep into analysis and theory development.

28/06/2016

I started reflecting on the potential upcoming interviews. They are all with old work colleagues. This feels a little weird and I get that slight anxiety when thinking about coming back as a trainee psychologist, a need to impress almost. I also wonder if it will make it easier for staff to open up. We shall see!

06/07/2016

I completed my first three interviews today. Prior to the meetings, I did some reading about carrying out grounded theory interviews.

From what I took from the reading, the two main aims of the research interviews are to hear participant's stories and to construct a meaning in order to develop a theory.

This seemed simple but complicated at the same time. I wondered if I would find it difficult to hold the construction in mind whilst really absorbing myself into the client's worlds.

I also found out that one of the staff members in the team I was visiting had just announced that they were leaving the service. I could sense that the team were upset and wondered how that may impact interviews that were focusing on the topic of change.

I also became aware that I felt a bit more of a burden within team who were probably preoccupied with other more urgent matters. I notice a desire to want to make interviews helpful or meaningful for staff. I thought I better pay attention to this in the interviews.

During the interviews, I was struck by my reaction when hearing about services that we previously worked with. I notice feeling immediate curiosity about their journey since I last worked in the team and during the interview I could not hide my automatic joy when hearing about some of the positive progress that some service users' had made. I wonder if

this influenced my follow-up questions are my interpretations or summaries. I guess that I will have to listen to the tapes again.

I noticed feeling a little anxious and preoccupied by the interview schedule which at times felt distracting and repetitive. I think this may have influenced how present I was. I may need to practice using the interview schedule on my own.

10/07/17

Just reflecting on the first few interviews. I don't think the existing relationship effected the interview too much, I think it actually made it easier for staff and me to get into the 'flow'. Talking about service users' that I already know was interesting though. I definitely noticed a curiosity and had to stop myself from asking too much about their progress.

17/07/16

I recently had an operation and have been signed off work. I feel a little bit out of it, and the research feels very far from my mind.

28/07/16

I have been e-mailing some local voluntary organisations to trying to recruit service user participants. Getting a little bit anxious about not having any interest of yet.

14/08/16

Received response from potential participant. They'd like to know more about the study which is promising!

21/08/16

no response from potential participant. Starting to think this is going to be harder than I thought.

12/09/16

completed two more interviews today. Found it a little hard to get back into the swing of things post-break from the course. Had some amazingly effective experiences in the interviews. Really interesting ideas and observations. Definite themes arising from interviews focusing on their importance of the therapeutic relationship. It seems obvious but I forget how important it is with this client group. The second interview had slightly less debt due to the reduced amount of time working in the service. I need to be mindful of this when recruiting future staff participants. Felt like I have guided questioning a little more with this participant. Need to remind myself to take a second to refocus and utilise interview schedule.

14/09/16

Response from potential participant. Still interested but life stuff understandably taking priority, asked me to e-mail them in a week.

22/09/16

Completed another staff interview, feeling more confident with the schedule. Feel as though I'm reaching saturation with staff. It's really becoming apparent just how important it is to interview some staff with lived experience soon in order to add a new dimension to the project.

Also met with external supervisor. We talked recruitment brainstorm strategies and agreed to email us some local services again. Will review on 13/10 Khomeini think the new recruitment strategy. Frustrating as I've been recruiting for months. Supervisor agreed to make contact with service user volunteers.

23/09/16

Had email from service user volunteer. She said she'd be happy to participate. This is great!

Also met with internal supervisor. Agreed to focus on transcribing and pate was competing recruitment.

05/10/16

Haven't heard anything from either potential service user volunteer participants yet. Really feel stop and start.

31/11/16

Getting a good start with part a. Trying to hone down to a focused question.

Was also due to me my first lived experience participant today but she had to cancel.

Completely understandable, but I really want to get started!

10/11/16

Met with my first service user participant. I thought the interview on really well. It was hard to follow at the interview schedule at times. Some really interesting topics came up in the interview. Shows how important is to interview those with the lived experience. Added a new lens to the work but also really matches up to what staff are saying.

01/12/16

Met with my second service user participant. The boundaries at the beginning of the interview felt a little blurred. The interviewee said that she was hoping to get referred to the service. Seek support from supervisor informed interviewee that the service would only be open to members and we would be unable to look around in the way she wanted. She said that she understood this when we met the interviewee said that she felt a little stressed as she

had to come a long way and had got lost. She was a little late and the consequence and felt upset about this. Interview itself was interesting and new ideas emerge during our discussion. At times felt a little poured into a therapy may and felt that I guided the session more than perhaps I should have felt desire to give more feedback and reassurance because of perceived individual to be feeling anxious. After the interview then participant requested to meet with the team psychologists and my supervisor of this project. It was felt that this was helpful in helping the interviewee feel heard in her struggles. The interviewee agreed to message some friends about my research to see if they be interested in participation which was which I was grateful of.

07/12/16

I received an email from another potential participant who was told about the project by her friend which is positive. I also heard back from another potential participant flagged to me by my supervisor. She was interested in the project. Things are looking up!

15/12/16

After a few days of e-mailing a potential third service user participant, I arranged to meet her today for the interview. The interview felt slightly less structured than others, I noticed that I didn't look at interview schedule more than once! The service user interviewee seemed to have a good sense of what the interview was about and so I didn't feel as if I needed to steer it in any way. The interviewee was very positive about some of her changes but I felt a strong sense from her that she wanted me to know that some things haven't changed. The interview also appeared to end in a bleak way, with the client saying she would kill herself if she didn't make any changes or get back to the person she once was. This felt quite difficult to end the interview with. We debriefed and the interviewee seemed okay. I wonder if the interviewee wanted me to know that things weren't all better or all okay, so she did not want me to get a

too positive sense of her progress. The client also receive supervision at the service we service we visited and we talked about how she could user offer support if needed.

15/12/16

Received confirmation of another interview to take place tomorrow at someone's home. This is the only interview taking place at someone's home, I felt a little uneasy as I've never met this person or know their history, but adequate lone working procedures were in place.

06/01/17

Have been transcribing interviews. Such a long process but so interesting. Really feel like I'm getting absorbed into the data.

20/02/17

Beginning coding. Decided to try and line by line as many transcripts as possible to really immerse myself in the data. It's working! Just taking a very long time.

05/03/17

Developing my theory at the moment. Such a hard process. Met up with my supervisor and an independent psychologist. It was so useful as we talked about some of the wording of my codes, why I chose them and how representative they were. I also suggested a prototype model.

One of the biggest challenges in incorporating both staff and those with lived experiences views. The design has been invaluable as I am developing a theme called 'attunement' which seems really key in the data when it comes to being supported to change. But, its hard trying to blend views together. I guess it's ok that they don't all fit. It is the differences that it is worth thinking about.

04/04/17

I'm refining my model and constantly going back to the data to ensure it is grounded in participant's views. It is so easy to step away from the data when you have a new idea. I am constantly returning to the data set to ensure I don't run away with myself.

10/04/17

I have e-mailed participants to get their perspective on initial themes. Intrigued about their responses!

Appendix I

Interview Schedule for Lived Experience Group

A Grounded Theory investigation of the experiences of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder (EUPD)

Date: 01/12/2015

Version: 1.1

Interview Schedule**Introduction:**

The focus of this interview will be around your experiences of changes over time in regards to your mental health and what these changes looked like. The interview will also touch on your experiences of mental health services over time as well as your life outside of mental health services. I would like to ask some initial questions about yourself and your diagnosis before we move on to the main bulk of the interview. Please feel free to stop the interview at any time or to ask questions at any point.

1. How old were you when you were diagnosed with EUPD?
2. How old are you currently?
3. What was your experience of receiving this diagnosis?

Main interview:

The remaining questions will focus on your experience of change over the years. I have some questions to ask but others may come up during the interview. Please feel free to stop the interview at any time or to ask questions at any point.

4. What was your perception of your difficulties when you were first diagnosed?
5. Has your experience of these difficulties changed over the years?
6. Prompts if participant identifies changes
 - a) In what areas of your life have you noticed changes?
 - b) In what way have each of these areas changed over time?
 - c) Would you describe these changes to be positive? If yes, why? If no, why?
 - d) How did you know that things were changing/ had changed?
 - e) What factors were important in facilitating this change?
 - f) What barriers may have prevented change?
 - g) Who/what has contributed to these changes in your life?
7. Prompts if participant doesn't identify changes
 - a) Why do you think this may be?
 - b) Are there any factors that have contributed to this?
 - c) When looking back at your experiences, what could have been helpful to facilitate change?
8. Have there been any pivotal moments for you over the years, where things significantly changed? If so, please tell me a little more about these moments.

9. Tell me a little about your experiences with Mental Health Services or other organisations over the years.
10. Can you identify differences in the service provided to you over time by Mental Health Services?
- a) If yes, what differences can you identify? What impact did these have on you?
 - b) If no, what similarities do you identify? What impact do these have on you?
11. Could you describe the most important lessons that you have learnt through your journey so far?

Debrief

Thank-you for your time. The interview has now come to an end. I would just like to check in with how you found the interview. How did you find the interview today? Were there any questions that you struggled with? How are you currently feeling? Do you feel you need any support now that the interview has finished? How might you go about accessing support? Was there anything you wanted to ask me? Is there anything that you would like to feedback to me about today's interview? Thank-you very much for your time.

Appendix J

Interview Schedule for Staff Group

A Grounded Theory investigation of the experiences of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder (EUPD)

Date: 01/12/2015

Version: 1.1

Interview Schedule

Introduction:

The focus of this interview will be around your experiences of working with individuals with a diagnosis of Emotionally Unstable Personality Disorder (EUPD) and your perceptions of change over time for these clients. The interview will also touch on your experiences of engagement with these clients as well as your perception about what factors contributed to service users making changes to their lives. I would like to ask some initial questions about yourself and your current and previous roles before we move on to the main bulk of the interview. Please feel free to stop the interview at any time or to ask questions at any point.

1. What is your current role?
2. What have your previous roles included?
3. How many would you say that you have worked with individuals with a diagnosis of EUPD?

Main interview:

The remaining questions will focus on your experience of working with service users with a diagnosis of EUPD and your perception of change over the years for these clients. I have some questions to ask but others may come up during the interview. Please feel free to stop the interview at any time or to ask questions at any point.

4. Can you tell me a bit about any difficulties faced by service users on receipt of an EUPD diagnosis? (You may draw from a few examples of service users that you have worked with, in order to gain a general sense of the difficulties these individuals may have experienced when they first entered mental health services.)
5. Please think about the people that you have worked with that have received a EUPD diagnosis and/or who you have experienced making changes over the time that you have known them and answer the following questions.
 - a) In what areas of service users' life did you notice changes?
 - b) In what way have each of these areas changed over time?
 - c) Would you describe these changes to be positive? If yes, why? If no, why?
 - d) How did the service user know that things were changing/ had changed?
 - d) How did you know that things were changing/ had changed?
 - e) What factors were important in facilitating this change?
 - f) What barriers may have prevented change?

g) Who/what has contributed to these changes in your life?

6. Please think about people that you have worked with that you did not observe making changes in during the time in which you worked together and answer the following questions.

a) Why do you think this may be?

b) Are there any factors that may have contributed to this?

c) What could have been helpful to facilitate change for the service users you worked with?

7. Tell me a little about service users experiences with Mental Health Services or other organisations over the years.

8. Have you noticed any pivotal moments where things significantly changed for the service users that you worked with? If so, please tell me a little more about these moments.

9. Can you identify differences in service users' engagement with Mental Health Services over time?

a) If yes, what differences can you identify? If no, please elaborate.

