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Connie Geyer

BSc (Hons), MA, Grad Dip

**AN EXPLORATION OF CHANGE AND 'BORDERLINE
PERSONALITY DISORDER (BPD)'**

Section A:

What is the status of the 'recovery approach' in relation to 'BPD', and how
can research inform its implementation?

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A grounded theory of experiences of change in people diagnosed with BPD

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CANTERBURY CHRIST CHURCH UNIVERSITY

CANTERBURY CHRIST CHURCH UNIVERSITY
Doctorate in Clinical Psychology (D.Clin.Psychol.)

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Acknowledgments

First and foremost I want to thank my research participants for their interest in this project and for speaking so openly about their personal experiences of change. The research process has also been an experience of change for me and will continue to affect the way in which I approach my clinical work and research. I hope that I can helpfully share this learning with others.

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Summary of portfolio

Section A brings together literature on recovery and 'BPD'. It is demonstrated that current understandings of recovery in relation to 'BPD' focus primarily on measurable, clinical outcomes but that little remains known about service users' personal experiences of their journeys. It is argued that qualitative research on service users' experiences of change in relation to BPD could help generate a BPD-specific recovery model, which could inform the increasingly dominant recovery approach in mental health services.

Section B describes a qualitative exploration of service user experiences of change in the context of group-based programmes for BPD. A BPD-specific model of change was developed using constructivist grounded theory methods and is presented and discussed. Clinical, research and theoretical implications are highlighted.

Section C offers a critical appraisal and reflections on the research process and its effects on the researcher.

Table of Contents

<u>SECTION A</u>	12
<u>ABSTRACT</u>	13
<u>INTRODUCTION</u>	14
OUTLINE	14
<u>METHODOLOGY</u>	15
<u>‘BPD’ AND ‘RECOVERY’</u>	15
WHAT IS BPD?	15
CONTROVERSY ABOUT THE BPD DIAGNOSIS	16
IMPLEMENTATION OF THE RECOVERY APPROACH	17
CLINICAL AND PERSONAL RECOVERY	18
DEARTH OF BPD-SPECIFIC RECOVERY MODELS	19
SERVICE USER CRITIQUE OF GENERIC RECOVERY INITIATIVES	19
THE RELATIONSHIP BETWEEN THE RECOVERY APPROACH AND THE BPD DIAGNOSIS	20
<u>THE CONTRIBUTIONS OF QUANTITATIVE RESEARCH TO AN UNDERSTANDING OF BPD-SPECIFIC RECOVERY NEEDS</u>	21
MCLEAN STUDY OF ADULT DEVELOPMENT	21
COLLABORATIVE LONGITUDINAL PERSONALITY DISORDERS STUDY	23
BPD-SPECIFIC PSYCHOTHERAPY OUTCOMES RESEARCH	24
OPERATIONALISATION OF RECOVERY IN BPD OUTCOMES RESEARCH	25
EMPLOYMENT: A NEGLECTED ASPECT OF RECOVERY	26
PRELIMINARY SUMMARY	26
<u>RECOVERY PROCESSES IN RELATION TO BPD</u>	27
DIALECTICAL-BEHAVIOUR THERAPY	27
SCHEMA-FOCUSED THERAPY	28
TRANSFERENCE-FOCUSED PSYCHOTHERAPY	28
MENTALIZATION-BASED TREATMENT	28
IMPLICATIONS OF THERAPEUTIC THEORIES OF CHANGE	29
QUALITATIVE RESEARCH ON RECOVERY IN RELATION TO BPD	30
<u>SUMMARY</u>	32
<u>LIMITATIONS OF THIS REVIEW</u>	34
<u>DIRECTIONS FOR FUTURE RESEARCH</u>	34
<u>REFERENCES</u>	36
<u>SECTION B</u>	45
<u>ABSTRACT</u>	46
<u>INTRODUCTION</u>	47
THE DIFFICULTIES ASSOCIATED WITH BPD	47

EVIDENCE OF CHANGE IN PEOPLE DIAGNOSED WITH BPD	48
THE DEVELOPMENT OF BPD-SPECIFIC PSYCHOLOGICAL THERAPIES	48
KNOWLEDGE GAPS	49
<u>RATIONALE FOR THE PRESENT STUDY.....</u>	<u>51</u>
<u>METHODOLOGY.....</u>	<u>51</u>
PARTICIPANTS.....	51
ETHICS	53
METHOD	53
DESIGN.....	53
INTERVIEW SCHEDULE	54
PROCEDURE.....	54
DATA ANALYSIS.....	55
QUALITY ASSURANCE.....	56
<u>RESULTS.....</u>	<u>57</u>
THE MODEL.....	58
TURNING-POINTS.....	59
THE CORE CHANGE PROCESS	60
1. LAYING FOUNDATIONS	61
2. EXPLORING SELFHOOD AND AGENCY.....	67
3. CONSOLIDATING/ "MOVING ON"	72
<u>DISCUSSION.....</u>	<u>76</u>
<u>STRENGTHS AND LIMITATIONS</u>	<u>79</u>
<u>IMPLICATIONS.....</u>	<u>80</u>
<u>SUMMARY.....</u>	<u>81</u>
<u>REFERENCES</u>	<u>83</u>
<u>SECTION C – CRITICAL APPRAISAL.....</u>	<u>89</u>
WHAT RESEARCH SKILLS HAVE YOU LEARNED AND WHAT RESEARCH ABILITIES HAVE YOU DEVELOPED FROM UNDERTAKING THIS PROJECT AND WHAT DO YOU THINK YOU NEED TO LEARN FURTHER?.....	89
IF YOU WERE ABLE TO DO THIS PROJECT AGAIN, WHAT WOULD YOU DO DIFFERENTLY AND WHY?	92
CLINICALLY, AND AS A CONSEQUENCE OF DOING THIS STUDY, WOULD YOU DO ANYTHING DIFFERENTLY AND WHY?.....	93
IF YOU WERE TO UNDERTAKE FURTHER RESEARCH IN THIS AREA WHAT WOULD THAT RESEARCH PROJECT SEEK TO ANSWER AND HOW WOULD YOU GO ABOUT IT?.....	93
<u>REFERENCES</u>	<u>96</u>
<u>APPENDICES.....</u>	<u>97</u>
APPENDIX 1 – METHODOLOGY.....	98
APPENDIX 2 – DSM-IV BPD DIAGNOSTIC CRITERIA.....	101
APPENDIX 3 – RECOVERY PRINCIPLES COMMONLY ADOPTED IN MENTAL HEALTH CARE	102
APPENDIX 4 – SAMPLE CHARACTERISTICS	103
APPENDIX 5 – ETHICS APPROVAL.....	104

APPENDIX 6 – R&D APPROVAL.....	104
APPENDIX 7 – INTERVIEW SCHEDULE.....	106
APPENDIX 8 – PARTICIPANT INFORMATION SHEET.....	108
APPENDIX 9 – CONSENT FORM.....	112
APPENDIX 10 – CODED TRANSCRIPT.....	113
APPENDIX 11 – EXTRACTS FROM RESEARCH DIARY.....	115
APPENDIX 12 – EXAMPLE OF ANALYTIC MEMO.....	119
APPENDIX 13 – FULL LIST OF FOCUSED CODES.....	122
APPENDIX 14 – CATEGORIES, SUBCATEGORIES AND FOCUSED CODES IN THE FINAL MODEL.....	125
APPENDIX 15 – NRES CLOSING SUMMARY.....	130
APPENDIX 16 – R&D SUMMARY.....	132
APPENDIX 17 – COVER SHEET FOR JOURNAL SUBMISSION.....	133
APPENDIX 18 – PRACTITIONER POINTS AS REQUIRED BY JOURNAL.....	134
APPENDIX 19 – AUTHOR GUIDELINES.....	135

MAJOR RESEARCH PROJECT

SECTION A

Connie Geyer BSc (Hons), MA, Grad Dip

What is the status of the 'recovery approach' in relation to 'BPD', and how can research inform its implementation?

Word Count: 5474 (plus 261 additional words)

Abstract

The recovery approach is becoming increasingly influential in the organisation and delivery of mental health care, including personality disorder services. However, until recently people with a diagnosis of borderline personality disorder (BPD) were considered untreatable and often excluded from services. Therefore, little is known about the status of the recovery approach in relation to people with this diagnosis. The objective was to synthesise the recovery literature and research in relation to BPD so that this can inform implementation of the recovery approach and guide future research. Databases were searched for peer-reviewed studies and book chapters relating to recovery and/ or BPD. A selective review of the literature was undertaken. A review of policy initiatives and the recovery literature suggested that people diagnosed with BPD might have specific recovery needs, which are marginalised in the recovery approach usually adopted within the NHS. A review of longitudinal and psychotherapy outcomes research suggested that BPD-specific recovery needs included long-standing temperamental, existential and vocational difficulties. A review of psychotherapeutic theories of change revealed that there are many hypothesised roads to change but that there is little empirical research in this area. There was very little qualitative research on service user experiences. Therefore, research is required into service user experiences of change, mechanisms of change and effective psychosocial interventions. Qualitative research into service user experiences of change could aid the development of a much-needed BPD-specific recovery model that is grounded in service user experience.

Keywords: borderline personality disorder, recovery approach, change

Introduction

The aim of this review was to consider what recovery might mean for people diagnosed with borderline personality disorder (BPD) and to identify significant knowledge gaps. The review was motivated by a clinical interest in improving recovery-oriented services for people diagnosed with BPD. While it was not within the scope of the review to critique the BPD construct, a critical perspective was adopted.

Outline

First, the BPD diagnosis will be placed in the context of current recovery literature and policy. It will be argued that people diagnosed with BPD have specific recovery needs, which are marginalised in the increasingly dominant 'recovery approach' within the NHS. In order to explore BPD-specific recovery needs and their trajectory, longitudinal research will be reviewed. Then, the role of psychological therapies in promoting recovery in people diagnosed with BPD will be considered. The empirical evidence base and theoretical underpinnings of four prominent BPD-specific psychological therapies will be critically reviewed. Significant knowledge gaps in relation to long-term outcomes and service users' appraisals and experiences of change will be revealed. Finally, a review of the very small, existing body of qualitative research on recovery in relation to BPD will demonstrate that there is some limited knowledge about service users' recovery goals but that experiences of recovery processes in relation to BPD have remained unexamined thus far. The review will conclude with directions for future research, highlighting the need for the development of a BPD-specific recovery model, which is grounded in service user experiences.

Methodology

While the author endorses the Division of Clinical Psychology's (British Psychological Society, 2013) position statement on diagnosis, the BPD diagnosis sets the context within which knowledge on this subject has been generated and debated, and was therefore used to identify relevant literature. Databases were searched for papers and chapters relating to BPD and/ or recovery (fully outlined in Appendix 1).

'BPD' and 'recovery'

What is BPD?

Approximately four per cent of primary care patients and up to eighty per cent of forensic populations meet diagnostic criteria for BPD (Blackburn, Crellin, Morgan, & Tulloch, 1990; Grant et al., 2008). People who meet diagnostic criteria are thought to have significant and complex problems in relating to themselves and others and in regulating their emotions and behaviours (Sanislow et al., 2002). Levels of psychic pain are considerable and can result in desperate and impulsive attempts to manage these. Substance misuse, self-harm, risky sexual behaviours and suicidality are frequent (Levy et al., 2006). Up to ten per cent of those with a diagnosis have been found to take their lives (Paris & Zweig-Frank, 2001). The difficulties of people with this diagnosis have been linked to adverse early life experiences, particularly attachment trauma (Bateman & Fonagy, 2006), sexual abuse (Yen et al., 2002), emotional invalidation (Linehan, 1993) and genetic vulnerabilities (Torgersen et al., 2000). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-tr; American Psychological Association (APA), 2000; p.654) provides the most widely cited definition of BPD (see Appendix 2 for diagnostic criteria):

“A pervasive pattern of instability of interpersonal relationships, self-image and affects, as well as marked impulsivity, beginning by early adulthood and present in a variety of contexts”

A brief review of the development of the 'borderline' concept into a psychiatric diagnosis demonstrates that historically, BPD has been associated with a negative clinical prognosis. Psychoanalysts coined the term 'borderline' to describe individuals who were deemed neither 'neurotic' nor 'psychotic' and who consistently showed poor psychotherapy outcomes (Stern, 1938). The diagnosis was developed later to categorise psychiatric patients who did not seem to respond to standard treatments (Gunderson & Singer, 1975). At best, recovery came to be seen as a form of age-related 'burn-out', characterised by reduced impulsivity and on-going interpersonal and emotional difficulties (Stevenson, Meares, & Comerford, 2003). However, this view has increasingly been challenged by research findings, which show that poor outcomes for people with this diagnosis often reflect iatrogenic effects rather than the intransigence of their difficulties (Fonagy & Bateman, 2006). This has enabled debate about the diagnosis and its detrimental effects on people's journey through the mental health system and towards recovery.

Controversy about the BPD diagnosis

Clinically, it has been argued that the BPD diagnosis is unhelpful and that the constellation of difficulties it refers to should be reclassified as an emotional regulation disorder (Tyrer, 2009) or post-traumatic stress (Yen et al., 2006). The publication of DSM-5 has not resolved these issues (Biskin & Paris, 2012). Feminist psychologists have argued that the diagnosis pathologises women's ways of surviving the impact of abuse (Proctor, 2007). Indeed, the diagnosis has been found to have detrimental social effects on those who receive it. Women have been found to experience heightened shame and self-stigma as a consequence of diagnosis (Rusch et al., 2006). Staff attitudes towards service users have been found to be less empathic and hopeful towards people diagnosed with BPD than towards those with other

diagnoses (Markham, 2003; Markham & Trower, 2003). Negative attitudes towards people diagnosed with BPD have often led to their exclusion from services (National Institute of Mental Health in England, 2003a). Thus, the BPD label has traditionally been a barrier to accessing recovery-oriented services. Recent policy guidance has acknowledged that this is an untenable situation, stating that BPD should “no longer [be] a diagnosis of exclusion” (NIMHE, 2003a). As the following section will show, the ‘recovery approach’ is becoming increasingly influential in the organisation of mental health services, including personality disorder services.

Implementation of the recovery approach

Recovery principles are increasingly dominant in the organisation and delivery of mental health services in the UK and are embedded in key policies, such as the ‘Guiding statement on recovery’ (NIMHE, 2005), ‘A common purpose: recovery in future mental health services’ (Social Care Institute for Excellence, 2007), and ‘Making recovery a reality’ (Sainsbury Centre for Mental Health (SCMH), 2008). They are also acknowledged in the National Institute of Clinical Excellence (NICE, 2009) guideline for BPD and ‘The personality disorders capability framework’ (NIMHE, 2003b). They include building a satisfying life, developing self-management and promoting social inclusion (see Appendix 3; SCMH, 2008).

The formal acknowledgment of these principles in key policy documents indicates that health services increasingly see it as their responsibility to promote personal growth in addition to clinical well-being, and that this responsibility extends to people diagnosed with BPD. The following section will consider whether these general recovery principles provide sufficient guidance to clinicians as to how to implement a recovery approach in relation to BPD. It will do so by clarifying the conceptual underpinnings of ‘recovery’.

Clinical and personal recovery

The 'recovery' concept can be traced back to the service user/ survivor movements of the 1980s and 1990s (e.g. Chamberlin, 1979). Service users primarily with psychotic diagnoses and traumatic experiences of the mental health system challenged the narrow medical conceptualisation of recovery as a return to a state of health (Davidson, Lawless, & Leary, 2005), and highlighted the importance of living a fulfilling life despite on-going mental health difficulties (Anthony, 1993). This trend in mental health coincided with campaigns from the wider disability rights movement, which fought for social inclusion and self-determination of people with chronic conditions (Holloway, 2008).

The debate led to a distinction being made between clinical and personal recovery (Davidson, Lawless, & Leary, 2005). Slade (2009) defines clinical recovery as an objectively observable outcome or state, which can be assessed by an expert and is invariant across individuals. Personal recovery, on the other hand, is understood as a uniquely personal, dynamic, non-linear process, or 'journey of the heart' (Deegan, 1996), towards living a hopeful life despite the setbacks caused by mental illness (Anthony, 1993; Davidson, Lawless, & Leary, 2005).

One could argue that the recovery principles that are widely adopted in the NHS provide clinicians with a sufficiently broad framework to apply across clinical groups whilst accommodating service users' personal recovery needs. However, a UK-based qualitative study of service user views on this matter found that recovery goals differed across care settings and clinical groups and therefore required local adaptation (Turton et al., 2011). Although the study did not specifically investigate BPD, its findings strongly suggest that people with this diagnosis might have different and/ or additional needs that are not recognised by current policies. Evidence that treatments can have iatrogenic effects if they are not tailored to the difficulties of

people diagnosed with BPD (such as heightened sensitivity to separations and difficulties down-regulating emotional arousal) highlights the need to examine BPD-specific recovery needs (Fonagy & Bateman, 2006).

Dearth of BPD-specific recovery models

The thorough literature search conducted for this review revealed a striking dearth of BPD-specific recovery models. However, such models could elucidate BPD-specific recovery needs and guide implementation of the recovery approach in relation to BPD. Perspectives of service users with a BPD diagnosis are underrepresented in key texts, such as Slade's (2009) influential guide for mental health professionals as to how to promote personal recovery of people diagnosed with mental illness. In contrast to this, the needs and experiences of people with psychosis are well-articulated (Ramon, Healy, & Renouf, 2007), and have been elaborated in the form of empirical, psychosis-specific recovery models. For example, Dilks, Tasker and Wren (2008; 2010) found integration with the social world to be a key therapy goal for service users experiencing psychosis. However, as the following section will show, such models may not be generalisable to people diagnosed with BPD.

Service user critique of generic recovery initiatives

Turner, Lovell and Brooker (2011), who are members of Emergence, a service user-led organisation for people affected by personality disorder, argue that social inclusion initiatives ignore the chronic existential and interpersonal pain that is unique to their difficulties. They propose that people diagnosed with BPD do not benefit from generic social rehabilitation programmes and require creative activities to promote meaningful connections between the internal and external world.

Highlighting the developmental nature of their difficulties, they argue that change in the context of BPD is best understood as 'self-discovery' rather than 'recovery'. They

define this as “an individual or peer-orientated attempt to uncover latent potential, undeveloped talents and abilities, coupled with an on-going capacity for personal growth and self-actualisation” (p.342). Although the commentary is unlikely to represent the views of all individuals diagnosed with BPD, it strongly suggests that there may be BPD-specific recovery needs, which are marginalised in generic recovery initiatives. The following section will highlight the limitations of the recovery approach in relation to the BPD diagnosis and consider differences between BPD and other diagnoses.

The relationship between the recovery approach and the BPD diagnosis

Principles such as promoting hope, agency and a meaningful and fulfilling life as defined by the person are likely to be particularly pertinent given the stigma and self-stigma attached to the BPD diagnosis (Rusch et al., 2006). However, social inclusion and community involvement present particular challenges for clients whose difficulties are linked to traumatic social experiences, most notably in the family group (Fonagy & Bateman, 2007; Linehan, 1993). Linehan (1993) links BPD-specific difficulties in emotion recognition and regulation to early exposure to invalidating environments. Fonagy and Bateman (2007) suggest that environmental deficiencies in childhood interfere with the development of the social affiliative system, resulting in BPD-specific deficits in higher-order social cognitive function, interpersonal understanding ('mentalization') and emotion regulation. Therefore people who meet diagnostic criteria for BPD are particularly vulnerable to distressing and traumatic experiences in social contexts. Generic social inclusion initiatives such as community involvement and vocational programmes are likely to expose clients to interpersonal challenges, which those with a BPD diagnosis might experience as traumatic and feel unable to manage (Turner, Lovell & Brooker, 2011). This sets them apart from people

with psychotic diagnoses, whose symptoms are maintained by social isolation and lack of social support networks (Erickson, Beiser & Iacono, 1998) and for whom social integration is thought to be an important vehicle of recovery (Dilks, Tasker & Wren, 2010). In order to explore BPD-specific recovery needs further, the following section will review longitudinal research on long-term outcomes.

The contributions of quantitative research to an understanding of BPD-specific recovery needs

In the past two decades longitudinal research has opened up new perspectives on recovery in relation to BPD. Between 1986 and 2001, five US-American follow-back studies (McGlashan, 1986; Paris, Brown, & Nowlis, 1987; Paris & Zweig-Frank, 2001; Plakun, Burkhardt, & Muller, 1985; Stone, 1990) found that contrary to common belief, improved emotional well-being and relationships were realistic long-term outcomes for people diagnosed with BPD. This surprising finding paved the way for two large-scale, multi-wave prospective follow-up studies that have significantly advanced contemporary understandings of BPD-specific recovery needs and trajectories: the McLean Study of Adult Development (MSAD) (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005), and the Collaborative Longitudinal Personality Disorders Study (CLPS) (Gunderson et al., 2000).

McLean Study of Adult Development

MSAD, an on-going research project, was launched in 1992 to investigate remission and recovery in a sample of 290 participants with BPD. Data was collected in two-year intervals and compared to an Axis II comparison group ($n = 72$). Remission was described as no longer meeting diagnostic criteria for a two-year period; sustained remission as no longer meeting diagnostic criteria for a four-year period. Recovery was defined as being in remission, having a Global Assessment of Functioning (GAF; Hall, 1995) score of 61 or higher, having at least one emotionally

sustaining relationship, and being able to work or study on a full-time basis. Initially, all participants were inpatients and had a mean GAF score of 38.9, indicating impairment in reality testing, relationships and work.

The findings of MSAD significantly advanced understanding of what recovery might mean in relation to BPD. Although full recovery status appeared to be harder to attain than remission, remissions and recovery were common. At 10-year follow-up, 50% of participants had attained recovery (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010). At sixteen-year follow-up 99% had remitted (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012). Relapse became less likely over time but occurred more rapidly in the BPD sub-sample (10% after an 8-year remission) (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005).

Potential intrapsychic correlates of recovery were explored. Recovered participants appeared to make less use of what the researchers identified as "immature" defences, such as image-distortion, maladaptive action, projective identification and splitting, and more use of humour than their non-recovered counterparts (Zanarini, Frankenburg, & Fitzmaurice, 2013). Unfortunately only one self-report measure, the Defence Style Questionnaire (DSQ; Bond, 1991), was used, which might have steered participants towards giving socially acceptable answers. However, the findings suggest that recovery might be associated with intrapsychic changes. This might also explain why relapses became less likely over time.

Interestingly, difficulties in relationships and employment seemed to be more pronounced in the BPD sub-sample and to be more persistent over time than acute symptoms and thus stopped many participants from achieving recovery status as defined by the researchers (Reed, Fitzmaurice, & Zanarini, 2012). The authors hypothesised that lasting dysphoric affects, such as anger, loneliness and emptiness,

and interpersonal ineffectiveness mutually reinforced each other, preventing full psychosocial recovery in people diagnosed with BPD. A distinction was made between acute symptoms and temperamental difficulties (Zanarini et al., 2005; Zanarini, 2012). Acute symptoms such as self-harm and suicidality were understood to be distinct diagnostic markers and to resolve relatively quickly. Temperamental features such as abandonment fears and dysphoric affect seemed to be less amenable to change and to contribute to on-going psychosocial impairment, suggesting that these constitute BPD-specific and longer-term recovery needs.

Collaborative Longitudinal Personality Disorders Study

CLPS, a prospective, multi-site study, annually followed and compared inpatients and outpatients from five diagnostic groups: schizotypal personality disorder (PD) (n = 86), BPD (n = 175), avoidant PD (n = 158), obsessive-compulsive PD (n = 154), and major depressive disorder (n = 95) (Gunderson et al., 2000; Skodol et al., 2005). Although fewer CLPS than MSAD publications specifically looked at remission and recovery in relation to BPD, a 10-year follow-up of the BPD subsample (Sanislow et al., 2009) showed that 91% of borderline participants had achieved a remission of two or more months. Eighty-five per cent had a remission of at least one year. Recurrence rates for BPD fell from 21% after two months to 11% after twelve months. Despite clinical improvements, psychosocial functioning remained or became impaired over time. Although the findings were less positive than those of MSAD, the study provided further evidence that symptomatic remissions appear to be common among people diagnosed with BPD, that the likelihood of relapse seems to decline with time, and that full psychosocial recovery appears to be more difficult to attain than remission, thus indicating BPD-specific recovery needs in this area.

The impressive lengths of follow-ups, use of multiple measures, control groups, prospective designs, and decent sample sizes were strengths in both studies. However, replication outside the United States and by other research teams is required. Nonetheless, cumulatively the findings of longitudinal research highlight that long-term outcomes for people diagnosed with BPD are far more favourable than had previously been assumed. They suggest that rapid relapses and enduring temperamental and psychosocial difficulties constitute BPD-specific recovery needs, which need to be addressed by current recovery initiatives.

The review will now consider what is known about the role of psychological therapies in addressing BPD-specific recovery needs. It will be demonstrated that not only are long-term outcomes in relation to BPD better but also that psychological therapies are more effective than was previously assumed. However, it will also be argued that the focus of outcomes research on clinical recovery in relation to BPD might obscure personal recovery needs of people with this diagnosis.

BPD-specific psychotherapy outcomes research

Since the 1990s, four new BPD-specific interventions have gained particular prominence: dialectical-behaviour therapy (DBT; Linehan, 1993); schema-focused therapy (SFT; Young, 1999); transference-focused psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 2006), and mentalization-based treatment (MBT; Bateman & Fonagy, 2006). Systematic reviews and meta-analyses have shown that these therapies appear to be superior to treatment-as-usual (Brazier et al., 2006; Stoffers et al., 2012). Despite their differences in content and approach, there is no strong evidence that one treatment is better than another (Zanarini, 2009). The following section will review what is known about the role of psychological therapies in addressing BPD-specific recovery needs. First, the operationalisation of the recovery

concept in psychotherapy outcomes research will be critiqued. Resultant knowledge gaps vis-à-vis recovery and BPD will be highlighted. Then, theories of change that underpin the four afore-mentioned therapies will be reviewed to consider possible recovery processes in relation to BPD.

Operationalisation of recovery in BPD outcomes research

Research into BPD-specific psychological therapies has primarily defined outcome in terms of reduction of acute symptoms. A recent Cochrane review of 28 randomised control trials (RCTs) of BPD-specific psychological therapies showed that the most commonly used primary outcome measures were presence and severity of affect dysregulation, impulsivity, self-destructive and suicidal behaviours, and interpersonal problems (Stoffers et al., 2012). Secondary outcomes were anxiety, depression, general psychopathology, and global assessments of functioning. Long-term social and vocational outcomes and temperamental features were rarely a focus of outcomes trials, although the previous section provided strong evidence that these represent BPD-specific recovery needs.