Debrief

Thank-you for your time. The interview has now come to an end. I would just like to check in with how you found the interview. How did you find the interview today? Were there any questions that you struggled with? Was there anything you wanted to ask me? Is there anything that you would like to feedback to me about today's interview? Thank-you very much for your time.

Appendix K

Study Poster for Lived Experience Group

The experience of
change within
Emotionally
Unstable Personality
Disorder/ Borderline
Personality Disorder

Have you received a diagnosis of emotionally unstable personality disorder? (Also known as borderline personality disorder)

Would you like to talk about your experiences of receiving this diagnosis?

Would you like to talk about whether things have changed for you over time? (If they haven't, then I'd still like to hear from you!)

As part of my doctoral research, I am interviewing people for up to one hour about their experiences of receiving and living with this diagnosis and whether they have noticed any differences over time. I would like to develop a theory of change for this diagnosis.

Please get in touch if you would like to be interviewed about your experiences. Contact [X](#) or X for more information.

Please note: This study requires participants to NOT be currently accessing Mental Health Services.

Appendix L
Study Poster for Staff Group

The experience of
change within
Emotionally
Unstable Personality
Disorder/ Borderline
Personality Disorder

Have you worked with individuals with a diagnosis of emotionally unstable personality disorder? (Also known as borderline personality disorder)

Would you like to talk about your experiences of working with these clients?

Could you talk about times when you have and haven't noticed changes for your clients over time?

As part of my doctoral research, I am interviewing people for up to one hour about their experiences of working with individuals with this diagnosis and whether they have noticed any differences over time. I would like to develop a theory of change for this diagnosis.

Please get in touch if you would like to be interviewed about your experiences. Contact x for more information.

Appendix M

Information Sheet for Staff Group

A Grounded Theory investigation of the experiences of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder (EUPD)

Participant Information Sheet: Staff

Date: 10/03/2016

Version: 1.2

Hello. My name is x and I am a Trainee Clinical Psychologist at x. I would like to invite you to take part in a research study. I have provided some information about the study in order for you to understand why the research is being carried out and what your role would involve.

You will be provided with a consent form associated with this information sheet in which you can formally consent to taking part in research, which you will retain for your records.

What is the study about?

This study will ask people who've worked with individuals with a diagnosis of Emotionally Unstable Personality Disorder (EUPD) (also known as Borderline Personality Disorder (BPD)) on their experiences of change. The study will also investigate the experience of change for individuals with a diagnosis of EUPD/BPD.

Specifically, I would like to explore whether you have observed changes over time for the clients you have worked with who have received this diagnosis and what factors may have contributed to this. Contrastingly, I would be interested to explore your experience of working with individuals who may not have been able to make changes and why you think this may be. I'd also like to find out a little more about how you think mental health services to be best able to support service users with a diagnosis of EUPD. I'm really interested in your views on this topic.

What is the purpose of the study?

Although understanding and service provision for EUPD has increased over recent years, there are still several topic areas with relatively little research. One of those areas focuses on people's individual experiences of their diagnosis and the way in which this may or may not change over time. Particularly, this study aims to identify whether there are any common themes within peoples experiences with a diagnosis of EUPD. The study also aims to understand the impact of mental health services on individual's experiences. This study will incorporate both service user and staff member's perspectives in order to develop a detailed and diverse understanding of the mechanisms of change. I hope that the results from this study will increase understanding of how services and therapists can most effectively support individuals who have been given this diagnosis.

What does it involve?

I am interviewing approximately 20 people about their experiences. These participants will include both individuals who have used services and staff members who have worked within mental health. The interviews will last up to 1 hour. I aim for the interviews to take place between spring and summer of 2016. I will record the interviews and will then transcribe them into written form. Any identifiable information (e.g. names of relatives or place of work) will be removed from the written transcript. This transcript will be shared with my research supervisors as part of the data analysis. I will then look for themes within the interviews in order to create a theory based on the experience shared by participants.

After development of the theory I may require supplementary data. This may involve asking you to attend for a second interview or to answer follow up questions via email or on the telephone. This will take no longer than 30 minutes and is completely optional.

Finally, you would have the option of giving some brief feedback on the initial results of the data to tell me how accurate my analysis is. This will take no longer than 30 minutes and is completely optional.

Why have I been invited?

You have been invited to take part in the project because the service you are involved with is undertaking research and you have been identified as a suitable candidate. If you would like to find out more information about this, then please let me know. I would be grateful if you could let me know whether you feel able to take part in the study, within the next 72 hours. If you would like additional time to decide, please let me know.

Do I have to take part?

No. Your agreement to take part in the study is completely your decision. If you do agree to take part in the study then I will ask you to complete a consent form. You have the right to withdraw from the study at any time and subsequently all of your data would be deleted.

What are the possible disadvantages and risks of taking part?

The interview will take time to complete, particularly if you agree to complete follow up questions (approximately 2hours). If you have any concerns about the time that participating in this research would take, please discuss this with the researcher and your team manager.

What are the possible benefits of taking part?

The study may help to increase our understanding of change within EUPD and the role that mental health services may play within this. The information would be of great use in helping services to understand this process of change and how best they can support service users. It is hoped that the interview will enable reflection on personal experiences which can be an empowering, positive experience.

Will my taking part in the study be kept confidential?

Yes. Everything said in the interview will remain confidential. However, if I become concerned about your safety or the safety of someone else, then I will need to break this confidentiality and will share this information with the most appropriate agency. I may need to break confidentiality if I have concerns about quality of care being provided to clients or in regards to the safety and wellbeing of other staff members working within X Trust.

After completion of the interview, your recording will be immediately transferred onto a Trust encrypted USB and will be stored in a locked cabinet on Trust premises. This recording will only be listened to by me and my two research supervisors. As soon as the project has been completed, this recording will be destroyed.

All anonymised data (i.e. the interview transcript) will be locked in a secure cabinet, separately from the main research data at X. All data will be stored securely for 10 years, in line with the Data Protection Act (Data Protection Act, 1998).

What will happen to the results of the research study?

It is hoped that the results of this research study will be published and released within a psychology journal to enrich our understanding of change within EUPD. It is also possible that the results will be distributed within X Trust and the research findings will also be disseminated to X. If you would like a copy of the results of this research study, then please feel free to contact myself and I will be happy to arrange for this information to be distributed to you.

It is important to note that any personally identifiable information will be removed from any published reports.

Who is organising and funding the research?

The research is funded by X as part of the Doctorate in Clinical Psychology. X Trust are also sponsoring the current study.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by _____ Research Ethics Committee.

Further information and contact details

If you would like any further information about the study then please do not hesitate to get in touch with myself on the number below. I can try to answer general questions about research, provide specific information about this project, discuss any concerns you have about taking part, or discuss complaint procedures if you are unhappy with any aspect of the project.

Please contact me by email: X or by telephone: X. Please feel free to leave a voicemail and I will get back to you as soon as possible.

If you would like to discuss any queries or concerns about the project with another member of the research team, please contact Dr X by telephone on: X. Dr X supervises the project but is not directly involved in the recruitment or interview process.

What if there is a problem?

If you have any concerns about any aspect of the project, please contact myself and I will do my best to answer any concerns or queries. Please contact me by email: X or by telephone via: X. Please feel free to leave me a voicemail and I will get back to you as soon as possible.

If you remain unhappy and want to complain formally, then please contact X on: X who will be able to take your complaint forward through X complaints procedure.

Furthermore, you can also seek advice from X Trust. Please phone X or email X

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against X/ X Trust but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Appendix N

Information Sheet for Lived Experience Group

A Grounded Theory investigation of the experiences of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder (EUPD)

Participant Information Sheet: Lived Experience

Date: 10/03/2016

Version: 1.2

Hello. My name is x and I am a Trainee Clinical Psychologist at X. I would like to invite you to take part in a research study. I have provided some information about the study in order for you to understand why the research is being carried out and what your role would involve.

You will be provided with a consent form associated with this information sheet in which you can formally consent to taking part in research, which you will retain for your records.

What is the study about?

This study will ask people who've worked with individuals with a diagnosis of Emotionally Unstable Personality Disorder (EUPD) (also known as Borderline Personality Disorder (BPD)) on their experiences of change. The study will also investigate the experience of change for individuals with a diagnosis of EUPD/BPD.

Specifically, I would like to explore whether you have observed changes over time for the clients you have worked with who have received this diagnosis and what factors may have contributed to this. Contrastingly, I would be interested to explore your experience of working with individuals who may not have been able to make changes and why you think this may be. I'd also like to find out a little more about how you think mental health services to be best able to support service users with a diagnosis of EUPD. I'm really interested in your views on this topic.

What is the purpose of the study?

Although understanding and service provision for EUPD has increased over recent years, there are still several topic areas with relatively little research. One of those areas focuses on people's individual experiences of their diagnosis and the way in which this may or may not change over time. Particularly, this study aims to identify whether there are any common themes within peoples experiences with a diagnosis of EUPD. The study also aims to understand the impact of mental health services on individual's experiences. This study will incorporate both service user and staff member's perspectives in order to develop a detailed and diverse understanding of the mechanisms of change. I hope that the results from this study will increase understanding of how services and therapists can most effectively support individuals who have been given this diagnosis.

What does it involve?

I am interviewing approximately 20 people about their experiences. These participants will include both individuals who have used services and staff members who have worked within mental health. The interviews will last up to 1 hour. I aim for the interviews to take place between spring and summer of 2016. I will record the interviews and will then transcribe them into written form. Any identifiable information (e.g. names of relatives or place of work) will be removed from the written transcript. This transcript will be shared with my research supervisors as part of the data analysis. I will then look for themes within the interviews in order to create a theory based on the experience shared by participants.

After development of the theory I may require supplementary data. This may involve asking you to attend for a second interview or to answer follow up questions via email or on the telephone. This will take no longer than 30 minutes and is completely optional.

Finally, you would have the option of giving some brief feedback on the initial results of the data to tell me how accurate my analysis is. This will take no longer than 30 minutes and is completely optional.

Why have I been invited?

You have been invited to take part in the project because the service you are involved with is undertaking research and you have been identified as a suitable candidate. If you would like to find out more information about this, then please let me know. I would be grateful if you could let me know whether you feel able to take part in the study, within the next 72 hours. If you would like additional time to decide, please let me know.

Do I have to take part?

No. Your agreement to take part in the study is completely your decision. If you do agree to take part in the study then I will ask you to complete a consent form. You have the right to withdraw from the study at any time and subsequently all of your data would be deleted.

What are the possible disadvantages and risks of taking part?

The interview will take time to complete, particularly if you agree to complete follow up questions (approximately 2hours). If you have any concerns about the time that participating in this research would take, please discuss this with the researcher and your team manager.

What are the possible benefits of taking part?

The study may help to increase our understanding of change within EUPD and the role that mental health services may play within this. The information would be of great use in helping services to understand this process of change and how best they can support service users. It is hoped that the interview will enable reflection on personal experiences which can be an empowering, positive experience.

Will my taking part in the study be kept confidential?

Yes. Everything said in the interview will remain confidential. However, if I become concerned about your safety or the safety of someone else, then I will need to break this confidentiality and will share this information with the most appropriate agency. I may need to break confidentiality if I have concerns about quality of care being provided to clients or in regards to the safety and wellbeing of other staff members working within XTrust.

After completion of the interview, your recording will be immediately transferred onto a Trust encrypted USB and will be stored in a locked cabinet on Trust premises. This recording will only be listened to by me and my two research supervisors. As soon as the project has been completed, this recording will be destroyed.

All anonymised data (i.e. the interview transcript) will be locked in a secure cabinet, separately from the main research data at X. All data will be stored securely for 10 years, in line with the Data Protection Act (Data Protection Act, 1998).