There are a number of possible reasons for this. Firstly, BPD-related outcomes research is relatively new. Therefore there has been limited scope for long-term follow-ups. Secondly, new therapies need to first establish that they effectively address acute difficulties such as life-threatening behaviours before demonstrating their effects on less pressing issues such as vocational attainment. Thirdly, BPD-specific therapies might not be designed to support long-term psychosocial adjustment. Zanarini (2009) notes that interventions predominantly focus on acute problems. Outcomes research therefore mirrors this focus. However, given the influence of outcomes research on mental health service commissioning in the UK (e.g. NICE guidance), there is a danger that the recovery concept in relation to BPD

might become reduced to symptomatic remission and neglect temperamental and psychosocial needs. The following section will illustrate this by example of vocational rehabilitation.

Employment: a neglected aspect of recovery

Securing and sustaining employment seems to be a neglected area of difficulty, which has not been sufficiently covered in outcomes research and is therefore neglected in clinical guidance relating to BPD. In their review of eleven studies between 1983 and 2011, Sansone and Sansone (2012) found that nearly half of participants diagnosed with BPD remained unemployed at follow-up periods of one to 27 years. A recent feasibility study evaluated the vocational and clinical outcomes of people who had completed one year of DBT-Accepting the Challenges of Exiting the System (Comtois, Kerbrat, Atkins, Harned, & Elwood, 2010). While the study was limited by its small sample size and the lack of a control group, it found that a specific focus on vocational and social functioning could help sustain, if not improve, workplace success for people diagnosed with BPD. However, the effectiveness of BPD-specific psychosocial rehabilitation initiatives is an underresearched area, and therefore less prominent in related clinical guidance than clinical interventions (NICE, 2009). More research is required to elaborate an understanding of psychosocial interventions in relation to BPD and to raise the profile of long-term psychosocial recovery needs in relation to BPD.

Preliminary summary

A review of longitudinal studies showed that clinical well-being in people diagnosed with BPD improves significantly over time. Temperamental and psychosocial difficulties appear to persist and warrant further research into how service users can be supported to manage them. Outcomes research demonstrated the

effectiveness of BPD-specific psychological therapies in promoting clinical recovery of people diagnosed with BPD. However, there is a danger that the recovery concept in relation to BPD becomes reduced to clinical recovery. Longitudinal and effectiveness research share the common limitation that they focus on recovery as an outcome but not as a process. However, recovery is now widely understood as both an outcome (clinical recovery) and a process (personal recovery). The following section will therefore consider what is known about recovery processes in relation to BPD.

Recovery processes in relation to BPD

First, hypothesised change processes, as put forward by the developers of the afore-mentioned BPD-specific psychological therapies will be reviewed. Then, the small body of qualitative research on service user perspectives and experiences of recovery in relation to BPD will be considered.

Dialectical-behaviour therapy

DBT is based on Linehan's (1993) biosocial theory, which proposes that an interaction between biological factors (e.g. emotional sensitivity, prolonged reactivity) and invalidating environments causes emotional dysregulation. This is seen to be the defining feature of BPD. Invalidating responses are thought to dysregulate emotions and hinder the acquisition of emotional literacy. This is thought to result in self-invalidation, which further intensifies and perpetuates emotional dysregulation. Recovery processes are hypothesised to reduce "ineffective action tendencies linked with dysregulated emotions" (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006, p.459). This entails learning to a) modulate extreme affects and reduce mood-driven maladaptive behaviours, and b) self-validate mental states (Lynch et al., 2006).

Schema-focused therapy

SFT is informed by cognitive-behavioural techniques, attachment theory and object relations theory (Rafaeli, Bernstein, & Young, 2011). Building on attachment theory (Bowlby, 1969), the theory underlying SFT postulates the existence of innate emotional needs for safety, nurturance, autonomy, and a sense of identity. If these needs are profoundly unmet in early life, maladaptive schemas develop and come to enduringly organise intra- and inter-personal relations. According to SFT, recovery comprises three stages: 1) bonding and emotional regulation, 2) schema mode change, and 3) development of autonomy. The BPD-specific schema mode changes thought to be indicative of recovery are that the Healthy Adult mode replaces the Detached Protector mode, provides empathy to the inner Abandoned/Abused Child, set limits for the inner Angry/Impulsive Child, and fights the Punitive Parent mode (Rafaeli et al., 2011).

Transference-focused psychotherapy

TFP is grounded in object relations theory (Kernberg, 1984). People who meet BPD diagnostic criteria are thought to have developed high levels of negative affect (especially aggression) because of constitutional and environmental factors. Negative affect is thought to overwhelm good representations of self and others and to be psychologically split off. The lack of integration between libidinal and aggressive drives is seen to cause emotional and interpersonal turmoil. TFP uses psychoanalytic techniques to facilitate integration of split representations. Recovery is understood as personality change marked by increased attachment coherence, reflective function and the use of "mature" defences (Levy et al., 2006).

Mentalization-based treatment

MBT (Bateman & Fonagy, 2006) is informed by attachment theory (Bowlby, 1969), developmental psychology, and neurobiology (Fonagy, Luyten, & Strathearn,

2011). Mentalization is defined as “the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes” (Bateman & Fonagy, 2010, p.11). MBT proposes that early traumatic attachment experiences interfere with neurobiological development and result in BPD-specific mentalizing deficits in attachment contexts (Bateman & Fonagy, 2006):

- 1) *Psychic equivalence* – Internal and external reality become equated, thus impairing reality testing and perspective-taking.
- 2) *Pretend mode* – There is a disconnection between thought and feeling.
- 3) *Teleological mode* – Mental states are only considered real if accompanied by physical action.

The recovery process is considered to be on-going and to consist of increased mentalizing in attachment contexts, initially in individual and group therapy and later in the person's relationships outside therapy.

Implications of therapeutic theories of change

The four therapeutic theories of change have different yet complementary theoretical foci, namely emotional dysregulation, self-defeating patterns, negative affect and mentalization. This suggests that the needs of people diagnosed with BPD are complex but that roads to recovery are multifaceted and promising. Empirical research into mechanisms of change is in its infancy (Clarkin & Levy, 2006).

However, there is emerging evidence that increases in reflective function are associated with positive clinical outcomes in the context of DBT, TFP and MBT (Goodman, 2013; Levy et al., 2006). This might also apply to SFT as the Healthy Adult mode is reminiscent of the concepts of reflective function in attachment theory (Fonagy & Target, 1997) and of ego integration and healthy ego function in object relations theory (Klein, 1975). However, in the absence of more sophisticated

mechanisms of change research, understanding of recovery processes in the context of BPD-specific psychological therapies remain largely theoretical.

Indeed, what has been missing entirely from the debate thus far is how service users experience and describe their journeys. Quantitative researchers operationalise recovery as measurable, researcher-defined, clinical outcomes. However, as we saw earlier, the service user recovery movements powerfully critiqued such a narrow focus and highlighted the importance of personal recovery as a uniquely personal journey (Anthony, 1993). It remains unknown whether commonly used outcome measures are valued by service users, and whether proposed therapeutic change processes are congruent with service users' experiences of their journeys and of therapy. A small number of qualitative studies have attempted to fill this knowledge gap. This work will be reviewed in the section below.

Qualitative research on recovery in relation to BPD

To the author's knowledge, to date only two published, peer-reviewed qualitative studies have explored service user perspectives and experiences of recovery in relation to BPD.

Katsakou and colleagues (2012) interviewed 48 people diagnosed with BPD who had received DBT or MBT or generic mental health services about their perspectives on recovery. Data was analysed using thematic analysis and grounded theory techniques. Four core themes were identified: 1) Personal goals and/or achievements during recovery, 2) Balancing personal goals versus service targets, 3) Current felt stage of recovery, 4) Problems with the word 'recovery'. Recovery was found to involve developing self-acceptance and self-esteem, gaining control over mood, improving relationships, engaging in activities and employment, and decreases in suicidality, self-harm and substance misuse. Some participants expressed

frustration that treatments focused on particular problem areas whilst neglecting others. Recovery was seen as a fluctuating process between gradual improvement and setbacks. Some participants criticised the word 'recovery' because they felt it implied being problem-free. The study showed that some recovery goals were compatible with recovery-oriented practice within the NHS, such as seeing recovery as a journey. However, others were not. For example, the authors argued that improving relationships is likely to be more complex for people diagnosed with BPD than those with other diagnoses.

Despite the impressive sample size, the study had methodological limitations. The extent to which final themes were inductively established or driven by researchers' preconceived ideas was unclear. Recovery was described as a fluctuating process. However, it was ambiguous whether participants distinguished between natural symptomatic fluctuations and recovery processes. Data extracts showed that participants frequently spoke about their future goals rather than their lived experiences. The word 'recovery' itself appeared to jar with some participants. Questions about recovery might therefore have hindered exploration of the unique ways in which participants understood their journeys. Finally, although grounded theory methodology was used, a theory of recovery in relation to BPD was not developed.

In a separate study, Holm and Severinsson (2011) interviewed thirteen Norwegian women diagnosed with BPD about experiences of overcoming suicidal behaviours. Data was analysed using thematic analysis and two main recovery processes identified. 'Struggling to assume responsibility for self and other' comprised 'The desire to recover by searching for strength', 'The struggle to be understood as the person you are', and 'Recovering by refusing to be violated'.

'Struggling to stay alive by enhancing self-development' had one sub-theme, 'Recovering by being able to feel safe and trusted'. The researchers concluded that such recovery processes could occur under conditions of validation, trust and safety.

The study had several limitations. Recovery processes were exclusively explored in relation to suicidal behaviour in women. This might not have coincided with participants' understandings of recovery nor might it be generalisable to the experiences of men. The researchers did not appear to reflect on their subject positions as psychiatric nurses in relation to the data but strove to "achieve an unbiased interpretation despite having previous knowledge of the subject matter" (p.168).

In summary, both studies found that developing personal strengths and relationships were important to participants' views of recovery. Both studies were limited because they held preconceived ideas about how people might understand their experiences. Katsakou et al. expected that their respondents would relate to the recovery concept. Holm and Severinsson assumed that change in suicidal behaviours was central to recovery processes in relation to BPD. One of the two studies suggested that the word 'recovery' was problematic for some participants.

Summary

A focused literature review was undertaken with the aim of establishing what recovery might mean in relation to BPD. It was demonstrated that recovery needs of people with a BPD diagnosis are underrepresented in the recovery literature and related policy. An argument was made that recovery-oriented practice in the NHS might need to be amended to meet the specific needs of people diagnosed with BPD. A review of longitudinal and psychotherapy research strongly suggested that hope for the future is justified, that symptomatic remission is common and can be aided by a

range of interventions, and that increases in reflective function might underpin therapy-related recovery processes. On a less positive note, there was a strong suggestion that symptomatic remission was easier to attain than long-term psychosocial recovery. Subjective experiences of dysphoria, temperamental factors and interpersonal and vocational difficulties seemed to be more likely to persist over time and to distinguish people diagnosed with BPD from those diagnosed with other personality disorders or depression.

Therefore it appears that the focus on reduction of acute symptoms does not reflect the spectrum of recovery needs of people diagnosed with BPD. In a context where findings from psychotherapy outcomes research increasingly inform health care provision in the UK, there is a danger that recovery might come to be seen exclusively in terms of symptomatic remission and that less acute but long-standing needs and difficulties become neglected. This could conflict with the NHS's explicit commitment to promoting personal recovery in relation to BPD. This is congruent with Turner et al.'s (2011) argument that BPD is characterised by enduring existential and interpersonal pain, which is not currently acknowledged by the NHS recovery approach.

Finally, there was a remarkable lack of qualitative research into service user experiences. It has not been explored how service users experience change in the context of BPD-specific psychological therapies, and whether the main outcome measures reflect user-valued recovery goals. Existing qualitative studies were flawed in that they held preconceived ideas about how people would make sense of their journeys. Importantly, a service user commentary and one of the few qualitative studies highlighted that the word 'recovery' itself was not acceptable to some people with BPD.

Limitations of this review

Due to the brevity of this review it was not possible to include research on difficulties congruent with a BPD diagnosis but not labelled as such, for example self-harm. While this would have extended the scope of the review beyond medical diagnosis, it would have yielded an unmanageable amount of literature. It was not possible to explore service user accounts of recovery in relation to BPD as it seemed to the author that this would warrant an independent study of how service users narrate and represent their journeys in text.

Directions for future research

On the basis of this review there appears to be a need for an empirically developed recovery model in relation to BPD. Such a model could aid the development of theories of recovery in relation to BPD, could guide clinical practice and provide ways of evaluating recovery-oriented practice and service organisation against BPD-specific recovery goals and needs. In order to work towards such a model, research into the following areas is required:

- 1) *Mechanisms of change*: Although BPD-specific psychological therapies have been shown to play an important role in clinical recovery processes for people diagnosed with BPD, mechanisms of change are largely hypothetical and need to be empirically investigated. Future studies could systematically establish the role of reflective function by using the reflective function scale (Fonagy, Target, Steele, & Steele, 1998).
- 2) *The effectiveness of BPD-specific psychosocial interventions*: There is a need for outcomes research on BPD-specific psychosocial interventions, including creative and vocational programmes, as these are currently underresearched.
- 3) *Service user experiences of change*: Qualitative research into service users' personal experiences of change is required to explore how people diagnosed with

BPD describe, experience and understand their journeys; to identify which changes matter most to them; and to specify the factors are seen to facilitate processes of change. This could be done through qualitative interviews and/ or analysis of published service user accounts using qualitative research methods such as thematic analysis (Braun & Clark, 2006) or grounded theory (Charmaz, 2009).

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SECTION B**Connie Geyer BSc (Hons), MA, Grad Dip**

Discovering “new ways of being” in interpersonal space:

A grounded theory of change of people diagnosed with borderline personality
disorder

Word count: 7996 (plus 163 additional words)

Abstract

Objectives: The objective was to explore personal experiences of change of people diagnosed with borderline personality disorder (BPD) who had partaken in psychological therapy. The aim was to develop the first model of change grounded in service user experience so that this could inform recovery-oriented practice in relation to this client group.

Design: A constructivist grounded theory design was chosen.

Methods: Eight people with a diagnosis of BPD who had completed group-based therapy programmes or were currently attending a peer support group were interviewed about their experiences of change using a semi-structured, open-ended format. An initial model was developed and refined through triangulation with three published accounts of experiences of change in the context of a BPD diagnosis.

Results: 'Discovering "new ways of being" in interpersonal space' was conceptualised as the core process underpinning pertinent activities and experiences relating to change in people diagnosed with BPD. This interactive, relational process was facilitated in environments that were felt to be both containing and open to conflict. It involved increasing levels of self-disclosure, information exchange, exploration of mental states, experimentation with new behaviours and the consolidation of new ways of being. The core process appeared to extend beyond the therapeutic setting if supported through a relationship with a secure base.

Conclusions: Regardless of therapeutic allegiance, effective interventions for people diagnosed with BPD might share a common core change process. Further research is required into change processes in the context of individual psychological therapies and negative therapeutic experiences.

Introduction

All psychological therapies aim to facilitate change so that the impact of mental health difficulties on the person's life lessens and new possibilities for being can develop. However, little is known about how people diagnosed with BPD experience change in the context of psychological therapy. Historically, people diagnosed with BPD were considered resistant to change and untreatable. This instilled hopelessness and pessimism among clinicians and service users and led to BPD being a controversial label, associated with negative attitudes from mental health staff (Markham, 2003), heightened self-stigma and shame (Rusch et al., 2006) and rejection by mental health services (National Institute of Mental Health in England (NIMHE), 2003). However, as the following sections will show, this position has become ethically unsustainable and empirically unwarranted. It will be argued that the development of new, BPD-specific psychological therapies necessitates qualitative research into how people diagnosed with BPD experience change in the context of psychological therapy. Such research could help generate a model of change, which is grounded in service user experiences and which could inform clinical practice and service evaluation against service user-valued changes.

The difficulties associated with BPD

People who meet diagnostic criteria for BPD are thought to have severe difficulties in relating to themselves and others and in effectively regulating their emotions and behaviours (Sanislow et al., 2002). These difficulties are common, affecting approximately four per cent of the primary care population (Grant et al., 2008). They cause great emotional suffering, ending in suicide for up to ten per cent of those with a diagnosis (Paris & Zweig-Frank, 2001). Those who survive often do so by managing their distress in desperate ways, including self-harm, substance

misuse and risky sexual behaviours (Levy et al., 2006). Public expenditure for related treatments is significant (Bohus & Kroger, 2011) but not necessarily cost-effective (Fonagy & Bateman, 2006). Given the high prevalence, suffering and economic cost involved, the difficulties of people diagnosed with BPD cannot be ignored. This is now acknowledged in a number of key policy documents, most notably "Personality disorder: no longer a diagnosis of exclusion" (NIMHE, 2003).

Evidence of change in people diagnosed with BPD

Important developments in research and psychotherapy have facilitated changing perceptions in relation to BPD. Since the 1980s findings from longitudinal studies have repeatedly refuted the assumption that people diagnosed with BPD cannot change. Ten years from inpatient admission, 50 per cent of people previously diagnosed with BPD were found to no longer meet diagnostic criteria, be in full-time employment and have at least one emotionally sustaining relationship (Zanarini, Frankenburg, Reich & Fitzmaurice, 2010). Sixteen years on, only one per cent continued to meet diagnostic criteria (Zanarini, Frankenburg, Reich & Fitzmaurice, 2012). These findings led to a reconsideration of the poor psychotherapy outcomes that had previously been reported (McGlashan, 1986). Rather than attributing poor outcome to service user characteristics, clinical academics came to understand that standard interventions had caused iatrogenic effects because they had not been tailored to the particular difficulties and needs of people diagnosed with BPD (Fonagy & Bateman, 2006).

The development of BPD-specific psychological therapies

The recognition that standard treatments could cause more harm than good fostered renewed interest in developing effective, BPD-specific psychological interventions. Since the 1990s, two psychological therapies have gained particular

prominence and are currently recommended by the National Institute of Clinical Excellence (2009): mentalization-based treatment (MBT; Bateman & Fonagy, 2006) and dialectical-behaviour therapy (DBT; Linehan, 1993). Both therapies are backed up by a growing body of research, which has shown that they are effective in reducing problem behaviours that are thought to be characteristic of BPD (Stoffers et al., 2012). These include self-harm, suicidality and higher than average health care utilisation such as frequent hospital admissions and presentation at emergency services. The findings of effectiveness research into BPD-specific psychological therapies have contributed to increased availability of suitable treatments for people diagnosed with BPD and will hopefully promote a better understanding of their difficulties by mental health professionals.

Knowledge gaps

However, there remain significant knowledge gaps in relation to BPD-specific psychological therapies and service users' experiences of these. Since BPD-specific psychological therapies are relatively new, the focus of research has been on randomised control research to demonstrate effectiveness in relation to the most acute problem behaviours associated with BPD. This behavioural focus has come at the expense of qualitative research into psychosocial processes of change in the context of therapy. To the author's knowledge to date only two studies have qualitatively investigated service user perspectives on recovery in relation to BPD, although not specifically in relation to psychological therapy (Holm & Severinsson, 2011; Katsakou et al., 2012). Both studies found that service users aspired to build self-confidence, improve relationships and pursue personally valued activities. However, neither study investigated the experiential processes by which individuals came closer to achieving these goals. As a result, it remains unknown how service users

experience personally meaningful changes in the context of psychological therapy. A number of theoretical and clinical knowledge gaps have arisen as a result of this.

Kabir and Wykes (2010) argue for the inclusion of 'user-valued measures' in randomised control research, as this type of research currently drives health care guidance in the UK but is not systematically informed by service user views. They define user-valued measures as those that the majority of service users would consider to be relevant to their predicament and to their expectations of services. In the absence of such measures in relation to BPD, I would argue that qualitative research is required into what constitute user-valued changes in the context of BPD-specific psychological therapies.

In contrast to psychosis (e.g. Dilks, Tasker & Wren, 2008), there is no existing theory or model of therapeutic change processes in relation to BPD grounded in lived experience. BPD-specific psychological therapies are underpinned by theories of how difficulties might develop and change, most notably mentalization theory (Bateman and Fonagy, 2006) and biosocial theory (Linehan, 1993). However, these theories are not systematically grounded in service user experiences. Recent research suggests that increased reflective function, defined as interpreting the behaviours of self and others as motivated by underlying mental states, is implicated in BPD-related change processes in transference-focused psychotherapy (TFP), MBT and DBT (Goodman, 2013; Levy et al., 2006). While this area requires further research, it seems possible that 'reflective function' is an 'experience-distant', abstract concept. The development of a theory or model of change, which is grounded in service user experiences, could enrich, add to and potentially refine current hypotheses of change as embedded in the main therapeutic approaches.

Rationale for the present study

The objective of this study was to investigate service users' personal experiences of change and as a result of this, to develop an understanding of shared and substantive change processes of individuals who have had psychological therapy for BPD. The overall aim was to construct a model of change grounded in service user experiences. To the author's knowledge, such a model or theory does not yet exist and could make an important contribution to theoretical developments in the field and to the planning, delivery and evaluation of BPD-specific interventions against service user-valued changes. The research questions were:

- 1) What kinds of changes did service users experience in the context of psychological therapy (both negative and positive)?
- 2) What were service user-valued changes?
- 3) What factors contributed to these changes?
- 4) What impact did these changes have on the person?
- 5) How could personally valued changes be supported/ promoted by services?

Eight people diagnosed with BPD were recruited from three London-based mental health services and interviewed individually using a semi-structured, open-ended format. Data was analysed using constructivist grounded theory methodology (Charmaz, 2009). An emerging model of change was developed and conceptually refined through triangulation with three published accounts of recovery experiences in relation to BPD.

Methodology

Participants

Convenience samples of individuals diagnosed with BPD were recruited from three London-based NHS outpatient psychotherapy services: a specialist mentalization-based service (n=3), a twice-weekly group-psychoanalytic service

(n=2) and a peer support network (n=3). The MBT service offered treatment for 18 months; the group-analytic service for 12 months, the service user support network was on-going and met four times weekly. Eight service users (three female, one gender-ambivalent; six white British, one Middle-Eastern, one black British) with a mean age of 47.5 years (range 21-55) were interviewed individually about their experiences of change in the context of psychological therapy. They had completed intensive psychological treatment in one of the therapy services or were currently attending the peer support group. All were unemployed at time of interview (see Appendix 4).

As participants came from a small number of group-based services within the same Trust, data was diversified using triangulation (Charmaz, 2009). An Internet search of published service user accounts of experiences of change in the context of a BPD diagnosis was undertaken. Three accounts were added to the analysis because they described experiences of different therapeutic modalities (DBT, individual psychoanalytic psychotherapy) and were self-generated as opposed to researcher-initiated. The accounts were read, paying particular attention to differences and similarities between emergent themes from the research interviews. This helped refine and elaborate categories until thematic saturation was reached.

The opportunistic sampling strategy and self-selection of services and individuals, including volunteering for interview or publishing one's experiences, may have introduced bias towards a more articulate sample with more positive experiences of psychological therapy than may be the case for the wider population of service users diagnosed with BPD.

Ethics

Ethical approval for the study was granted by the National Research Ethics Service Committee London - Camden & Islington (Appendix 5). Approval to conduct the study in a local Trust was obtained from the relevant Research and Development department (Appendix 6). The study adhered to the British Psychology Society code of ethics and conduct (BPS, 2009).

Method

Constructivist grounded theory methodology (Charmaz, 2009) was chosen because it is recommended in areas where there is little pre-existing theory and where psychosocial and group processes require elucidation and synthesis into a model. A constructivist epistemology was adopted because it acknowledges that the researcher does not discover objective facts but rather actively participates in the construction of 'situated knowledges' (Haraway, 1988). Reflexivity about knowledge construction was particularly indicated as the research focused on a group of service users whose difficulties have been linked to environmental invalidation of their experiences (Bateman & Fonagy, 2006; Linehan, 1993).

Design

Common and substantive processes of change were explored using a constructivist grounded theory design (Charmaz, 2009). This involved:

- 1) Individual, qualitative interviews and conjoint data coding
- 2) Development of an emerging model based on the 'constant comparative method' (Glaser & Strauss, 1967) and 'memo writing' (Charmaz, 2009)
- 3) Triangulation with three published accounts on recovery in relation to BPD to refine and develop the model
- 4) Saturation of themes enabled development of the final model

Interview schedule

An interview schedule was designed specifically for the project and in consultation with service users from participating services. It contained twelve open-ended questions (Appendix 7). The schedule provided a general framework for the interviews and allowed for adapted or additional questions in response to participants' individual answers. This helped explore participants' personal experiences and generate rich data.

Procedure

Five NHS services specialising in treatment for people diagnosed with BPD were approached between November 2011 and January 2013. Four services agreed to take part; three services yielded participants. Clinical members of staff identified service users who met the following eligibility criteria:

- BPD diagnosis
- Over 18
- Capacity to consent
- Proficient in English
- Having completed psychotherapy (for those recruited through a psychotherapy service)

Recruitment took place between October 2012 and December 2013. During an informational meeting, potential participants were informed about the research verbally and in writing (Appendix 8) and had the opportunity to ask questions. Informed consent was obtained separately (Appendix 9). Eighteen individuals were approached, eight agreed to participate. Although there were no drop-outs, arranging interviews took considerable time and rescheduling. Given the time constraints, recruitment therefore had to stop at eight participants although the original target had been twelve.

Interviews (range = 51 to 131 minutes, mean = 84 minutes) were held in confidential NHS settings in autumn/ winter 2012 and concluded with debriefing and risk management as required.

Triangulation was motivated by the following questions:

- 1) Might there be contextual factors, which impinge on experiences of change, such as treatment modality or format?
- 2) Does the emerging model fit with accounts of change that were self-generated by service users rather than initiated through a research interview?

A google search of the search terms 'service user account', 'BPD', 'borderline personality disorder', 'memoir' and 'change' yielded two published books (Reiland, 2004; van Gelder, 2010). These described personal experiences of psychoanalytic psychotherapy and DBT respectively. A third account (Anonymous, unknown) was included because it elucidated experiences of change in the context of inpatient treatment.

Data analysis

Interviews were audio-recorded, transcribed verbatim, line-numbered and fully anonymised (Appendix 10). The analytical process involved initial and focused coding, category and sub-category development and triangulation to diversify data (Charmaz, 2009). Published accounts were read and re-read, paying particular attention to similarities and differences to the themes generated from interview data. A reflective journal and research memos provided an audit trail of the analysis and helped bracket researcher preconceptions (see Appendices 11/12).