What will happen to the results of the research study?

It is hoped that the results of this research study will be published and released within a psychology journal to enrich our understanding of change within EUPD. It is also possible that the results will be distributed within X Trust and the research findings will also be disseminated to X. If you would like a copy of the results of this research study, then please feel free to contact myself and I will be happy to arrange for this information to be distributed to you.

It is important to note that any personally identifiable information will be removed from any published reports.

Who is organising and funding the research?

The research is funded by X as part of the Doctorate in Clinical Psychology. X Trust are also sponsoring the current study.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by _____ Research Ethics Committee.

Further information and contact details

If you would like any further information about the study then please do not hesitate to get in touch with myself on the number below. I can try to answer general questions about research, provide specific information about this project, discuss any concerns you have about taking part, or discuss complaint procedures if you are unhappy with any aspect of the project.

Please contact me by email: X or by telephone: X. Please feel free to leave a voicemail and I will get back to you as soon as possible.

If you would like to discuss any queries or concerns about the project with another member of the research team, please contact Dr X by telephone on: X. Dr X supervises the project but is not directly involved in the recruitment or interview process.

What if there is a problem?

If you have any concerns about any aspect of the project, please contact myself and I will do my best to answer any concerns or queries. Please contact me by email: X or by telephone via: X. Please feel free to leave me a voicemail and I will get back to you as soon as possible.

If you remain unhappy and want to complain formally, then please contact X on: X who will be able to take your complaint forward through X complaints procedure.

Furthermore, you can also seek advice from the X. Please phone X email X

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against X/ X but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you

Appendix O

Consent Form for Lived Experience Group

Researcher: x (Trainee Clinical Psychologist)

'A Grounded Theory investigation of the experiences of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder (EUPD).'

Version: 1.2

Date: 10/03/2016

Please read the below statements and put your initials in the right hand box if you understand agree to each of the statements below		
1	I have read and understood the information sheet dated 10/03/2016, Version Number 1.2 for the following study: A Grounded Theory investigation of the experiences of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder (EUPD).	
2	I understand that I have the right to withdraw from the study at any time without giving reason without my medical care or legal rights being affected and subsequently, all my data will be destroyed.	
3	I am aware and agree to partaking in an interview which will be voice recorded as part of the subsequent data analysis.	
4	I understand that the voice recordings will be transcribed and that any personally identifiable information will be removed.	
5	I agree that anonymous quotes from my interview may be used in published reports of the study findings.	
6	I understand that the interview data will be kept confidential unless there are concerns about mine or someone else's safety.	
7	I understand that my interview recording will be stored on an encrypted USB which will only be listened to by the researcher and two supervisors. As soon as the project has been completed, this recording will be destroyed. I understand that anonymised data (i.e. the interview transcript) will be locked securely for 10 years at X	
8	I would like to receive a feedback summary after results of the study have been collated and analysed.	

9	I would be happy to be contacted after completion of the interview for a follow up interview which can be completed over the phone or via email. This will take a maximum of 30 minutes.	
10	I would be happy to be contacted after completion of the interview to give feedback on the findings of the study. This will enable me to say how accurately I feel that my views were captured by the researcher.	
11	I agree to take part in the above study.	

Name of Participant _____ Date _____ Signature _____

Name of Person taking consent _____ Date _____ Signature _____

Appendix P

Consent Form for Staff Group

Researcher: x (Trainee Clinical Psychologist)

‘A Grounded Theory investigation of the experiences of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder (EUPD).’

Version: 1.2

Date: 10/03/2016

Please read the below statements and put your initials in the right hand box if you understand agree to each of the statements below		
1	I have read and understood the information sheet dated 01/12/2015, Version Number 1.1 for the following study: A Grounded Theory investigation of the experiences of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder (EUPD).	
2	I am aware and agree to partaking in an interview which will be voice recorded as part of the subsequent data analysis.	
3	I understand that the voice recordings will be transcribed and that any personally identifiable information will be removed.	
4	I understand that my interview recording will be stored on an encrypted USB which will only be listened to by the researcher and two supervisors. As soon as the project has been completed, this recording will be destroyed. I understand that anonymised data (i.e. the interview transcript) will be locked securely for 10 years at X	
5	I agree that anonymous quotes from my interview may be used in published reports of the study findings.	
6	I understand that the interview data will be kept confidential unless there are concerns about mine or someone else's safety.	
7	I would like to receive a feedback summary after results of the study have been collated and analysed.	
8	I would be happy to be contacted after completion of the interview for a follow up interview which can be completed over the phone or via email. This will take a maximum of 30 minutes.	
9	I would be happy to be contacted after completion of the interview to give feedback on the findings of the study. This will enable me to say how accurately I feel that my views were captured by the researcher.	

10	I agree to take part in the above study.	
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Name of Participant _____ Date _____ Signature _____

Name of Person taking consent _____ Date _____ Signature _____

Appendix Q

Coded transcript

This has been removed from the electronic copy

Appendix R

Focused Codes

1. Struggling for a long time
2. Cycles of destructive coping
3. Fragmented self makes self direction difficult
4. Being bad
5. Struggling for a long time
6. Aligning with other diagnosis
7. Being inadequately diagnosed
8. Being kept in the dark
9. Diagnosis disables change
10. Feeling damaged by diagnostic label
11. Developing trusting relationship with professionals enables change
12. Developing an attachment
13. Identifying with the power of peer support
14. Being held by services
15. Being a stabilising force through chaos
16. Building and developing a support network
17. Building the foundations for change: ground work
18. Understanding the diagnosis enables change
19. Relationship to self
20. Developing new ways of coping with emotions
21. Being more able to cope through experience
22. Being more able to communicate internal world
23. Using rational brain over emotional one
24. Emotional intensity decreasing over time
25. Becoming less impulsive over time
26. Becoming more in control of emotions
27. Coping skills becoming ingrained
28. Managing emotions: a work in progress
29. Recurring suicidality
30. Being able to contextualise difficulties within the lifespan
31. Developing an understanding of developmental origins of difficulties
32. Gaining new understandings of old behaviours
33. Telling story
34. Being compassionate to self
35. Developing strength over time through adversity
36. Being able to draw on past experiences to enable current coping
37. Validating impact of past traumas on current self
38. Increasing theory of mind
39. De-centring
40. Being more able to mentalise
41. Developing healthier boundaries
42. Developing healthier relationships

43. Becoming more comfortable around others over time
44. Gaining confidence over time
45. Becoming more assertive over time
46. Developing interpersonal skills
47. Opening up to others
48. Relating to help
49. Being empowered by others
50. Finding therapy helpful
51. Challenging self beliefs
52. Using service to meet needs
53. Feeling less dependent on others e.g. therapist over time
54. Reduced need for crisis support over time
55. Improving relationships with professionals over time
56. Using staff to practice skills
57. Noticing the little things: a dual process
58. Having changes acknowledged by others
59. Noticing change within distress
60. Ongoing difficulties with relationships
61. Being valued through employment
62. Empowering others, empowers me
63. Shifting of identity
64. Seeing diagnosis as positive
65. Struggling to let go of past self and accept current self
66. Shifting identification with diagnosis
67. Becoming a stabilising force for others
68. Developing skills through vocation
69. Growing acceptance of self
70. Giving up the fight
71. Accepting new realities
72. Being limited by Mental Health
73. Taking personal responsibility for change
74. Changing is fearful and risky
75. Being resistant to change
76. Being more amenable to change when younger
77. Having hope that things can change
78. Needing to be ready to change
79. Being blind to change
80. Oscillating between closeness and distance to old self
81. Having limited external support
82. Feeling more, with limited tools to manage it
83. Feeling unworthy of change
84. Being pulled back by trauma
85. Low times aren't as low
86. Having blips
87. Increased time spent coping between blips
88. Changing suddenly: new insights

89. Identifying with turning points
90. Having needs met
91. Getting attunement right: staff, service
92. Changing is a dual process
93. Open ended availability of support is important
94. Needing a drip-drip approach
95. Looking at whole person
96. Being able to manage behaviours enables deeper work to begin
97. Rippling of change: internal and external
98. Applying skills: a dual process
99. Needing to manage personal expectations of change
100. Staff knowing their own boundaries
101. Knowing and responding to own needs: putting own needs first
102. Being more able to communicate needs
103. Being let down by services
104. Being pulled back
105. Mental health overriding physical health
106. Services making things worse
107. Changing through the passage of time
108. Timing needing to be right
109. Changing without realising
110. Changing is an individual experience
111. Changing is an ongoing process
112. Developing strength over time
113. Change is slow

Appendix S

Examples of Analytic Memos

The below memo's have been chosen because they hope to demonstrate the process of theory development, code refinement and relationships between processes and codes. Differing levels of categories and codes were described using the keys below.

Categories were bold.

Sub-categories were bold and italicised.

Focused codes were underlined.

Open codes were italicised.

Memo 1

This memo included initial thoughts about the role of an evolving identity and the processes which enhanced and hindered this experience.

Participants often discussed differing selves, '*the old self*' compared with their current self. It seemed that participants sense of self was an evolving process, influenced by internal processes and interactions with others.

Telling their story seemed to be an important part of the process, which enabled individuals to be more compassionate to themselves through gaining insight about their experiences and what had led them to struggle. It seemed that individuals were more able to narrate their internal world to others which helped develop a sense of a life story. This impacted on the individual's ability to manage their emotional intensity and individuals could develop new ways of coping with emotions over time. Alongside changes internally, came changes externally and individuals noted an increased ability to develop healthier boundaries and subsequently developing healthier relationships over time. It seemed that over time individuals moved away from their old self, and moved towards developing a new narrative.

These changes could be enhanced by staff, who enabled individuals to experience having their needs met by others and by the self. Individuals could be pulled back by professionals, services and others who were misattuned to the needs of the individual.

Memo 2

This second memo demonstrates the development of the above category, which further breaks down the intricacies and reciprocity within the change experience.

In the final model, the core change process identified was that of 'shifting positions'. This process was identified as being one which involved shifting relationship to the self, to others and to asking and receiving help. It was denoted from a participant quote but was felt to capture the active nature of change and the individuals key role within it. Furthermore, earlier memos noted differing relationships with the self, with others and with help and it appeared

that these interactions formed the foundations for change and of 'shifting positions'. All of these relationships impacted on each other, which will be explained below.

Self

The **development of insight** and understanding into one's own difficulties seem to be an evolving process and one that was key in enabling the challenging of negative beliefs about the self in order to relate to oneself in a more compassionate way. Being more able to contextualise difficulties within the lifespan and gaining an understanding of the developmental origins of difficulties. Through the acknowledgement of past difficulties on current behaviours, participants could often be more compassionate to themselves through validation of the impact of past trauma. This new insight also enabled new understanding of old behaviours which left individuals feeling freer to tell their story and explore different ways of understanding themselves.

This process was facilitated in some way by **developing reflective capacity** over time making it easier for participants to de-centre and stepping outside their own thoughts and feelings. This also coincided with the development of understanding others mental states, through mentalisation and increased theory of mind.

Participants often talked about a process of **learning emotional coping**. This often included developing emotional literacy and being able to communicate their internal world themselves and others. Developing new ways of coping with emotions often involved increasing tolerance of emotions was also noted for individuals as well to as increasing meta-awareness of emotions and riding the wave of emotional intensity, sometimes using mindfulness skills. Over time, participants were able to draw on past experiences to enable coping with their emotional states. There was a general trend for emotional intensity to decrease over time, for individuals to become less impulsive over time, to be more in control of emotions and for some individuals, for coping skills to become ingrained. It was noted that managing emotions was a work in progress for individuals with EUPD, as opposed to one with a finite end.