Initial coding. Four interview transcripts were coded line-by-line in QSR NVivo 9 because they reflected a range of experiences (therapy; life experiences) and characteristics (gender, age, ethnicity), which could potentially be relevant to

understanding different experiences of change. Line-by-line coding produces richer codes than thematic analysis, facilitates close engagement with participants' worldviews and tacit assumptions and reduces the likelihood that researcher preconceptions are imposed on the data (Charmaz, 2009). Following Glaser (1978), I coded data by using gerunds to maintain a focus on participant actions and processes, e.g. accepting change or turning anger inwards. There were 1915 unique initial codes.

Focused coding. Using a frequency count and the constant comparative method (Glaser & Strauss, 1967), initial codes were reviewed to establish what appeared to me to be the most conceptually significant codes (Charmaz, 2009). Consistent with a constructivist framework these decisions opened up particular analytic avenues while foreclosing others. One-hundred-and-nineteen focused codes were derived from this process (Appendix 13).

Category and sub-category development. Focused codes were checked back against the data and elaborated, challenged and synthesised through analytic research memos (Appendix 12). This gradually enabled development of categories and subcategories relating to substantive processes and patterns (Appendix 14). Relationships between categories and sub-categories were conceptualised, resulting in a preliminary model of change.

Triangulation. The initial model was checked and refined through triangulation with three published accounts of recovery in relation to BPD, resulting in the final model.

Quality assurance

A psychologist experienced in grounded theory methodology supervised the project. It was incompatible with a constructivist epistemology to seek 'validity' checks of codes from supervisors, colleagues or research participants. However, I

reviewed my coding with supervisors and a peer research group and reflected on the impact of my engagement with the data on coding and theory development. To this effect, I also kept a reflective research journal and analytic memos. Ultimately, the reader has to decide whether the generated categories and model appear to be grounded in the data and 'work' (Glaser, 1978) to succinctly conceptualise key social-psychological processes.

Results

A model was developed to capture common and substantive processes of change experienced by people diagnosed with BPD in the context of therapeutic programmes. Given that all interview participants and two of the three sampled service user accounts described experiences in groups, the final model predominantly applies to experiences of change in and arising from group contexts. However, there was some indication that interpersonal experiences were also a key condition for experiences of change in the context of long-term individual psychotherapy:

My recovery was not an individual effort but was only possible with the help of more great people than I could ever list. (Reiland, 2004, p. xiii).

Therefore, many of the processes captured in the model might also promote change in the context of individual interventions. The final model is presented in Figure 1. Throughout, interviewees and service users who published their experiences are referred to as "participants". **Categories** are indicated by bold font, subcategories by underlining, *features of subcategories* by italics, and "in vivo" quotes by quotation marks.

The model

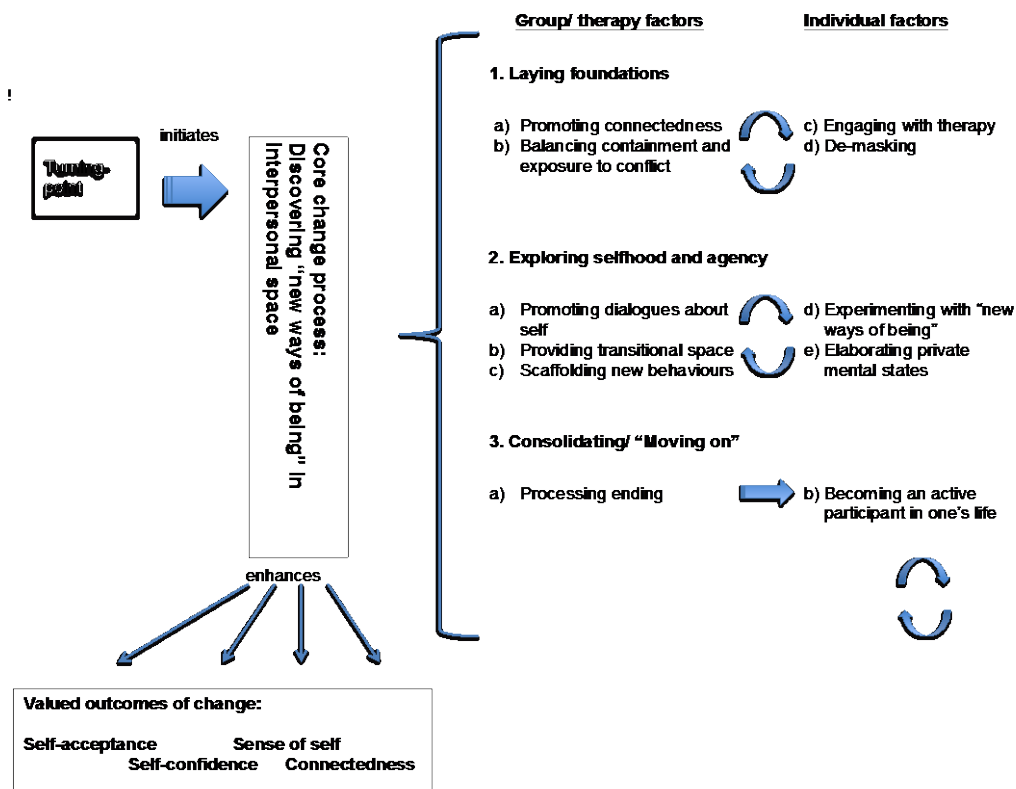


Figure 1. Discovering “new ways of being” in interpersonal space

In the final model, ‘Discovering “new ways of being” in interpersonal space’, was defined as the core process underpinning key experiences and activities relating to change. Activities relating to change occurred at the level of the therapy/ group and the individual, and interacted with each other. The central change process arose in therapeutic contexts but appeared to generalise beyond these. Thus, the model reflects a tension between linear experiences of change in the context of group-based programmes with a beginning, middle and end on the one hand, and participants’ parallel experiences of change as a set of on-going, reciprocally influential processes that could extend beyond group programmes. Each aspect of the model will be defined and illustrated with quotes.

Turning-points

Turning-points were defined as subjectively meaningful life experiences that facilitated a desire for change. The category embraced experiences of change in general rather than change specifically in relation to services and therefore does not have direct implications for services. However, it helpfully illustrated the wider context of experiences of change throughout life as experienced by the research participants. Participants identified memorable life experiences, which alerted them to their need and wish for help and enabled them to constructively engage with mental health services and group-based therapeutic programmes for BPD in particular. Frequently, **turning-points** were negative experiences such as lack of progress in standard mental health treatment, being confronted with uncaring attitudes from mental health staff or being in crisis, the impact of which the following quote summarises:

When you're so low there, there is no more, no further to go, that's the rock... rock bottom, that's when you hit rock bottom, that's when you realise you have to change. (P1, lines 1172-1175)

However, there were also examples in which concern from trusted others initiated a desire for change and engagement with services:

[Friends] just got so concerned and they said, "Have you ever seen a psychiatrist?" and I said, "No, why?" And they said, "I think you ought to see one" and then that was it. (P4, lines 88-91)

While turning-points could initiate change, change itself was experienced as an on-going and demanding process:

You know people need time to recover and they need the space and the time to slowly alter their thinking and their behaviour. (P2, lines 134-136)

The core change process

The on-going core change process was conceptualised as 'Discovering "new ways of being" in interpersonal space'. It involved experiences of self-exploration and growth of people diagnosed with BPD who partook in specialist, group-based therapeutic programmes. Discovering "new ways of being" was understood as an intrinsically relational and interactive process in which participants observed each other, shared viewpoints and advice, and based on this, began to experiment with "new ways of being" (P8, line 982). It was highly valued because it enhanced self-acceptance, self-confidence and sense of self:

The most important change probably is, I know this sounds really cheesy [...] but I kind of know myself a bit better now. (P3, lines 125-127)

I never accepted myself for who I am. You know, and I'm walking down... I came out of the station and I looked and I saw my reflection on the glass, I thought, "Oh wow you look good. You look alright". I've never done that all my life, I hated myself; I really hated myself. (P1, lines 251-256)

Change is confidence, real big, big major change. And uhm not letting my family particularly walk over me. (P6, lines 5-6)

However, self-discovery also entailed an increasing responsibility toward oneself, which did not end with therapy and could feel demanding at times:

I've been given a sense of my own identity and the therapy hasn't, hasn't solved that, it's given me an awareness of it and now I've got a lot of hard work that I have to do constantly to uhm keep my own mind, know the boundaries between myself and other people. (P8, lines 202-205)

Therefore, the core process was understood to arise in group-based, and possibly individual-based interventions but to then become internalised and generalise to other contexts. Three distinct but reciprocally influential major categories appeared to feed into the core process. These were conceptually summarised as: 1. **Laying foundations**, 2. **Exploring selfhood and agency**, and 3. **Consolidation/ "Moving on"**. Each process consisted of group level activities and individual level activities, which interacted with each other.

1. Laying foundations

This process consisted of both group and individual level activities that laid the foundations on which the work of 'Discovering "new ways of being" in interpersonal space' could take place. It was particularly pronounced at the beginning of therapy but continued throughout.

Group level activities

Promoting connectedness. Therapeutic groups were experienced as offering a sense of belonging, interpersonal connectedness and acceptance that had previously not been consistently available to participants. In the context of the group, participants

compared themselves to others and discovered similarities between self and other that had previously not been recognised:

The more I go to the group, the more I find out I'm like these people. (P7, line 16-17)

This really is like family here for me. (P6, line 631)

It works because of the quality of the relationships because coming here is like coming home. Because I'll never be judged or turned away or rejected or left. (P8, lines 375-377)

Balancing containment and exposure to conflict. A balance between emotional containment and interpersonal conflict promoted possibilities for change, whereas imbalances in this area could lead to withdrawal and disengagement. Groups contained emotional distress by acknowledging it without judgment and by promoting individual ways of coping:

I am very lonely. If I didn't have the group, I would probably be dead by now. (P7, line 275-276)

It wasn't like anyone was like, "Oh P3! You are crying in front of other people? Oh my gosh!" because that would have made things worse. But it just kind of slightly shoved a box of tissues in my way and then you have to deal with it. It turned things on its head. (P3, lines 548-552)

Although working with conflict appeared to be a more central experience of group-analytic participants than MBT and peer support participants, disagreements were a vital part of groups and if explored sensitively, enabled participants to challenge long-held beliefs about themselves and others:

I look at them and say, “you know what, they’re doing this because they’re aggressive, they’re violent”. But it’s not that, it’s just a normal disagreement between people. (P1, lines 323-327)

Suddenly I was messing up and I had to bring it back into the group and get all the judgement and the “who do you think you are” and um, “you took advantage of her” and I was you know, really um determined not to have that because it was the role playing like “you’re a man, you should know better” and I was saying, “No! I was as vulnerable as her. We were both vulnerable, we both recognised that we made a mistake.” (P2, lines 671-677)

Thus it appeared that exposure to conflict could promote tolerance for difference and disagreements, increasing self-knowledge and the ability to assert oneself. However, balancing containment with conflict was a difficult process, which could foster avoidance and withdrawal. For example, P5 felt that he had to “pull out of the group for a while” (line 438) because:

It's been said about how to be non-judgmental but I find as time is going by I'm becoming more and more judgmental about what my views are on certain issues. (P5, lines 435-437)

P5 did not seem to feel safe enough to share his views in the group and this seemed to link to difficulties in engaging in an individual level activity, De-masking, which will be described shortly.

Individual level activities

Engaging in therapy. This involved acknowledging ambivalent feelings about therapy and taking a considered risk in the hope that more good than bad would come from it:

I was utterly engaged before we started. My one horror really was that they would reject me and not want me on the course. (P8, lines 143-145)

I felt really frightened going there because I didn't, hadn't been there, people had been there loads of times, and meeting all new people that I didn't know and all that, but it was great! (P6, lines 367-370)

Some participants seemed to test whether they would be turned away. However, a combination of personal openness and environmental containment seemed to enable participants to settle into their respective programmes:

I think two or three days after I started I relapsed and I couldn't... I didn't tell them or anything, talk about it at first then I talked about it afterwards when I started the big programme I started to talk about everything. (P1, lines 1037-1040)

I tried so hard to push everyone away and no one went. (P3, line 385)

De-masking. Some participants used the metaphor of the "mask" to describe how they had tended to interact with and present themselves to others:

I mask my true feelings [...]. I prefer people to only know what I want them to know so no one can truly say to me, "I know you". (P5, lines 176-182)

A lot of my life has been about playing a role uhm and I went from one place and set of people, social groups, professional groups, and I presented myself entirely to suit them, entirely. (P8, lines 198-200)

Being part of a group challenged participants to relinquish preferred public presentations of self and to begin to reveal themselves to others:

So all those masks end up falling on the floor - all the polite and "I'm nice" and "I'm this" and "I'm a wonderful...", all that just disappears and you end up seeing the person stripped, which is a very vulnerable and a very... it's not a dignified situation to be in but it's really important if you've got emotional trauma you need to recognise (P2, 634-639)

I managed to open up to people and it wasn't like the worst-case scenario. Nothing really bad happened. (P3, lines 537-538)

De-masking also occurred in individual therapy ("I'd gone in intending to pierce his façade, and instead he had gently unveiled mine." (Reiland 2004, p.33)). It could be described as a process by which private aspects of the self were gradually shared with others. Such revelation was required to open up possibilities for 'Discovering "new ways of being" in interpersonal space'. It therefore facilitated

another element of the core process, **Exploring selfhood and agency**, which will be described shortly.

Group/ individual interactions

It seemed that positive experiences of the group, including its capacity to balance containment and exposure to conflict, promoted engagement with therapy and with interpersonal differences. This facilitated self-disclosure. In turn, participants' increasing openness and engagement enhanced the safety and containing functions of the group. Conversely, imbalances between containment and conflict could result in reinforced masking and disengagement and limit scope for **Exploring selfhood and agency**.

2. Exploring selfhood and agency

This category describes how group members actively wrestled with issues around selfhood, agency and how to bring these into their relationships with each other. "New ways of being" were developed, tested and refined in interpersonal settings, thereby widening participants' behavioural repertoire and scope for action.

Group level activities

Promoting dialogues about the self. This was defined as a co-constructive activity by which participants entered into conversations about themselves with each other and explored selfhood and possibilities for change:

Well a lot of me, a lot of me changed because I know, basically when I got into having things like therapy and all that, that changed then because I think a lot of time you know people need...I don't think they get a chance to talk about things (P4, lines 157-161)

It is for the first time in my life I had to sit with all these people and speak about myself... (P1, lines 772-774)

Talking about the self was not a monologue, however, and involved the active and constructive involvement of at least two parties. For example, it contrasted with experiences of receiving a diagnosis: “‘Personality disorder’, it just was, just a judgement of my whole self”, (P8, lines 340). Talking about the self involved the dialogic involvement of trusted others who challenged dominant perceptions of self and enabled thinking about the self in a “multidimensional way” (P3, line 228):

... Have I thought about it from a different angle and that’s what I really wanted out of a therapist all this time. I didn’t want, “poor you”. I wanted someone to sit there and think about it another way because I’ve gone over these things in my head so many times. Sometimes that’s all I could do. Just sit there, stare at the wall and just think. (P3, 219-223)

Providing a transitional space. Groups provided a non-judgmental transitional space, in which different parts of self could be playfully explored and experimented with without needing to become fixed. The examples of two participants who experimented with name and gender identification changes respectively, illustrates this:

I’ve been going from my first name back to my chosen name back to my first name. The facilitators are all confused when they see me now. When I saw the

OT earlier he asked, "Who are you today?" I said, "You'll find out in my check-in" [laughs]. (P5, lines 344-348)

They're a very non-judgemental group of people and I fit myself in there when I'm there. Uhm, they've been very cool about my change from [male] to [female] Uhm, they listen. They try to help. If they don't know how to help, they just offer support, which can sometimes be enough to tip you, to go in the right direction rather than the wrong direction. (P7, lines 255-261)

Scaffolding new behaviours. Group members supported each other by drawing on their personal experiences and offering advice, as illustrated by the P7 quote above. This promoted experimentation with new behaviours, which were tested out and, depending on their usefulness, discarded or incorporated into participants' behavioural repertoire:

I've been told so many times about the elastic band, the red biro, the ice cubes and that stuff didn't work for me. But if, if someone says, "Have you tried throwing a pear against a wall?" and it's like, "No I haven't because it's messy". "Well yeah, if you think about it, you can clean up the pear but it's really hard to clean up kidney damage and scars and all the rest of it" so it did work (P3, lines 334-339)

The above quote illustrates that reciprocity was inherent in scaffolding behaviours. Thus, the interactive nature of this process is highlighted. Scaffolding was

closely linked to the individual level activity, Experimenting with “new ways of being”, which will be described below.

Individual level activities

Experimenting with “new ways of being”. This involved active engagement with new information and testing this out and integrating it in a way that felt helpful and genuine to participants. For example, P7 thought of himself as bad, but members of his support group said he was kind. Although he argued that, “for the life of me I can’t see myself in that description,” (lines 113-114) he experimented with relating to himself as if this description was true. He found that this helped him to refrain from self-harming and avoid hospital admission. Similarly, P6’s therapist and drama therapy group scaffolded assertive behaviour so that she could evict an unwanted houseguest. She went home and tried out what she had practiced in therapy. When “it wouldn’t work what [Therapist]’d done” (line 252-253), she actively drew on assertiveness skills that she had acquired in therapy and found her own way of evicting the guest. Experimenting with “new ways of being” was therefore not a process of copying others. It was an active process of engaging with new information from others and using this to construct ways of being, which felt true and empowering to the self.

Elaborating private mental states. This was defined as a process by which participants showed curiosity about their internal world, increasingly elaborated private mental states and thereby widened their choices and realm of action in relation to thoughts, feelings and impulses. It involved the gradual tolerance of unwanted feelings and acknowledgement of mixed feelings towards self and others:

If someone had said to me 18 months ago that I'm an angry person I would have got angry and I would've just kind of like flipped out a bit. [...] Whereas now I can say, "Yeah I was a bit angry wasn't I" uhm but it's also about acknowledging good aspects as well. (P3, lines 145-149)

By distinguishing between thoughts and intentions for action, participants seemed to create emotional distance from distressing thoughts and widen their choices and scope for action vis-à-vis feelings, thoughts and impulses:

It's only a thought you know it's going to go away. [...] If I walk by a pub one day and it crosses my mind to have a drink, I look at the pub there and say, "oh to hell with it not now, leave it". So it's a thought just the way, you know you find a way to deal with that thought. (P1, lines 543-551)

Group/ individual interactions

Dialogic engagement with the self invited participants to consider different ways of being, scaffold new behaviours and experiment with "new ways of being" in the safety of the group before taking this into the outside world. Experimentations with new ways of being could be shared in the group and therefore reinforced dialogues about selfhood and agency. The group setting seemed particularly suited to observation of others and by doing so, enabled participants to step out of immersion in their own experience and elaborate their own mental states:

It's always easier to look at someone else's issues because you're not emotionally involved so you can kind of clearly understand what's going on.

So it was always useful to come into a place where there's other members going through similar things but you, because you've got a bit of perspective and a bit of distance you can see them screaming and shouting and swearing and you think okay so when I've done it, it's difficult to understand why I'm doing it. (P2, lines 137-145)

3. Consolidating/ "Moving on"

This aspect of the core process focused on consolidating learning and "moving on" and into life beyond therapy where applicable:

I've acknowledged the things that have happened, I've digested it, I've analysed it, I've thought about it, I've twisted it, I've turned it and I've digested and I am moving on and that's kind of the place I am at the moment. (P3, 783-786)

Within the study sample, there was a notable difference between participants who had attended formal therapy and those who were members of the on-going service user support group. For the former, "moving on" entailed ending therapy i.e. reducing interpersonal support. For the latter, "moving on" was a process, which continued to be supported by the group.

Group level activities

Processing ending. This was defined as a collaborative process by which the group/therapists and participants jointly thought about and managed the ending of therapy and the disturbing feelings this stirred up:

Even talking about [ending] was different for me, because I just ignore it, ignore it, ignore it, until I fall off the edge of a cliff. So there was a sort of a gradual kind of uhm not even acceptance but just acknowledging that it was there and thinking with [the therapist] about different ways of managing it. (P8, lines 873-877)

He had found a way to reassure me that my disturbing feelings [about ending] were short-lived, that my progress had not been lost. (Reiland, 2004, p.414)

Individual level activities

Becoming an active participant in one's life. Participants began to actively create opportunities for self-discovery and “new ways of being” beyond therapy and group settings, suggesting that this was an important process initiated in a therapeutic context but transcending it. Importantly, it seemed to have self-reinforcing properties that promoted positive changes in spite of on-going difficulties, as a quote from a service user account illustrates:

My life continues to be filled with many struggles [...]. But I am in recovery. I have reason and purpose. I have a life worth living. I have family and friends. I have security, community and a sense of belonging. [...] I have hope because I have too much to lose. (Anonymous, p.6)

Becoming an active participant in one's life consisted of a number of activities:

- *Drawing on therapy experiences.* Participants internalised and drew on their therapy experiences. This seemed to aid on-going self-discovery through internal dialogue and a sense of connectedness:

I know what [my therapist] would say, you know. So, and then I say, “yeah but” you know and then I will come out with what I need to do or need to say you know. And it is really, really helpful. (P6, lines 651-657)

The therapeutic relationship has come to an end but I carry her with me.
(P8, lines 843-844)

- *Making space for enjoyment.* Engaging in creative and fulfilling activities provided on-going opportunities for participants to discover and experience themselves in new ways:

I love [pottery]. I do. I lose myself. You know, my mind, I forget everything when I'm doing it. I just forget who I am or any of my problems, or anything when I'm in the work. (P6, lines 869-872-872)

Towards the end of the therapy here I started to be a bit more uhm empowered in myself. And to feel you know yeah I can do things and I can do them for myself, for enjoyment, not just to please somebody else. (P8, lines 658-661)

- *Becoming a mental health advocate.* Six of eight participants became or wanted to become mental health advocates, suggesting that sharing one's experiences with

others in a helpful way was a way of continuing to discover “new ways of being” in interpersonal spaces beyond therapy. It also seemed to represent a wish to facilitate this change process in others:

I still go to meetings and I speak about how I feel about drink or drugs and I speak about how I feel mentally and my depression and things that bring it out, because maybe 60 or 70% of the people sitting in that room they actually suffer from some kind of mental illness. (P1, lines 1083-1088)

I would like to work for a mental health charity cos they've done so much for me in the past [...] that I would love to help them dish out some help to other people (P7, lines 508-511)

However, there was also indication that mental health advocacy roles posed their own challenges in relation to negotiating selfhood, agency and responsibility towards self and other, and that this could impede self-discovery in other arenas:

In many senses it feels worthwhile, but the balance is tipping too heavily in the direction of exhaustion, and I'm also starting to feel trapped. I don't want to be the borderline poster child forever. (van Gelder, 2010, p.174)

I think working for the Trust does put me in a difficult position uhm with the service here uhm because I desperately want the service to continue as it is for other people and to benefit people in the way that it has benefitted me. (P8, lines 770-774)

- *Taking responsibility*. Participants committed to responsibilities such as managing finances, looking for work and renting a property. This seemed to be an outcome of having discovered responsible ways of being as well as an on-going process of wanting to build on these:

[Renting a flat] brought out a responsibility, which I never had before.

(P1, lines 398-399)

If I want something I can buy it. If I haven't got the money, I can't have it. That's how I look at life now. (P5, lines 519-520)

Taking responsibility also extended to one's mental health, acknowledging on-going difficulties and seeking help for these where required:

I thought I was *that* past it. I'm not *that* past it. Uhm, I'm not a 100% recovered or anything like that. I'm recovering, kind of thing. (P3, lines 800-802)

Eighteen months [of therapy] is not really long. You know. But I've applied to [a non-statutory psychotherapy provider]. (P6, lines 304-306)

Discussion

A constructivist grounded theory analysis suggested that 'Discovering "new ways of being" in interpersonal space' was a core process underpinning experiences of change of people diagnosed with BPD who had participated in group-based

therapeutic programmes. This interactive, relational process was facilitated in environments that were felt to be both containing as well as open to conflict. It involved increasing levels of self-disclosure, information exchange, exploration of mental states, experimentation with new behaviours and the consolidation of new ways of being. The core process extended beyond the service context but in the majority of cases appeared to be facilitated through on-going contact with services. The following section will discuss the findings in relation to the existing literature and highlight clinical and theoretical implications. Thereafter, strengths and limitations of the research will be considered.

Service user-valued changes were not restricted to improvement in clinical 'symptoms' but included broadening horizons so that new ways of being could continuously be explored and consolidated. This is consistent with the concept of personal recovery (Slade, 2009), which holds that recovery is an on-going process of personal growth despite the setbacks and limitations posed by mental health difficulties (Anthony, 1993).

An important finding of the study was that common change processes could be identified across a range of therapeutic modalities. This suggests that despite a current political drive towards enfranchisement of BPD-specific therapies, a range of interventions can initiate common and service user-valued change processes, provided that they offer opportunities for self-discovery and experimentation with selfhood in interpersonal settings. Triangulation with service user accounts suggested that the core process might also be relevant to those undertaking individual psychotherapy. However, further research is required to investigate whether additional and/ or other processes occur in this context.

The study suggests particular BPD-relevant 'user-valued measures' (Kabir & Wykes, 2010) that could be used to inform outcomes research. Self-acceptance, including acceptance of on-going difficulties, appeared to constitute an important indicator of personal recovery and of therapeutic effectiveness from a service user perspective. At present, increases in self-acceptance are not systematically assessed as part of effectiveness research of psychological therapies for BPD. Self-acceptance measures such as those outlined by Blascovich and Tomaka (1991) could be included in future randomised control trials and service evaluations to assess service performance against user-valued outcomes and changes.

Although the findings of this study indicate that 'Discovering "new ways of being" in interpersonal space' was an increasingly self-reinforcing process that transcended therapeutic contexts, it also appeared that it was supported by on-going contact with services, for example through advocacy roles or support groups. Empirical research supports the notion that a 'secure base' (Bowlby, 1988) is necessary for the development of independence (Allen et al., 2003). This suggests that phased discharge and opportunities for reciprocal relationships, for example through service user involvement, may be central to change processes in people diagnosed with BPD.

It seemed to the author that the centrality of 'Discovering "new ways of being" in interpersonal space' for people diagnosed with BPD has important implications for psychological practitioners. Social theorists have argued that postmodern individuals actively use 'technologies of the self' to continuously construct and re-construct themselves, and that the 'psy' disciplines have established themselves as powerful experts in the development and dissemination of such 'technologies' (Rose, 1996). Self-construction and developing self-knowledge

appeared to be acutely pertinent to people diagnosed with BPD. The findings of this research suggest that the core change process hinged on a dialogic, collaborative approach rather than an expert-driven approach. Indeed, an expert-driven approach might reinforce what participants described as wearing 'masks'. Positively experienced therapeutic conditions appeared to be those that allowed for active engagement in the process of self-construction. Group settings might therefore be particularly suited for people diagnosed with BPD, as they limit the use of 'psy' expertise and encourage peer-oriented, collaborative discoveries of new ways of being. However, further research into differences between individual and group-based programmes for people diagnosed with BPD is required to explore this point.