Others

The development of reflective capacity naturally impacted on patterns of relating to others. Some individuals described becoming more comfortable around others over time and often described opening up to others, partly through gaining confidence and becoming more assertive over time through trial and error and developing their interpersonal skills. It seemed that this increasing tolerance of being around others enabled the individual to gain confidence and to **not be afraid to talk**.

Through using their voice and experimenting with being around other people in new ways, participants often found themselves putting physical distance and emotional distance between themselves and other in their life, often people who were abusive in some way. When discussing this process, participants described, **learning to say no** as a key process, one that was not easy and did not come naturally, but that participants described as important. Participants and staff talked often about this process being one of developing healthier boundaries which sometimes had a ripple effect, enabling developing of healthier relationships to others. The process of learning to say no to others was not possible without the individual opening up to others. Over time, individuals described feeling less afraid to talk to others, whether this be family, friends, strangers or professionals.

Help

The relationship to help was a particularly important process within the current research, reflective of the joint recruitment of both individuals who had used services and those who worked within them.

Being more able to access help was a notable change for all research participants and subtleties involved accessing help in a healthier way, including using services to meet ones needs. For example, which accessing crisis support when needed. This process often involved a reduced dependency on professionals over time and often reduced their need for crisis support over time, enabling service users to develop improved relationships with professionals. Engaging with staff enabled challenging of beliefs, at times through actions and at other times through the subtlety of engagement. Participants reported finding therapy a helpful way to explore personal difficulties.

During the period of engagement with staff, this process often using staff to **practice skills**, such as emotional regulation strategies. The relationship was a joint enterprise and involved collaboration from both staff and service users to facilitate change. This skill practice involved beginning to notice difference, and all participants noted that noticing the little things was a dual process. Participants and staff talked about the power of having changes acknowledged by others, even within distress. It appeared that skills practice enabled an increase tolerance and acceptance of change.

Memo 3

This memo involved exploring the processes by which the above developments and shifting of identity could occur. The importance of attunement was noted in earlier memos but it was not known how it interplayed with other elements of the model until the development of the below memo.

The experience of **attunement** between services, others and to staff was incredibly powerful in maintaining a safe base for exploration of the shifting self and promoting change and hope.

This was identified as a joint process whereby service users were encouraged to open up to others whilst experiencing having their needs met by staff in a boundaried way. Individuals developed a sense of knowing and responding to their own needs, through an increased ability to communicate internal needs to others. This relates to relating to the self differently and the process of developing emotional coping, a process by which articulating one's feelings and thoughts was key.

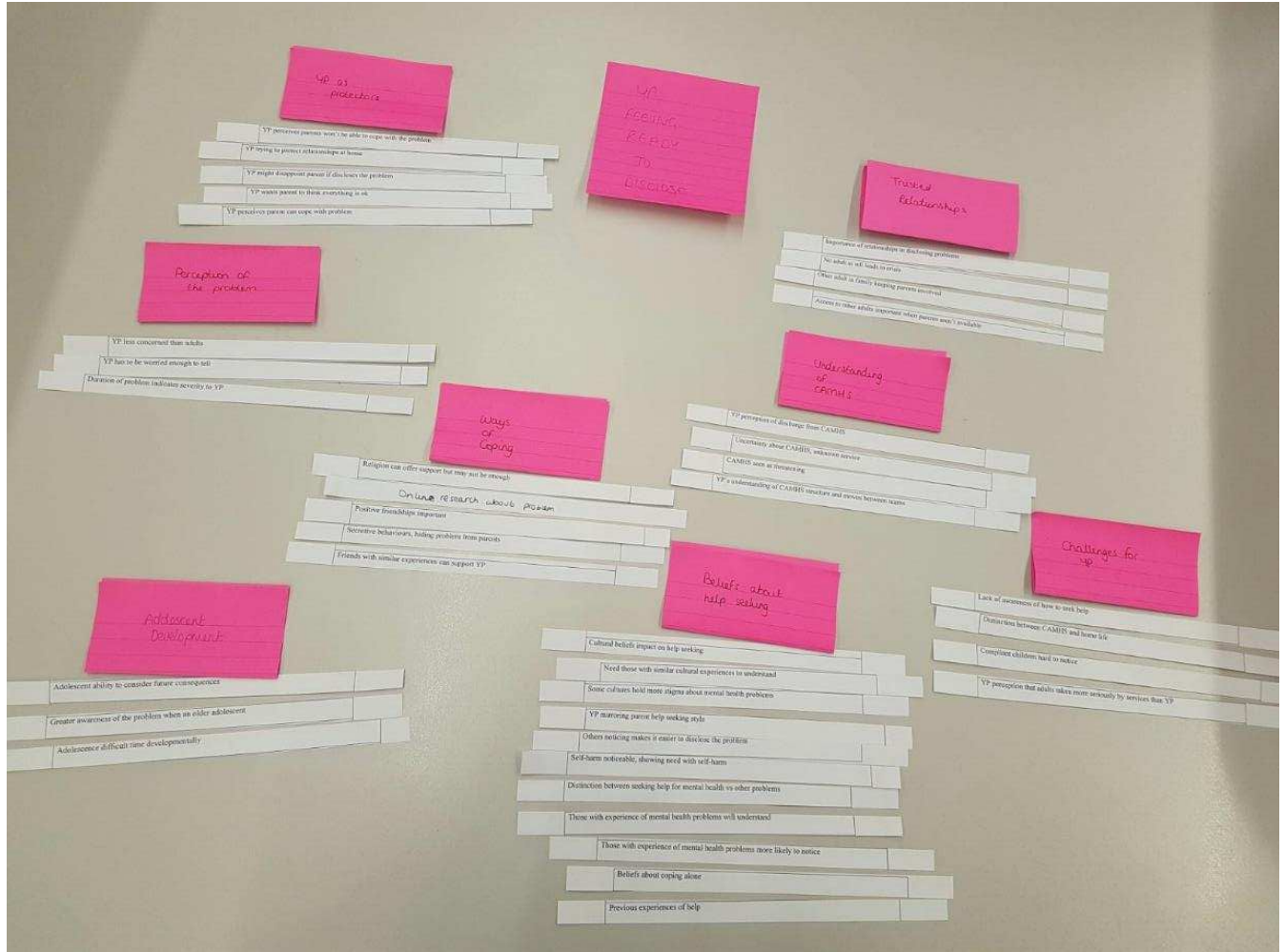
Participants also noted a need for staff to go at the service users pace. This pace of change was often described as slow, with staff needing a 'drip- drip' approach.

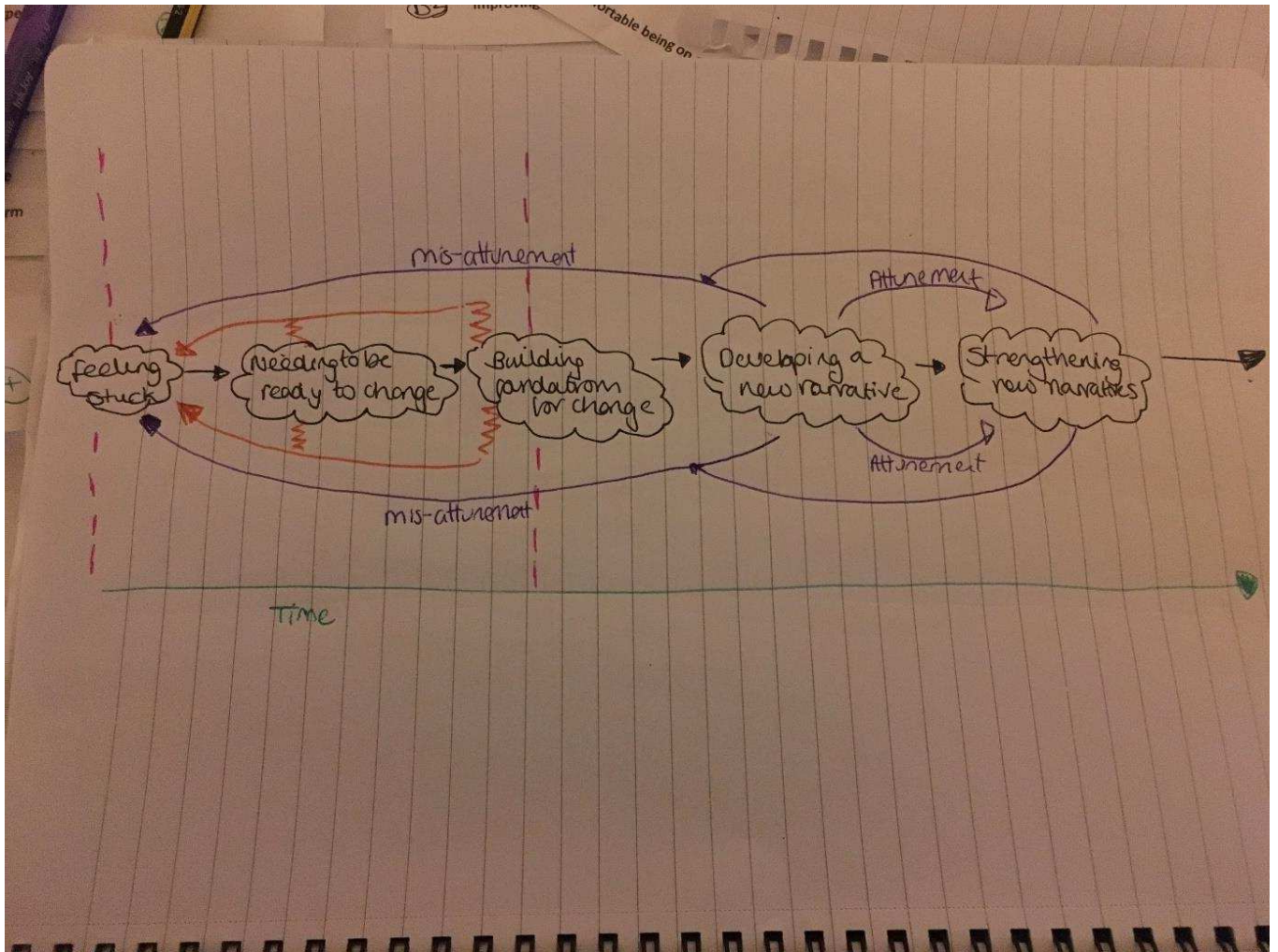
Within this process of attunement, staff noted the importance of reflecting on their expectations of change and subsequently needing to manage their personal expectations of

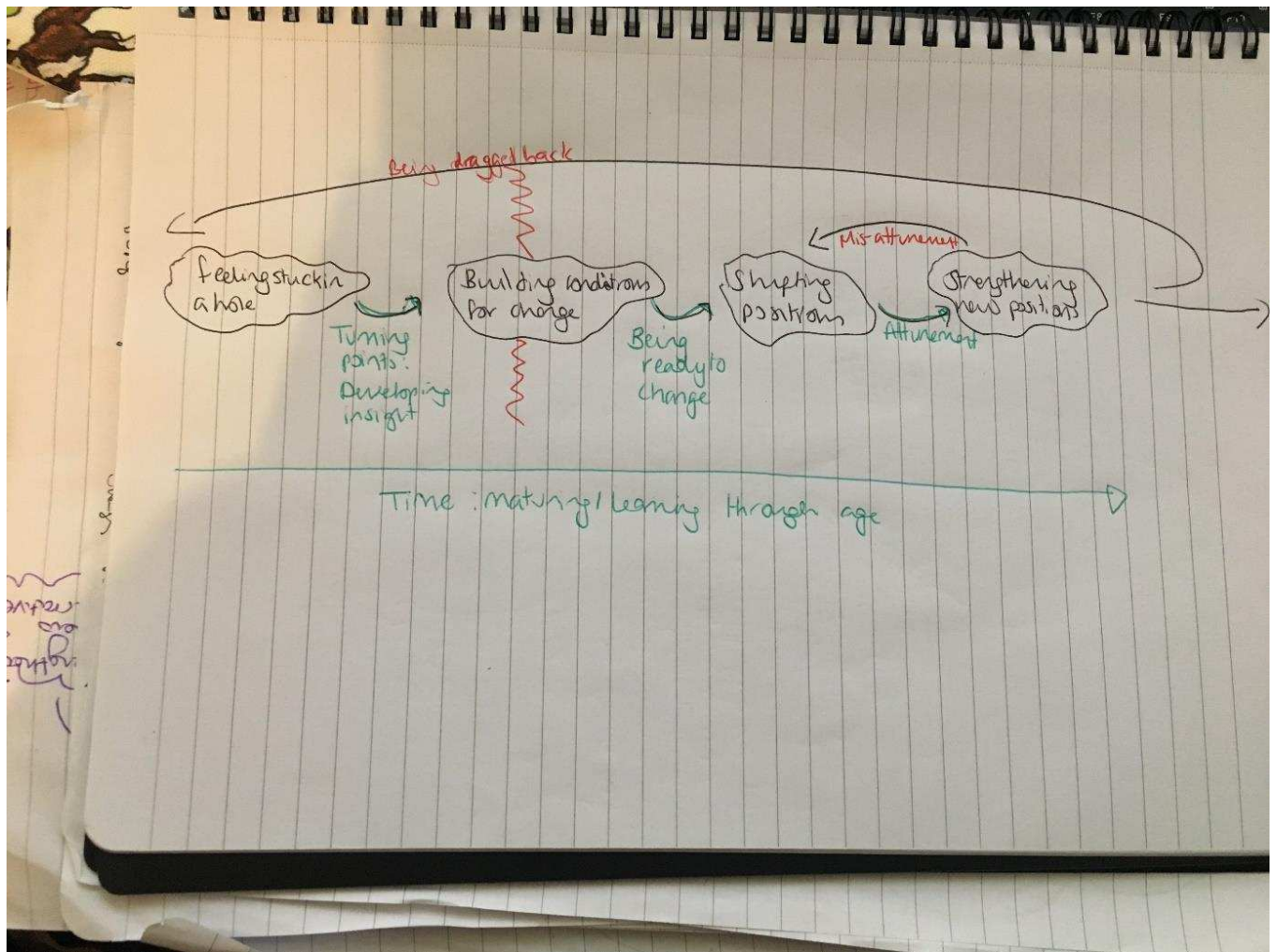
change and needing to and know their own boundaries in order to optimise attunement. The importance of the team was identified as helpful for enabling staff reflection.

Within the process of attunement, changing was identified as a dual process. It was felt that as the service user changed, the staff and services needed to change with them. It was reflected on that as service users began to change, it enabled refreshed optimism for the team around them, highlighting the rippling effect of change for both the service user and the help. Both staff and those with lived experience recalled the experience of being able to manage behaviours enabling deeper work to begin. It appeared that unease that self harming and other behaviour caused staff got in the way of working therapeutically at times, mirroring the chaos experienced by those with lived experience. The noticing of change and practicing of skills was reflected as a dual process for both staff and service users', being modelled and mirrored by staff whilst being practiced and honed by service users'.

Appendix T Pictures Documenting Theory Development Process







Appendix U

List of Codes and Example Quotations

Category	Subcategory	Focused codes	Example quotation (pseudonyms used)
Feeling stuck	Existing not living	Struggling for a long time	“So obviously fundamentally your mental health deteriorates and deteriorates and deteriorates and you know she has been seriously unwell erm you know and close to dying on a few occasions now because she fundamentally she overdoses you know until she's nearly dead.” (Sally)
		Cycles of destructive coping	"When I was doing that crazy lifestyle on the hamster wheel doing managerial hours...I was eating on the train, and then I started drinking, just to cope, just to survive, just to think." (Ariel)
		Fragmented self makes self direction difficult	“It must be for they ask people what they want when they're coming in and they have no idea cause erm I suppose again it ties into that sort of identify stuff that people might have an identity err that sort of tied up with their diagnosis and things like that so the idea of what what they might be aiming for is really really difficult.” (Matthew)
	Experiencing self as defective	Being bad	“I think the other problem with EUPD is the because there are really low levels of self-worth self you know self-esteem you know whatever you want to call it or the defectiveness stuff it's really hard for them to perceive themselves in any other way as failures.” (Martha)

		Struggling for a long time	“I think any bit is going to be slow you know there’s I always say to whoever I'm working with that you've had this and its years and years of layers on you so it could take a long time for those layers to come off.” (Margaret)
	Maintaining stuckness	Aligning with other diagnosis	“I almost dismissed the BPD to be honest and I just focused on the depression and anxiety because those were the things that meant something to me whereas BPD didn’t, it didn’t fit with what I felt was going on.” (Kelly)
		Being inadequately diagnosed	“I think there's a lot of lazy diagnosis and diagnosis by people that don't know enough.” (Martha)
		Being kept in the dark	“And it was um, I tell you how we found, well my student nurse told me by mistake cos it was in my notes... none of the nursing staff would talk to me about it. Nobody would talk to me about it.” (Sandra)
		Diagnosis disables change	“I do believe people can change but a you hear someone saying well you know that's just me I have personality disorder and I even possibly the words because of this people can’t expect me to change.” (Matthew)
		Feeling damaged by diagnostic label	“It gave me a hell of a lot more questions, and more reasons to hate myself and more reasons to continue doing the stuff because I started hating myself even more.” (Christie)
Building the foundations for change		Developing stability	Developing trusting relationship with professionals enables change

			<p>them how you would like to be treated.” (Margaret)</p> <p>“We would talk a lot about things um, this is what you’re experiencing and this fits with you know with BPD and as such it’s I can’t help, I can’t make those changes, I can’t tell you what to do, I can’t do this, you have to.” (Kelly)</p>
		Developing an attachment	<p>“I think for some people I mean I think that's [attachment] a major part of it yeah... I think that that's hugely important in order to for that other work [interpersonal work] to be done.” (Matthew)</p>
		Identifying with the power of peer support	<p>“Yeah, um also I think now it probably helps because I do have, because I’ve gone to groups and stuff so I have friends who have also have um borderline personality disorder so you know if it’s something that I think is directly linked to that I can talk to them about it, Which helps because they completely get where I’m coming from, I don’t need to like explain it, have it sound silly or anything because they know.” (Nicola)</p>
		Being held by services	<p>“They weren’t gonna let me go until they were absolutely sure that I was gonna be OK.” (Sandra)</p>
		Being a stabilising force through chaos	<p>“What helped with the sort of change ...we were just fortunate at that time that we were able to kind of establish three people three strong people working around her.” (Carol)</p>
		Building and developing a support network	<p>“I didn't want to be alive, and I would have done if my, I um my parents have always been really supportive and if it hadn't of been for them, I would have definitely, I'd not be here now, but they were just sort of keeping me, how do I normally describe it? They were like keeping me, they had a net for me, they kept me from falling through.” (Nicola, line)</p>

	Understanding the diagnosis	Building the foundations for change: ground work	“I started to look at the diagnosis on the DSM criteria and um different peer led organizations and I thought ‘bloody hell’, I do actually meet a lot of the criteria.” (Ariel)
		Understanding the diagnosis enables change	“Erm I think some of what’s I’ve seen some where it’s even erm the changes between accepting the diagnosis and not accepting the diagnosis So that seems to be a sticking point really early on with engagement here I suppose cause I’m doing a group that’s kind of our newest members erm it seems like that’s the the like yeah pivot of change kind of thing at the moment.” (Chloe)
Shifting positions	Relationship to self		
	Learning emotional coping	Developing new ways of coping with emotions	“Feelings don’t sort of go away, they’re still here it’s just that you can sort of talk to your emotions a bit.” (Nicola)
		Being more able to cope through experience	“ I just try and just observe it in a detached way, and know that it will pass, even though there’s a massive part of me that really doesn’t want to believe that at the time because it’s so painful and all pervasive, but I know from experience, I might have been like it a fortnight ago or a month ago or 6 months ago.” (Ariel)
		Being more able to communicate internal world	“It felt like a big significant shift when they were able to actually talk about their distress and their sort of tentative thoughts about what their distress was coming from.” (Matthew)
		Using rational brain over emotional one	“I know logically that’s silly because you know, it just is, but emotionally, the feelings don’t sort of go away, they’re still here it’s just that you can sort of talk to your emotions a bit.” (Nicola)
		Emotional intensity	“So I notice the intensity changing and sort of shifting to pregnancy and stuff” (Nicola)

		decreasing over time	
		Becoming less impulsive over time	<p>“Interviewer: What areas of a service users’ life have you noticed changed over the years would you say? Martha: Hmm. I think erm reduction in self-harming behaviours it's sort of obviously it's kind of a classic on really isn't it.” (Martha)</p>
		Becoming more in control of emotions	<p>“She still gets really tearful but she's managing her emotions a lot better and that's because I think the practice that she puts in for herself like with the yoga and the meditation and things.” (Martha)</p>
		Coping skills becoming ingrained	<p>“I think I’m using my skills now like I use my left and right hand and I wouldn’t know that I’m doing it.” (Sandra)</p>
		Managing emotions: a work in progress	<p>“Yeah, I really feel that if I could get some EMDR therapy and some specialist help to help me manage the emotional intensity that I struggle with, so that I could be well more of the time and on more of an even keel then I would absolutely come back with some umph and make a difference in the world again, you know yeah.” (Ariel)</p>
		Recurring suicidality	<p>“I attempted suicide earlier this year and, and that was just a click, just a flash moment.” (Kelly)</p>
	Developing insight	Being able to contextualise difficulties within the lifespan	<p>“Yeah you know, transposing what I knew now or then and transposing it into my own real life, my childhood, my teenage years, you know me as a person and the way I thought, the things I did, um and it all started to make sense, and, and I think, it’s the perfect description of me.” (Kelly)</p>
		Developing an understanding of developmental origins of difficulties	<p>“The fact that I have this diagnosis is [laughter] when I, now that I know about things and I look at them and I sit there and I think ‘well, there are 4 of us, one of us was bound to [laughter] have that.’ (Sandra)</p>