Strengths and limitations

To the author's knowledge, this study was the first to develop a model of change that is grounded in the experiences of people diagnosed with BPD. Therefore, it makes an important empirical contribution to largely theoretical debates about change in relation to BPD. A further strength was that it spanned different therapeutic modalities (MBT, group-analytic, support groups, and through triangulation also DBT and individual psychoanalytic therapy). Most research in the field focuses on one BPD-specific therapy at a time, obscuring possible overlaps and commonalities between them. The fact that it was possible to identify common and substantive processes of change across these modalities challenges assumptions of difference between BPD-specific therapies, which currently drive their enfranchisement in research and the NHS.

The constructivist approach of the research acknowledges that the developed model represents one of many possible interpretations of the data, one that arose in

interaction between these research participants and the author. Therefore, it opens up a debate rather than providing a conclusive theoretical model of change processes.

Limitations were the small sample size, opportunistic sampling and that interviewees were recruited from the same NHS Trust. This increased the possibility of selection bias. It might be that services and service users with particularly positive experiences volunteered to take part and that change processes may be experienced differently by those with more negative experiences.

A further limitation was that all but one account were based on experiences in groups. Although there was some suggestion from triangulation that similar processes may be involved for people undertaking individual therapy, the model as it is cannot be generalised to this context. Triangulation could have been more extensive but this was not possible due to time constraints.

Implications

The study has a number of clinical implications:

- Regardless of therapeutic allegiance, clinicians can promote service user-valued changes by creating interpersonal opportunities for self-discovery and experimentation with new behaviours.
- An evolving secure base function appears to provide an important context for change processes. This suggests that rapid and full discharge from services might not be conducive to promoting increasingly self-generated processes of change in people diagnosed with BPD.
- A dialogic, co-constructive setting appears to facilitate the core change process while expert-driven approaches might undermine it.

The study also has theoretical and research implications:

- People diagnosed with BPD value change processes that enable them to become increasingly active in their lives and promote self-acceptance, confidence and sense of self. Currently, increases in self-acceptance are not systematically assessed as part of effectiveness research of psychological therapies. Future studies could remedy this shortcoming by including self-acceptance measures, such as those outlined by Blascovich and Tomaka (1991).
- Triangulation suggested that the core process might also be relevant to those undertaking individual psychotherapy. However, further research is required to investigate this fully, and to compare change processes in individual and group settings.
- Further research is required into negative therapeutic experiences and the experience of change in this context.

Summary

This was the first study to develop a model of change in relation to group-based programmes for BPD grounded in service user experiences. A constructivist grounded theory analysis of eight individual interviews with people who had participated in group-based programmes and three published accounts of people diagnosed with BPD suggested that 'Discovering "new ways of being" in interpersonal space' was a common core change process irrespective of therapeutic modality. This process could extend beyond the therapeutic setting if it was adequately supported through a relationship with a secure base. Self-acceptance emerged as a possible indicator of therapeutic effectiveness from a service user perspective and could be included in outcomes research as a user-valued measure.

Further research is required into change processes in the context of individual psychological therapies and negative therapeutic experiences.

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MAJOR RESEARCH PROJECT

SECTION C

Connie Geyer BSc (Hons), MA, Grad Dip

Critical Appraisal

Word count: 1854

Section C – Critical Appraisal

What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Although I have worked on a number of qualitative and quantitative research projects, this was the first study where I was solely responsible for study design, service and participant recruitment, data collection, data analysis, overall project organisation and write-up. This brought challenges as well as satisfaction. I was pleased to be able to research an area that was of great interest to me but had to develop organisational, analytical and interviewing skills to be able to carry out the project in a relatively short period of time.

In order to balance research activities with clinical training and other course requirements I had to manage my time exceptionally well and respond flexibly to timetable changes that were outside my control. For example, data collection was stressful. A number of interviews needed to be rescheduled several times. However, service relocations meant that I only had a limited time in which I could interview participants onsite. I learned to manage and contain my anxieties about not getting the required number of participants. I adjusted the timeframe for the project whilst still being able to complete it on time. As a result of this I have become confident in my ability to multitask and carry out a challenging piece of research in a climate of organisational change.

I had not used grounded theory methods before and therefore learned a number of analytical techniques such as line-by-line coding, the constant comparative method and memo writing. I found line-by-line coding particularly challenging at first, as it was not always easy to find an action focus and achieve a balance between abstraction and groundedness in the data. However, with increasing comfort and

competence in this procedure I found that this was a useful way of listening to the data afresh and shedding my own assumptions. For example, at the start of the analytical process I sometimes felt tempted to formulate participants by drawing on psychological models that were familiar to me. However, coding transcripts line-by-line made me increasingly aware of my use of professional jargon and ideas, and therefore enabled me to reflect on my preconceptions and think about the data differently.

A distinct research ability that I developed as a consequence of this research was conducting qualitative research with people diagnosed with BPD. Difficulties in negotiating interpersonal relationships are common among this client group and affected the research process at several stages. Recruitment involved meeting with potential participants and services several times to present the research, seek feedback and give plenty of time for participation to be carefully considered. While this was time-consuming, it also enabled the gradual building of trusting relationships between me and service users. With hindsight I believe that this had a positive effect on the quality of data that I was able to collect and may be necessary when conducting research with this client group. Setting up interviews required me to be particularly aware of communications that could be experienced as pushy or coercive (for example offering one interview date only) and to remain patient and hopeful when interviews were not attended. A mindful, calm and open attitude was also important during interviews. Despite showing enthusiasm for the project, participants took time before beginning to talk about the research topic. It wondered whether they first needed to get a sense of me as a person and establish rapport and trust by talking about an experience or interest, which was not directly related to the project but of personal importance to them such as their pet. I noticed that when I tried to direct the

conversation to the project too quickly, this affected rapport negatively. However, when I actively demonstrated an interest in participants' opening statements and gave them control over the interview process, an atmosphere of trust was created and participants began to speak more openly about their personal experiences of change. I learned that a flexible, semi-structured interview format is necessary when conducting interviews with this client group.

As a result of this research I have come to reflect extensively on the researcher's impact on the interview situation. I noticed that conversations opened up when I shared my thoughts with participants in a considered way, for example by reflecting back or checking my understanding of what they had told me. A more neutral and reserved researcher stance, on the other hand, unsettled participants, was experienced as judgmental and critical, and therefore hindered the interview process. I came to understand that active 'mentalizing' (Bateman & Fonagy, 2006) is crucial when conducting qualitative interviews with people diagnosed with BPD. This involves being curious about participants' thoughts and feelings, refraining from making assumptions about their mental states, and regularly making one's own mental states transparent in a considered way. I found that a constructivist grounded theory methodology (Charmaz, 2009) was therefore particularly indicated when doing qualitative research with this clinical group, as it acknowledges the researcher's active participation in the research process and recognises that the quality of interaction between researcher and participants has a significant effect on the kind of data that is collected.

The organisation of the many initial codes was challenging and I would like to undertake training in qualitative software packages such as NVivo to be able to do

manage larger qualitative data sets. I would also like to hone my analytical and conceptual skills by undertaking further grounded theory research in the future.

If you were able to do this project again, what would you do differently and why?

Developing trusting relationships with services and service users was a crucial but time-consuming aspect of the research. If I were to do the project again, I would start informational meetings sooner to maximise the number of potential participants.

Due to time constraints, the sampling strategy was opportunistic. I had a self-selected sample of people who had partaken in group-based programmes for BPD. I was able to recruit a fourth service that also offered individual therapy. Unfortunately there were no recruits from this service, however. A fifth psychological therapies service was approached but declined to take part. If I were to do the project again, I would meet with service managers of psychological therapies services in the hope that this would help identify successful recruitment strategies of such services and their service users. Including service users who had had individual psychological therapy would be an important addition to the project as it could elucidate whether the change processes in my model also apply to people with a diagnosis of BPD who have not had group therapy. Equally, it would be interesting to diversify the sample by interviewing people with experiences of group programmes but not in the context of a BPD diagnosis. This could help establish in how far the change processes in my model were specific to people diagnosed with BPD and in how far they might be representative of group therapy processes.

If I were to analyse the data again, I would grant myself more creative and intellectual freedom when writing research memos. I put pressure on myself to write 'perfect' memos as I had heard that these could often become part of the final write-

up. However, this thought made it difficult for me to effectively use memo writing during times when I felt lost in the 'maze' (Henwood & Pidgeon, 2003) of data.

Clinically, and as a consequence of doing this study, would you do anything differently and why?

As a consequence of this study I have become much more aware of the importance of self-discovery and experimentation with new ways of being in people diagnosed with BPD. It struck me that experimentation with different ways of being was a very active and dialogic process and that this process was experienced as particularly helpful when it allowed participants to negotiate their own ways of doing things. Therefore I have become much more attuned to these processes, and my contribution to them as a clinician, when working with clients diagnosed with BPD. For example, I have become more reflective about ways in which I might impose particular ways of being on others, for example by rushing in with an interpretation in psychodynamic work or overemphasising psychoeducation in cognitive-behavioural therapy. My interactions with research participants were significantly enhanced when I was both curious about their mental states and reasonably open about my own. Therefore I feel increasingly drawn to a mentalization-based approach in my clinical work. Although I have mainly provided individual therapy for people with difficulties that would be congruent with a BPD diagnosis, as a result of this research I am keen to develop group therapeutic skills in this area.

If you were to undertake further research in this area what would that research project seek to answer and how would you go about it?

My research could be seen as an exploratory or pilot study for a more ambitious project. If I were to undertake further research in this area, I would still like to investigate experiences of change. However, I would aim to refine and develop my model. I would broaden the investigation by diversifying the sample and recruiting

from several Trusts and a wider range of services. I would include people with experiences of individual therapy and people with negative therapeutic experiences. This would help specify change processes that are specific to experiences of people diagnosed with BPD, and could help explore the impact of negative therapeutic experiences on overall experiences of change (or lack thereof).

Ethical approval for this study did not allow me to extend the sample within the timeframe I had available. However, if it had been possible, I would have undertaken theoretical sampling and would have interviewed people with experience of group-based programmes but not a BPD diagnosis. I would add this component to a new research project, as it could help elucidate in how far the change processes that I identified were unique to people with a BPD diagnosis and in how far they reflected common experiences in groups.

The aim of an extended research project would be to extend the model of change processes that was developed as part of this research. Such an advanced model could then be tested in a quantitative study. For example, it could be tested whether the change processes identified in the model are correlated with therapeutic effectiveness across a range of therapeutic modalities. If the model was found to correlate with therapeutic effectiveness, an adherence scale could be developed to help clinicians and services evaluate their interventions against service-user valued processes of change.

Finally, as this project was part of a doctoral degree I worked as a lone researcher. Preferably, I would like to undertake further research in this area with the input of a wider research team and steering group made up of other researchers, clinicians and service user representatives. This would enable consideration of

different perspectives and interpretations of the data and would be likely to enhance the output of the research team.

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Running header: Critical appraisal

MAJOR RESEARCH PROJECT

SECTION D

Connie Geyer BSc (Hons), MA, Grad Dip

Appendices

Appendix 1 – Methodology

Four database searches aimed to ensure broad, albeit selective coverage of the current knowledge base. Bibliographies were searched for further relevant references.

1. Scopus, PsychInfo, the Cochrane Library (1980 to April 2013) and Google Scholar were searched for the search terms:

“recovery” AND “mental health”

Book chapters, journal articles, empirical studies and policy documents were included, which enabled a broad overview of the origins of the recovery concept, its empirical underpinnings and its evolution into the NHS recovery approach.

2. Scopus, PsychInfo, the Cochrane Library (1980 to April 2013) and Google Scholar were searched for the search terms:

“Borderline Personality Disorder” AND “recovery”

Exclusion criteria were: foreign language, not peer-reviewed, conceptual reviews of the borderline construct, case illustrations, individual psychotherapy trials, pharmacological studies, general focus on personality disorders rather than BPD in particular.

Inclusion criteria were: empirical (qualitative or quantitative) study of recovery in relation to BPD.

Of 71 papers, eight met inclusion criteria. Two qualitative studies explored recovery in relation to BPD. The remaining papers quantitatively investigated recovery through longitudinal follow-ups (three papers) or summarised psychotherapy outcomes research (three papers).

3. In order to identify a wider range of follow-ups and the most recent ones, Scopus, PsychInfo, the Cochrane Library (2003 to April 2013) and Google Scholar were searched for the search terms:
"Borderline Personality Disorder" AND "follow-up"
References of relevant articles were examined for additional papers. In total, six publications from two major longitudinal research projects were identified.
4. Psychotherapy literature was selected on the basis that it offered a comprehensive overview of the therapy model as endorsed by its originators. The evidence base for these psychotherapies was established in reference to two high-quality systematic reviews (Brazier et al., 2006; Stoffers et al., 2013). A supplementary search with the search terms "Borderline Personality Disorder" AND "clinical trial" yielded two additional studies, which did not meet Stoffers et al.'s (2013) inclusion criteria but which were of interest to this inquiry.

Quality assurance

Quality of qualitative research was assessed by considering factors such as the novelty of the claims made, their grounding in the data and the reflexivity of the write-up (Mays & Pope, 2000).