		Gaining new understandings of old behaviours	“One of the biggest things as well was realizing that when I, when you know, when I kept saying ‘I want to be dead, I want to be dead’ I realized I didn’t want to be dead, I just wanted my head to shut down, I just wanted to be asleep for like a week.” (Christie)
		Telling story	“The change within that but I know with this person I’m talking to you know you first of all when I step back and saw it that is amazing how she’s managed to form some relationships yeah you know create a support network so yeah I I think you know other elements would be you know being heard being understood being able to tell her a story.” (Carol)
		Being compassionate to self	“It’s a bit like reparenting in a way, you know and If I can, cos a lot of people say ‘oh I don’t bother if it’s just for me’, I do, I buy fresh herbs, I always have them on the top, not always but they’re always on the top of my food, toast seeds in coconut you know, I make my food delicious and gorgeous because I deserve it and I’m a really foodie.” (Ariel)
		Developing strength over time through adversity	“My mum who was very abusive and I can tell you the point at which I developed my will and determination.” (Ariel)
		Being able to draw on past experiences to enable current coping	“I know now I need to realise when those people do say it, that I need to take that on board that I guess I sort of have felt this bad before, which means I will get through it.” (Christie)
		Validating impact of past traumas on current self	“Sometimes a little skill that like that will come in and then and then it and linking sometimes linking their I think what is astonishing to use is that they don’t often understand that their the fact that they were sexually abused as a child causes them difficulties today you know.” (Martha)
	Becoming more reflective	Increasing theory of mind	“They’re actually taking into account how his is going to impact on the

			other person rather than I don't know punching the wall whatever might have happened." (Matthew)
		De-centring	"I suppose there's always well a I think there's got to be some process of stepping back and thinking you know what actually what's going on here and can we all of us including us and including other teams think about what's going on here." (Matthew)
		Being more able to mentalise	"And he understood the impact that it had, his behaviour, um, and he was actually the first person who wanted to be in a community meeting that was about him, about his breach, and he wanted to apologise to the community because he, he, he knew he caused hurt and so there's something about him getting to the point." (Sasquia)
	Relating to others		
	Learning to say no	Developing healthier boundaries	"You know so he's done that and there's people now that keeps at arm's length because they don't make him feel any good you know or they just abuse him and that so he has learnt how to do that and he feels a lot, he says he can breathe now." (Margaret)
		Developing healthier relationships	"I know with this person I'm talking to you know you first of all when I step back and saw it that is amazing how she's managed to form some relationships yeah you know create a support network." (Carol)
	Not being afraid to talk	Becoming more comfortable around others over time	"I can see small changes with her is that she's coming unless she's really low and then you don't see her for a little bit but she's coming to the x maybe three times four times a week so for her she's been working on not feeling so isolated and that's very small steps and you know she could be good and she's engaging and then she could you couldn't see her for a couple of weeks it's really up and down." (Margaret)

		Gaining confidence over time	“She might not be doing as well as next door or whatever but she's doing well compared to how she was when when she walked in here when I first started key working her she couldn't even hold her head up you know she was so anxious and now she can walk in and say hello and go in the kitchen and start cooking with people but she can't she can't see it because she's a real negative person.” (Margaret)
		Becoming more assertive over time	“I'm thinking about X who went to the, to the conference after not going out at all without the help of her husband, then divorcing her husband, so there's so, there's a lot about her assertiveness that's changed.” (Sasquia)
		Developing interpersonal skills	“Assertiveness people being able to be more assertive towards other people and tell them when they're doing something that annoys them or they would like them to do something differently that sort of change I think is good I suppose that can erm that can be assertiveness as it's also sort of things about confidence and people feeling able to speak out in a group.” (Matthew)
		Opening up to others	“I'll talk about it a lot more than I used to as well, I didn't used to, I used to hold a lot of I in because I didn't want to upset mainly my parents, but I talk about it a lot more now, which I think helps, cos if you keep it inside your head, then you can build it up a lot more than what it actually is.” (Nicola)
	Relating to help		
	Being more able to access help	Being empowered by others	“I'd never shared them [poetry] with anybody and the expression on his [therapist] face and the way he looked was like 'he thinks these are really good', and he encouraged me to join the creative writing group I joined.” (Christie)

		Finding therapy helpful	“She understood through that process of therapy you know that that you know she could be held it could be contained she could she could be heard she could tell the story but there could also be a difference in her life.” (Carol)
		Challenging self beliefs	“What we did, is we, we signaled to her in most credible way so far that we all thought that she deserved a better life and that challenged her belief that she didn’t, that she was not deserving.” (Sasquia)
		Using services to meet needs	“And you know, my CPN, after I got pregnant, because my ex was threatening me with social services and stuff, I went back and saw him and I actually asked, I said, cos he said it’s the biggest change that he ever saw in anyone, from when I was not pregnant to when I was pregnant he said It was just, amazing, and my doctor said that as well, the one that had been seeing me regularly, he said it’s just amazing the way that you’ve changed and your focus has shifted, and everything is like, like a different person, so I asked him to um, have a couple of sessions with me so that if my ex did try anything, that he could say that I was of sound mind.” (Nicola)
		Feeling less dependent on others e.g. therapist over time	“And there's a lady that has just come in this morning I don't err X I have to say this but she just got a taxi for the first time ever in her life she's nearly fifty ever got a taxi she can't travel independently where I think the kind of factors again are that she's engaged here.” (Carol)
		Reduced need for crisis support over time	“The amount of time spent in crisis reduces.” (Matthew) “And then there were longer periods between admissions.” (Kelly)
		Improving relationships with professionals over time	“Oh that’s a huge change and when we met x at first, she wouldn’t engage with care-coordinators at all, she wouldn’t engage with us... but

			she's ready and she's doing the work and she's doing it with us.” (Sasquia)
	Practicing skills	Using staff to practice skills	“He [psychiatrist] allowed me to find anger within myself that I had never found, I mean I used to throw things, I was really good at smashing things, but I never would express why he would always, if I threw things, he wanted me to tell him why I was angry.” (Sandra)
		Noticing the little things: a dual process	“How I try to sort of reason with the guys to say you can either keep beating yourself up and its gunna make you slower and slower and slower and you're not gunna get there, or you can say, fair enough, I'm not where I want to be, it's really, really very painful and I, I might be pissed off because I'm not running as fast as I could but this is how it is so lets, lets start noticing the little things.” (Sasquia)
		Having changes acknowledged by others	“And you know, my CPN, after I got pregnant, because my ex was threatening me with social services and stuff, I went back and saw him and I actually asked, I said, cos he said it's the biggest change that he ever saw in anyone.” (Nicola)
		Noticing change within distress	“I think we've been the first people to say, ok, I see its really difficult for you but this, it still has to stay on the agenda, I wouldn't be a good worker for you if I would just leave you where you are because feel comfortable there so it's, there's something about keeping the agenda going” (Sasquia)
Embracing the changing self	Exploring new ways of being	Ongoing difficulties with relationships	I think I have to admit that I find it difficult to maintain intimate relationships, and if I'm honest, I don't know if it's so much of a change, I think I can see now with 50 years of life under my belt that I've always struggled with that.”(Ariel)
		Being valued through employment	“I go through mega anxiety and wanting to resign and thinking, ‘ I can't handle it' and then I get there

			and I love it and apparently I'm quite good according to the feedback and then I come out and I'm on a high and I love it, it's just like, it makes me feel so good, you know so it's a massive impact for a small amount of work." (Ariel)
		Empowering others, empowers me	"My students are lovely and um they were, a lot of them were very receptive to that and were encouraged by that, and that really made me feel great, so I just know, I don't want other people to suffer as much as I have through the services." (Ariel)
		Shifting of identity	"I have to say I have trained my GP now, she understands that I know more about it, about personality disorders than she does, and she bows down to my superior knowledge [laughter]." (Sandra) "I am trainer, I'm a peer trainer, I am an educator, I'm not a service user." (Christie)
		Seeing diagnosis as positive	"I certainly can see the benefits of my diagnosis, I see my diagnosis actually as a ticket to change." (Sandra)
		Struggling to let go of past self and accept current self	"I'm used to a lot of responsibility, and yet I struggle to work half a day in [charity shop] now, that's crazy, that's really hard to accept that change." (Ariel)
		Shifting identification with diagnosis	"so no I don't see my diagnosis as, the way that I did, and certainly now, some of those things I see – certainly the way that I am – I can see the benefits of it." (Sandra)
		Becoming a stabilising force for others	"I support, yeah, yeah definitely, and also my friends with these problems, I also help them, because I'm in a lot more stable place than they are, most of the time." (Nicola)
		Developing skills through vocation	"Because I think, you know I can come complacent on the courses I do so I make sure every term I change, I've been doing the same course, But I change it up, because I don't want to be sitting there thinking, I could

			do this in my sleep, I don't want it you know so its important." (Christie)
	Letting go	Growing acceptance of self	"So it's starting to accept that I am good at some things." (Christie)
		Giving up the fight	"But I change it up, because I don't want to be sitting there thinking, I could do this in my sleep, I don't want it you know so its important." (Sandra)
		Accepting new realities	" I think that um it feels like it's been a long term tsunami that's just come and knocked me back, but with that constant washing of waves like the sea, gently eroding the cliffs, it, it, it, has an effect, and I've had to surrender to that and view it through my spiritual values and just surrender and trust there's a higher meaning to it, trust it's part of my life purpose, and find the humility in that and know that it's given me deeper compassion and empathy to help others and it's just what is and we can't change everything in life." (Ariel)
		Being limited by Mental Health	"I do feel that chronic mental health issues and additionally physical health issues that have come about it the last couple of years as well have really left me feeling quite disabled and that's a change I'm struggling to adapt to." (Ariel)
	Living not existing	Feeling able to start living again	"I sometimes almost feel like I'm a kid again, like you know, the wonderful things around you, I get really excited about stuff, um but like most people, most adults wouldn't really get excited about." (Nicola)
		Greater appreciation of life	"I can love more, I can experience things about, everything, more. I feel happy more, I feel I can appreciate artwork more. I can be more creative, I can...all of those things." (Sandra)

Taking responsibility for change	Taking personal responsibility for change	“I’m celebrating 10 years of deciding to be alive.” (Sandra)
	Changing is fearful and risky	“Erm we did have one client here erm she's no longer with us now, her she didn't like the word recovery or talk about you're getting better or you're doing really well because for her it was abandonment.” (Margaret)
	Being resistant to change	“A whole a lot of effort goes into resisting any sort of movement.” (Matthew)
	Being more amenable to change when younger	“I’ve seen things like that I’ve seen loads of really positive things like erm one of our our younger members erm has been you know I think less fearful of change than perhaps some of our older erm members.” (Chloe)
	Having hope that things can change	“We have to find a way to have hope for our members and actually it can be hard it can be hard for us.” (Martha)
	Needing to be ready to change	“It’s about the cycle of change, you have to be in the right bit of the cycle to change, you have to be and I really do believe that there is no point in putting someone in there, into, for someone to get, asking someone to do STEPPS if their brain and their openness to new ideas and new ways of thinking isn’t there.” (Sandra)
	Being blind to change	“I think it's really hard for our members to see change.” (Martha)
Pull backs	Oscillating between closeness and distance to old self	“Everyone stopping to help others you know, I was taking photos for other people, it was fantastic, I loved it, and it made me feel, people are nice, you know humanity is great, and yet, since then I’ve come back and my life is the same as it was before I went, it was a glimmer of

			what I used to be, of what I would like to be, but it isn't the reality of what my life is so it and it's been, its gone, and I'm back to square one." (Kelly)
		Having limited external support	"She you know, she describes her life now as nothing she has nothing it's just nothingness you know so she lost everything and now she is in a place where she would she would describe as having no one." (Sally)
		Feeling more, with limited tools to manage it	"Also I think the other think that starts to happen is that people do start to get in touch with their actual emotions the actual emotional content of what they are struggling with which of course is seen as positive but also is quite a dangerous things as well but again I think people are sometimes left a little bit OK I'm suddenly feeling all this pain and all this distress and not quite sure what to do with it and I think that is quite erm quite a vulnerable time." (Martha)
		Feeling unworthy of change	"It's really hard for them to perceive themselves in any other way as failures." (Martha)
		Being pulled back by trauma	"Erm trauma, you know trauma is going to hinder change people are consistently you know if people aren't able to move on from the traumatic events that they've kind of been through or if that suddenly get stirred up you know." (Sally)
		Low times aren't as low	"And I wouldn't do that now, not that I've ever felt, since I've had her as bad as I used to, but I have had times where I've felt quite down." (Nicola)
		Having blips	"Erm I'm just trying to think of here there there've been a couple of bits that they seem quite they can seem quite dramatic and then they can sort of slip back, but I think that I don't think that they sort of slip back completely." (Matthew)
		Increased time spent coping between blips	"I think it probably is as low but it's not as long and I think when it's, when I'm in, because I could go

			depressed, like last week I was feeling suicidal, don't worry I'm not a suicide risk today because I'm not feeling suicidal today but last week I was. And I saw it and I observed it mindfully and I thought 'here we go again.'" (Ariel)
Turning points		Changing suddenly: new insights	"I was starting to understand what they'd been telling me for years, because I was starting to stand outside myself, look at myself and look at me, and what I was feeling or thinking and doing during the course of a period of time and it started to, I think it just clicked, and there was an acceptance of actually that makes sense, and it, what was quite a sort of um a moment a eureka moment." (Kelly)
		Identifying with turning points	"Um, I didn't ever think it would get better, because it was just sort of set staying the same, where I'd go up and down and have really bad, bad times um and then like, I got pregnant, and that changed everything." (Nicola)
Attunement		Having needs met	"He was offered trauma therapy and this is, these things just don't happen in x world because, the you know the conditions are horrible and the money is never there and nobody gives a shit about people like him, and, and we sort of introduced a practical, very, very strong challenge to this." (Sasquia)
		Getting attunement right: staff, service	"But not pushing them to not you know it's just that sort of you know just trying a get a measure of it each time they come in you know striking when the little spark's there holding back when it isn't I think it's just about being flexible adaptable erm creative." (Carol)
		Changing is a dual process	"Absolutely. And it's you know there contrast between this and my last role now that the disadvantages of it I think in terms of change I think we can sometimes overly not get people to utilise their their sort of self-advocacy and their skills you

			know there's there's there's a line there's a dangerous line between us over over caring and over caring and under caring [laughter].” (Martha)
		Open ended availability of support is important	“I didn’t get any treatment, I’m still trying to get help. [crying].” (Ariel)
		Needing a drip-drip approach	“I don't think it happens very often in a kind of in a kind of err ooooh mostly it's it's much more of a drip drip.” (Martha)
		Looking at whole person	“I will say that because my, because my mental health was bad, my physical health was ignored, and that one of the reasons why my, certainly my arthroscopic conditions were totally disregarded, I was told I was wasting time, money etc and my joints have deteriorated to a point where I now have to use a wheelchair much more than I ever would have done, if it had been picked up, if I had been a normal person.” (Sandra)
		Being able to manage behaviours enables deeper work to begin	“I think because once you get rid of the thing that most people find difficult with PD is their behaviour they you know they're difficult and they're obstructive and they're self-harming all over the place and they you know they cause lots of problems and they they're manipulative and you know in quotes and you know so that as you start to get that behaviour under control you then can establish you know more err helpful relationships with services with their relationships with each other you know with family members.” (Martha)
		Rippling of change: internal and external	“I think because I really got into the programme I felt that I was taken seriously by the mental health team and psychiatrists and people.” (Christie)
		Applying skills: a dual process	“They’re looking back towards what is going on and think and being able to at least name it and say what is happening, but I think as a as teams

			and clinicians we have to be able to do that as well.” (Matthew) “We expect them to have a tool box to help we need to think what's in our tool box to help them.” (Martha)
		Needing to manage personal expectations of change	“You know I think you learn all the time erm with one of the ladies I key work I was a little bit too fast trying to change cause I could fix it erm and I'm not here to fix but that's been a learning curve for me.” (Margaret) “Yeah I don't think we should expect that you know we can't expect that someone delivers a someone somebody described it as a nuclear powered intervention and that person will forever be changed.” (Matthew)
		Staff knowing their own boundaries	“I've developed a real awareness within myself of when I've reached capacity.” (Carol)
		Knowing and responding to own needs: putting own needs first	“I just kind of have to hang on lightly, rather than trying to resist it, and now that it will pass and do enough things to distract myself, clear my diary down a bit, manage myself and minimise the triggers.” (Ariel)
		Being more able to communicate needs to others	“So she's very articulate now, very able to say what she is struggling with erm you know perhaps able to name some emotions.” (Sally)
Misattunement		Being let down by services	“I think that's devastating, and the services are failing me and um that's not good enough, but they're quite archaic in general.” (Ariel)
		Being pulled back	“I think the danger is you can work with somebody to get things to change for them but if the family if they're still within a family that doesn't want that.” (Martha) “my sister every now and then she will, she'll go, 'you're not falling apart on me are you?' and that'll just be because I'm, I'm upset about something.” (Sandra)

		Mental health overriding physical health	“Being sectioned many a times, put on secure wards, and collapsing in front of nurses and things, being told my sister was diagnosed 3 years before me with MS, being told I was making it up, that I wanted to be like my sister, so instead of being taken for medicals or appointments, they just sectioned me, and shoot me in the arse with something to calm me down, until I collapsed outside of the borough, got taken to a hospital and they said ‘sorry you’ve got MS’ and I said no shit Sherlock.” (Christie)
		Services making things worse	“There are so many people with personality disorder who've been you know made worse by the system.” (Matthew)
Time		Changing through the passage of time	“Yeah and knowing yourself a bit more, I think that helps. I think that helps with, I’m not sure it helps everyone actually but with the borderline personality disorder it’s definitely helped me, as I’ve gotten older and got to know myself more, I’ve got to know how I’ll react to certain things, so it gives me a bit of an opportunity to handle myself better, I think.”(Nicola)
		Timing needing to be right	<p>“I don’t know I suppose yeah you need to be ready to work on these things and whatever I don’t know attachment and safety you know suddenly she must have just somehow perhaps reached the crucial level.” (Chloe)</p> <p>“I just think it caught her at the right time and I remember sitting in a group with her and we were talking about err filters and it was like a little lightbulb went on and she suddenly went oh she literally did go understand what some on her deep rooted feelings about herself and where they emanated from.” (Martha)</p>

	Changing without realising	<p>“And they gradually start embracing some of that stuff whether its subconsciously or consciously they’re starting to kind of you know.” (Sally)</p>
	Changing is an individual experience	<p>“[change] it's not one glove for everybody every single person that comes they maybe have the same diagnosis but they're all different” (Sandra)</p> <p>“theres an anarchy, a happy anarchy about that, that people reach the stages they reach to, in their own time, in, when, when, when things are ready to go that next step I think” (Sasquia)</p>
	Changing is an ongoing process	<p>“Yeah [laughter], yeah, this little woodpecker inside a metal bucket in my head, that’s going, ‘nah, nah, nah, nah, nah. nah, nah’ at me and that is absolutely true, Just every now and then it’ll just bang on the ceiling so it’s really loud. Yep, he’s got quieter. He’s got quieter, we’ve definitely put padding in certain areas of the bucket.” (Sandra)</p> <p>“My feminist values are still very strong but I can feel all kinds of deep changes going on and I think it’s to do with the menopause, and about how I present myself to the world and how I need to be and yeah.” (Ariel)</p>
	Developing strength over time	<p>“I think going through all that adversity makes you stronger, it’s like a process of alchemy.” (Ariel)</p>
	Change is slow	<p>“Slow change and lower lower it's sort of it again it's the whole thing is balance isn't it.” (Martha)</p>

Appendix V

Respondent Validation Email and Responses (pseudonyms used)

Email:

Dear X,

Thank-you for participating in my research, exploring the experience of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder.

I have attached the preliminary themes from analysis (called categories and sub-themes). I would be grateful if you could take a look at these themes and let me know how well these themes capture your experiences.

I wanted to highlight that all of the interviews noted that the change process is not straight-forward but is much more complex than that. Hopefully the later categories go some way to explain some of ups and downs of the process.

Major Categories	Sub-categories	Additional Information
Feeling stuck in a hole	Existing not living Beliefs about being 'faulty' Stuckness reinforced by others	This phase described a point where individuals may have felt stuck and unable to change. These feelings were sometimes reinforced by receiving the diagnosis and unhelpful contact with mental health services.

Influenced by	Turning-points: developing insights	For some people, feeling able to engage in the next process, ‘developing the foundations of change’ was often related to experiencing a turning-point, which enabled a shift in perspective about the individual’s role within their life. This change of roles often correlated to feeling more able to take an ‘active’ role in one’s own life.
Developing the foundations for change	Understanding the diagnosis Developing a stable base	This category highlighted the importance of developing a stable base for change. This included gaining information about the diagnosis, as often this process was missed or

		<p>poorly executed by mental health services.</p> <p>Secondly, developing trusting, consistent relationships (with staff, family members, peer support groups or friends) was found to be helpful in enabling change.</p>
<p>Influenced by</p>	<p>Readiness to change</p>	<p>Participants and staff often noted the importance of needing to be ready to change before moving onto the next stage of ‘shifting positions’.</p>
<p>Shifting positions</p>	<p>Relationship to self:</p> <p>Learning emotional coping</p> <p>Developing insight</p> <p>Becoming more reflective</p> <p>Relationship to others:</p>	<p>This was identified as the core change experience. This often involved developing new ways of being in relation to the self, in</p>

	<p>Learning to say no</p> <p>Talking to others</p> <p>Relationship to help:</p> <p>Accessing help</p> <p>Connecting to progress</p>	<p>relation to others (family, friends) and to help (Mental Health Services).</p>
Embracing new positions	<p>Growing sense of self</p> <p>Accepting the now</p> <p>Living, not existing</p> <p>Varying distance to past self</p>	<p>This category discussed ways in which individuals could continue developing new positions. For some people, this included growing acceptance of the self and of the diagnosis as well as developing new roles and identities. This included becoming an employee or a supportive friend for example.</p>
Other processes	How these processes relate to change	Additional information
Being dragged back	Being dragged back to feeling stuck through internal drivers	This category explained the varying power of

	(trauma and negative beliefs) and by ongoing stressors in one's life	the stuck self and its ability to pull individuals back to a place of feeling stuck. This could be because of trauma or external stressors for example.
Attunement: The experience of someone being reactive and responsive to another person's needs.	Attunement to someone's needs enables growth and change	Change was found to be fostered and enriched through the process of attunement. This was where services, friends, family and peer support were found to be in line with the individual's needs, enabling personal growth.
Misattunement: The experience of being unable to meet another person's needs.	Misattunement to needs disables growth and change (from services and from others in life)	Change was often stunted through mis- attunement, whereby individuals experienced a mis-match between their needs and others responses. This was often reflected in

		contact with Mental Health Services who weren't attuning to the individual's growth and differing needs.
Time	People change naturally through age and experience	Most participants discussed the importance of time, in enabling maturity and learning through experience, both of which naturally facilitated change.

I would be grateful if you could send any feedback by Friday the 14th of April at 12.00pm.

Thank-you again for your participation,

Kind Regards,

Responses:

Hi x

Im sorry I haven't had loads of times but I have read the themes you have identified today. I think it's a fairly accurate reflection of the process and nothing stood out dramatically to me that I wanted to add or change. Hope its all going well. (Carol)

Hi x

This looks really interesting. I would love to receive the final copies of your work if possible, it looks very informative. Feels a long time ago since doing the interview though – not sure I can remember it well!

Thank you.

And best of luck with it all (Chloe)

Hello x

I think you have captured the themes extremely well and identified all of the key elements to enable change to occurred and be maintained

Well done

Take care (Sandra)

Appendix W

Audit Trail

The following research processes (listed in earlier in Appendix) were reviewed by the external project supervisor. At various points of the research process an independent professional also reviewed aspects of theory development, to ensure quality and reflexivity.

1. All open coding of interview transcripts was reviewed by project supervisor.
2. Two transcripts were co-coded (one by project supervisor and one by external professional).
3. List of focused codes (Appendix S) was reviewed by project supervisor.
4. Research memos (Appendix T) were reviewed with project supervisor.
5. Initial theory development structures (Appendix U) was reviewed at three points by project supervisor and twice by an independent professional.
6. Final categories and subcategories (Appendix V) was reviewed by project supervisor.