Key references, which guided quality checks, were:

Barbour, R.S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog? *British Medical Journal*, 322, 1115-1117.

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *British Medical Journal*, 320, 50-52.

To assure the quality of quantitative studies included in this review I considered a range of factors, for example: was there a clear research question or hypothesis, a well-defined sample (i.e. diagnosis established through standardised and recognised methods and tests), was the methodology suited to the research question and was the interpretation of results justified by the statistical analysis and data.

Key references were:

Abalos, E., Carroli, G., Mackey, M.E., & Bergel, E. (2001). *Critical appraisal of systematic reviews*. Geneva: The World Health Organisation.

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Appendix 2 – DSM-IV BPD diagnostic criteria

Five of nine diagnostic criteria must be met for a diagnosis to be made:

- 1) Frantic efforts to avoid real or imagined abandonment
- 2) A pattern of unstable and intense interpersonal relationships
- 3) Identity disturbance
- 4) Impulsivity, often of a self-damaging nature
- 5) Recurrent suicidal or self-injuring behaviour
- 6) Marked and rapid shifts in mood
- 7) Chronic feelings of emptiness
- 8) Difficulties managing anger
- 9) Transient, stress-related paranoid ideations, delusions or severe dissociative symptoms

Appendix 3 – Recovery principles commonly adopted in mental health care

Recovery principles as summarised by Sheperd, Boardman, & Slade, (2008):

- Building a meaningful and fulfilling life, as defined by the person, irrespective of mental health
- A focus on strengths and well-being rather than pathology and illness
- Promoting hope and agency
- Promoting self-management
- Moving from an expert-patient relationship to a relationship between partners on a journey of discovery
- Promoting social inclusion and community involvement
- Discovering a sense of personal identity, which is separate from disability
- Acknowledging the power of language to create possibilities for recovery
- Developing recovery-based services
- Involving family and peers in recovery plans

Appendix 4 – Sample characteristics

This has been removed from the electronic copy.

Appendix 5 – Ethics approval**Appendix 6 – R&D approval**

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Appendix 7 – Interview schedule

Interview Schedule

Preamble

“The main focus of the interview is on your personal experiences of change over time in relation to your mental health. That’s what we will be spending most of the time on. But to start us off, I would like to ask you a few general questions about yourself and your past use of mental health services. This will be useful background information. We won’t spend too much time on this.”

- 1) How old were you when you first came into contact with mental health services?
- 2) How old are you now?
- 3) What sorts of mental health services have you been using?
- 4) How old were you when you were diagnosed with BPD?
- 5) What do you make of the BPD diagnosis?

Main part

“Thank you. That is really helpful to know. I would now like to move on to the main part of the interview. I am particularly interested in your personal experiences of change over time. I have thought of a number of questions beforehand but there may be more questions that come up during the interview. We can stop at any time. Please feel free to tell me if you do not wish to continue.”

- 6) Could you briefly describe what your difficulties were at the time when you were diagnosed?
- 7) Where would you say you are now, in this moment, with these difficulties?
- 8) (If participant states that difficulties have changed for the better):
It sounds as though there have been changes since your difficulties first started.
 - a. Could you tell me which of these changes have been the most important to you?
 - b. How did you notice that things were changing?
 - c. What did you make of these changes at the time?
 - d. How did it feel when things started changing?
 - e. What made these changes possible?
 - f. What could have jeopardised these changes?

- g. What difference have these changes made to your experience of yourself?
 - h. What difference have these changes made to your life?
- 9) (If participant states that difficulties have remained fairly stable or got worse):
- It sounds as though things have remained fairly stable/ got worse.
- a. Have you always thought of it like this, or have there been times when you felt differently?
(If participant gives examples of positive changes, move back to questions listed under 7) as applicable).
 - b. What are your ideas why your difficulties have remained stable/ got worse?
 - c. What has kept things in place/ made them worse?
 - d. How has this affected your view of yourself?
 - e. How has this affected your life?
 - f. What, if anything, could have made a positive difference in your life?
 - g. What were your expectations for change when you first came into contact with mental health services?
 - h. How have your expectations developed over time?

Ending questions (all participants)

- 10) What, if any, were your expectations for change when you first came into contact with mental health services?
- 11) How have your expectations developed over time?
- 12) How could services better promote changes that are meaningful to you?

Debrief

"Many thanks. The interview is now coming to an end. I would just like to check in with you how you have found the interview and how you are feeling. Some of the questions may not be relevant to you but I have got to ask them. How did it feel to do the interview? Was there anything that was particularly difficult to talk about? How do you feel about it now that the interview is coming to a close? Do you feel you need more support after the interview has finished? How might you go about getting this support? Are you concerned about harming yourself or someone else after the interview has finished? Do you have any questions about the interview or the study? Many thanks for your time."

Appendix 8 – Participant information sheet

‘Moving on from ‘BPD’: A study of personal experiences of change over time’

Participant information sheet

My name is Connie Geyer. I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to tell you about my research project, hoping that you might be interested in taking part.

What is the study about?

This study looks at personal experiences of change in people diagnosed with Borderline Personality Disorder (BPD). I would like to explore whether you have noticed personal changes over the years, how you have noticed these changes, and what sorts of changes have made a real difference to you. We may talk about your relationships, your sense of self, and your daily activities. We will focus on what has mattered most to you. If you cannot think of any changes at the moment, or feel that you have not experienced change, then this is also relevant.

Why is the study being done?

In the past it was assumed that people diagnosed with BPD are unlikely to experience positive changes. This led to a lot of pessimism, hopelessness, and poor service provision. Over the last twenty years research has shown that difficulties do change and can lessen over time. For example, new therapies have been shown to help reduce self-harm, suicidal behaviours, and improve relationships. However, few studies have looked at how people with BPD have experienced change in their personal lives, and the kinds of changes that have mattered most to people given this diagnosis.

I hope that the findings will improve our understanding of how personal changes are experienced by people in day to day life. This may help services and therapists in supporting people through this complex process.

What does the study involve?

I am interviewing 10 to 15 people about their experiences. Interviews will take between 30 and 90 minutes. They will be audio-recorded and typed up. Anything that could identify you will be removed from the typed-up interview (e.g. if you mention the street you live on or the name of a service). To assure the quality of my work, my research advisors will have access to the anonymised typed-up interviews and will supervise my work. I will read and re-read the transcripts. I will identify common themes across the interviews and will develop an emerging theory of experiences of change.

Following on from this, I will collect more data to refine my findings. This could include a second individual interview with yourself, or it may mean that I conduct a focus group with people in another setting or analyse data from other sources, such as biographies or Internet forums.

Why am I being approached?

Your service is taking part in this research project. All people who have been identified by a named clinician as meeting the entry criteria for this study are being approached. I am happy to answer any questions that you may have about the project. You have at least 24 hours to decide whether you wish to take part or not.

Do I have to take part?

No. You are in no way obliged to take part in this research. Whether you decide to take part or not, or stop once the study has started will not affect your care in any way.

If you do decide to take part, you have the right to withdraw your consent at any time without giving a reason. In that case your interview recording will be deleted and not used for research purposes.

Will my participation be kept confidential?

I will inform your GP or care coordinator (if you have one), that you have agreed to take part in this study. Everything you say in the interview is confidential, unless I have reason to believe that you or another person is at risk of harm. In that case I will have to breach confidentiality and share risk-related information with your service, or other relevant authorities as necessary.

All information will be kept securely and confidentially on password-encrypted computers or CDs. Participant-identifiable information will be locked separately from data. Data will be kept securely and confidentially for 10 years. All data use is strictly within the Data Protection Act (DPA 1998).

What are possible risks in taking part?

The interview may touch upon experiences that might be distressing, embarrassing or uncomfortable. You do not have to discuss anything that may affect you in any of these ways. Should you become unduly distressed during the interview, please let me know. You can take a break or stop the interview at any time. Should I feel that the interview is a distressing experience for you, I will ask you whether this is the case and I may stop the interview.

All participants will be debriefed when the interview has finished. I will ask you about your experience of the interview, your current mood, how safe or at risk you feel, and the level of support that is available to you.

Interviews and debriefing will take place on NHS premises. In the event of imminent risk to yourself or others, I will immediately contact staff on site to ensure that you remain safe after our meeting has finished. I will also share risk-related information with the duty system of your mental health care provider (e.g. community team, GP) and follow their risk management plan.

In addition to their usual mental health care services, participants are eligible to attend and get further support from [delete as applicable: identifiable

information removed]. The Samaritans (Tel.: 08457 90 90 90) provide a 24-hour helpline.

What are possible benefits of taking part?

The findings of this study could potentially enhance our understanding of the kinds of personal changes that are relevant to people diagnosed with BPD, and help services do more to promote these changes.

Has the research been approved?

The project has been approved by my training organisation (Canterbury Christ Church University). Dr Sarah Dilks (██████) and Ms Anne Cooke (Canterbury Christ Church University) supervise this project. The research has been reviewed by NRES Committee London – Camden & Islington.

How is the research funded?

The research is partially funded through my training programme. This includes reimbursement of participants' travel expenses within 'Region' (London, Sussex, Kent). A small fund is available to reimburse participants for their time.

What next?

You may wish to have a discussion about this project in your service, with family, friends, or other significant people in your life. I will be in contact with you in the next couple of days to see what your decision is. Should you decide to take part, interviews are likely to take place between summer 2012 and spring 2013.

I will contact you to arrange a mutually convenient and suitable time and place for the interview. Prior to the interview starting, I will ask you to sign a consent form, indicating your willingness to take part in the study.

What will happen to the results of the research?

I hope to publish the results of this study in scientific journals and in media for mental health service users and health care professionals. Please be assured that only anonymised quotes will be used and that individual participants will not be identifiable in the write-up.

Further information

Please feel free to contact me should you have any more questions about this study:

Connie Geyer
Dpt. of Applied Psychology
Canterbury Christ Church University
Broomhill Road
Southborough
TN3 0TG
E-Mail: cq237@canterbury.ac.uk

You can contact the Patient Advice and Liaison Service (PALS) [identifiable information removed], which offers general advice, information and support to service users and carers:

Tel.: [identifiable information removed]

E-Mail: [identifiable information removed]

Complaints procedure

If you are at all dissatisfied with the conduct of this research please first contact the researcher (Connie Geyer, cg237@canterbury.ac.uk, Tel.: 01892 507 773). If you still wish to complain about any aspect of the research project, please contact Prof Paul Camic, Research Director, Dept. of Applied Psychology, at paul.camic@canterbury.ac.uk or on 01892 507 773. Canterbury Christ Church University is the sponsor of this research and is therefore responsible for its conduct. If you feel that you have been harmed by this research please contact Prof Camic and he will discuss with you the complaints process of the University.

Many thanks for your time.
Connie Geyer

Appendix 9 – Consent form

Consent Form

'Moving on from 'BPD': A study of personal experiences of change over time'

Researcher: Connie Geyer (Trainee clinical psychologist)

<i>After having read the consent form, please read the following:</i>		<i>Please initial box</i>
1	I confirm that I have read and understand the information sheet dated 17/07/2012 Version 2 for the above study.	
2	I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
3	I understand that my participation is voluntary and that I am free to withdraw at any time, without it affecting the standard of my care or my rights in any way.	
4	I understand that the interview will be digitally recorded for the purpose of data analysis, and I hereby give permission for the interview to be recorded.	
5	I understand that the interview will be transcribed and that any information that might identify me will be removed from the transcript. I hereby give permission for anonymised quotes from my interview to be included in publications.	
6	I understand that the content of the interview is confidential as long as the researcher is not concerned about my safety or the safety of others.	
7	I agree to take part in the above research study.	
8	I wish to receive a summary of the results at the completion of the study.	
9	I understand that data collected during the study may be looked at by individuals from regulatory authorities and/ or [identifiable information removed], where it is relevant to my taking part on this research. I give permission for these individuals to have access to my records.	

Name of Participant _____ Date _____ Signature _____

Name of Person taking consent _____ Date _____ Signature _____

When completed: 1 copy for participant; 1 copy for researcher.

Appendix 10 – Coded transcript

As line-by-line coding was done in NVivo, the appended transcript was specifically created to illustrate initial coding to the reader. Unfortunately it was not possible to retain original line numbering in this format.

This has been removed from the electronic copy.

Text	Initial coding	Possible categories

Appendix 11 – Extracts from research diary

September 2011

The service user information meetings that I held prior to signing up services seemed to be an important way of establishing trust and building relationships with the research participants.

On my first meeting with the peer support group, I was made to wait 45 minutes and was met with suspicion and reservation. Despite having shown up at noon as requested, the group decided to take a break at this point. When the meeting recommenced, members of the group made it very clear that they had more important things to discuss and that there may not be enough time for my research after all. I felt that members were communicating that the group was very important to them and that they were taking it seriously. This helped me manage my own discomfort. I acknowledged the importance of the group and that I did not want to keep them from anything.

After a further 40 minutes I was then invited to speak about the project. I felt very anxious by this point and this showed in my voice. I explained that I feel anxious speaking in groups and this evoked a warm and understanding response. Showing my own vulnerability appeared to be very important in forming a relationship to the group.

We ended up talking about the research for 50 minutes and there was a lot of interest among members. Five people wanted to sign up immediately. A number of people thanked me at the end of the meeting for having enabled a discussion that they felt they had not had before. People had talked about unfavourable responses at A&E and from other professionals, and that this was what was deterring them from seeking help, rather