Appendix X
REC Approval

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Appendix Y

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Appendix Z

Author Guidelines for the Journal of Personality Disorders

Journal of Personality Disorders

Instructions to Authors

Types of Articles

Regular Articles: Reports of original work should not normally exceed 30 pages (typed, double-lined spaces, and with standard margins, including tables, figures, and references). Occasionally, an author may feel that he or she needs to exceed this length (e.g., a report of a series of studies, or a report that would benefit from more extensive technical detail). In these circumstances, an author may submit a lengthier manuscript, but the author should describe the rationale for a submission exceeding 30 pages in the cover letter accompanying the submission. This rationale will be taken into account by the Editors, as part of the review process, in determining if the increased length is justified.

Invited Essays and Special Articles: These articles provide an overview of broad-ranging areas of research and conceptual formulations dealing with substantive theoretical issues. Reports of large-scale definitive empirical studies may also be submitted. Articles should not exceed 40 pages including tables, figures, and references. Authors contemplating such an article are advised to contact the editor in advance to see whether the topic is appropriate and whether other articles in this topic are planned.

Brief Reports: Short descriptions of empirical studies not exceeding 20 pages in length including tables, figures, and references.

Web-Based Submissions: Manuscripts must be produced electronically using word processing software, double spaced, and submitted along with a cover letter to <http://jpd.msubmit.net>. Authors may choose blind or non-blind review. Please specify which option you are choosing in your cover letter. If you choose blind review, please prepare the manuscript accordingly (e.g., remove identifying information from the first page of the manuscript, etc.). All articles should be prepared in accordance with the Publication Manual of the American Psychological Association. They must be preceded by a brief abstract and adhere to APA referencing format.

Tables should be submitted in Excel. Tables formatted in Microsoft Word's Table function are also acceptable. (Tables should not be submitted using tabs, returns, or spaces as formatting tools.)

Figures must be submitted separately as graphic files (in order of preference: tif, eps, jpg, bmp, gif; note that PowerPoint is not acceptable) in the highest possible resolution. Figure caption text should be included in the article's Microsoft Word file. All figures must be readable in black and white.

Permissions: Contributors are responsible for obtaining permission from copyright owners if they use an illustration, table, or lengthy quote (100+ words) that has been published elsewhere. Contributors should write both the publisher and author of such material, requesting nonexclusive world rights in all languages for use in the article and in all future editions of it.

References: Authors should consult the publication manual of the American Psychological Association for rules on format and style. All research papers submitted to the *Journal of Personality Disorders* must conform to the ethical standards of the American Psychological Association. Articles should be written in nonsexist language. Any manuscripts with references that are incorrectly formatted will be returned by the publisher for revision.

Sample References:

Davis, C. G., & McKearney, J. M. (2003). How do people grow from their experience with trauma or loss? *Journal of Social & Clinical Psychology*, 22(5), 477-492.

Dweck, C., & Wortman, C. (1982). Learned helplessness, anxiety and achievement. In H. Kron & L. Laux (Eds.), *Achievement, stress, and anxiety* (pp. 93-125). Washington, DC: Hemisphere Publishing Group.

Roelofs, J., Meesters, C., Ter Huurne, M., Bamelis, L., & Muris, P. (2006). On the links between attachment style, parental rearing behaviors, and internalizing and externalizing problems in nonclinical children. *Journal of Child and Family Studies*, 15, 331-344.

Appendix A1

NRES End of Study Form

END OF A STUDY

(For all studies except clinical trials of investigational medicinal products)

To be completed in typescript by the Chief Investigator and submitted to the Research Ethics Committee (REC) that gave a favourable opinion of the research within 90 days of the conclusion of the study or within 15 days of early termination.

For questions with Yes/No options please indicate answer in bold type.

1. Details of Chief Investigator

Name:	[REDACTED]
Address:	[REDACTED]
Telephone:	[REDACTED]
Email:	[REDACTED]
Fax:	[REDACTED]

2. Details of study

Full title of study:	A Grounded Theory investigation of the experiences of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder (EUPD)
Research sponsor:	[REDACTED]
Name of REC:	[REDACTED]
	[REDACTED]

3. Study duration

Date study commenced:	16/03/16
Date study ended:	14/04/17
Did this study terminate prematurely?	Yes / No If yes, please complete sections 4, 5, 6, & 7. If no, please go direct to section 8.

4. Recruitment

Number of participants recruited	12
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Proposed number of participants to be recruited at the start of the study	20
If different, please state the reason or this	Unable to find enough participants who met criteria. Several potential participants had left volunteer role just before study began.

5. Circumstances of early termination

What is the justification for this early termination?	N/A
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6. Temporary halt

Is this a temporary halt to the study?	Yes / No
If yes, what is the justification for temporarily halting the study? When do you expect the study to re-start?	e.g. Safety, difficulties recruiting participants, trial has not commenced, other reasons.



7. Potential implications for research participants

Are there any potential implications for research participants as a result of terminating/halting the study prematurely? Please describe the steps taken to address them.	N/A
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8. Final report on the research

Is a summary of the final report on the research enclosed with this form?	Yes / No If no, please forward within 12 months of the end of the study.
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9. Declaration

Signature of Chief Investigator:	
Print name:	
Date of submission:	24.04.17

Appendix B1

Study Summary Form for HRA and REC

End of Study Summary:

A Grounded Theory investigation of the experiences of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder



Trainee Clinical Psychologist

Study Aim:

This study aimed to develop a holistic theory about the experience of change for individuals who had received a diagnosis of Emotionally Unstable Personality Disorder which extended beyond the context of formal psychological therapy and could be applied meaningfully across Mental Health settings.

Research Questions:

- e. What are the experiences of change for individuals with a diagnosis of EUPD?
- f. How do individuals describe change?
- g. To what do individuals attribute change?
- h. How is change described within the context of MHS?

Methodology:

Twelve individuals were interviewed using semi-structured format about their experience of change. Five individuals with a diagnosis of EUPD who were now working or volunteering

were interviewed alongside seven staff members with experience of working with individuals with this diagnosis.

Lived Experience Participants Recruited

Participant	Role	Gender	Age	Ethnicity
Lived experience participant 1	Trainer	Female	49	Black British
Lived experience participant 2	Trainer	Female	50	White British
Lived experience participant 3	Volunteer	Female	55	White European
Lived experience participant 4	Self-employed	Female	26	White British
Lived experience participant 5	Support worker	Female	50	White British

Clinical Staff Recruited

Participant	Role	Gender	Age	Ethnicity
Clinician 1	Team leader Key worker	Female	52	White Other
Clinician 2	Mental health nurse	Female	43	White British
Clinician 3	Occupational therapist	Female	55	Not disclosed
Clinician 4	Assistant psychologist	Female	33	White British
Clinician 5	Counselling Psychologist	Male	42	White British
Clinician 6	Recovery worker	Female	54	White British

Clinician 7	Mental Health Nurse	Female	54	White British
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Procedure:

Participant interviews ranged between 36 and 92 minutes. The interviews were transcribed and anonymised. Interviews were analysed using a Grounded Theory Methodology in order to develop a theory of change for individuals with an EUPD diagnosis.

Results:

The key change experience was defined as one of ‘shifting positions’ where the individual with EUPD began evolving their relationship to themselves, to others and to help. This process was often facilitated by development of safe and trusting relationships, gaining understanding about the diagnosis in combination with a personal readiness to change. The change process could simultaneously be enhanced and set back by staff and Mental Health Services.

Clinical and Research Implications:

This change process mirrors and expands the findings of previous research and offers a change model applicable across settings. Future research should include the perspective of carers and clinical settings should explore how best to support staff to attune to individuals needs in order to facilitate change.

Appendix C1

Study Summary for Participants

End of Study Summary:

A Grounded Theory investigation of the experiences of change for individuals who have received a diagnosis of Emotionally Unstable Personality Disorder



Trainee Clinical Psychologist

Study Aims:

Increasingly, research has begun to focus on the experience of change for individuals with a diagnosis of Emotionally Unstable Personality Disorder (also known as Borderline Personality Disorder). This is thought to be important to ensure that Mental Health Services are supporting individuals to change in the best way possible and to move away from stigma and discrimination that individuals who have received this diagnosis often face.

The study aimed to develop a theory of change for this diagnosis, one that incorporated the perspectives of people who had received this diagnosis, as well as individuals who work clinically to support individuals with lived experience. Previous research has focused on experiences of change within psychological therapy and it was hoped that this theory would apply beyond therapy in order to more accurately capture the types of support that individuals with this diagnosis experience from Mental Health Services, as individuals do not always access psychological therapy.

Recruitment:

Five individuals with lived experience of Emotionally Unstable Personality Disorder who were now volunteering or in paid employment and seven staff members working clinically with individuals with this diagnosis agreed to take part.

Method:

Participants were interviewed and the interview recordings were then transcribed. Key themes were identified within the data and constantly compared and contrasted across all transcripts to identify main themes. These themes were then linked to explain how different processes and experiences impacted on each other in order to develop an understanding of the change experience.

Findings:

Below is a summary of main findings.

- The change process was identified as complex and was one that could be influenced by many different things.
- The key change experience was identified as ‘shifting positions’ which involved the individual beginning to change the way that they related to themselves, to others and to accessing help in order to develop a stronger sense of self and identity.

- This experience was often influenced by developing safe and trusting relationships with others and gaining some understanding about the diagnosis could often made individuals more confident to take risks and begin to make changes. These experiences could come from contact with Mental Health Services but some participants found stability, understanding and support from other places including peer support, family and through friends; all of which could help facilitate change.
- Individuals also identified the importance of being ready to change. If individuals were not ready to make changes then often, individuals would stay feeling quite 'stuck'.
- The study also found that change could often be encouraged by Mental Health Services, friends and family if they were aware and responsive to an individual's need. On the other hand, services and significant others could also pull people back from making changes and could lead someone to feeling quite stuck.
- People with a diagnosis of EUPD also noted that they could get pulled back into feeling stuck by experience and reminders of past trauma and nearly experiences.
- However, participants often reported that they weren't always set back completely and stated that over time, they began to develop emotional coping skills, insight into why they experience difficulties as well as increased reflective ability. Participants also said that they found it easier to talk to others over time and set personal boundaries. In regard to relationship to services and to seeking help, participants said that they found it easier to access help over time in a way that could more helpfully meet their needs. Participants also talked about using staff as a way of practicing new ways of being with the outside world.
- Finally, participants noted that change was partly due to time, and growing in strength through experience.

Suggestions for Future Research:

- The current research identified that many individuals often receive their diagnosis poorly, which often reinforces distrust of services and often left people feeling disempowered. A more detailed and compassionate diagnosis process is required and one in which the individual is given information about the diagnosis as well as time and space to ask questions.
- It would be beneficial for services to be transparent with service users' about the importance of being ready to change. Services should be a source of stability for service users' who do not feel ready to change.
- Mental Health Services need to constantly be adapting practice in order to support individuals wherever they are within their change experience. This is a tricky balance between offering support, safety and security whilst encouraging change and independence. Staff teams within all forms of Mental Health provision would benefit from adequate support and time in order to discuss and reflect on these processes.

- The current research did not include the voice of the carer/ family member. This research highlighted the importance of an individual's surrounding support system and so future research should aim to find out about carers views of change.
- Participants acknowledged the importance of peer support. It would be useful for future research to begin to evaluate how peer support services and networks may influence and potentially enhance the change process.
- Finally, participants noted that change takes time. Participants talked about receiving inadequate support from Mental Health Services throughout their change experience and it is vital that services offer long term, flexible support for individuals with a diagnosis of EUPD.

I would like to thank all interviewees for your time and openness during the research process. Please feel free to contact me if you have any further questions. My email address is:

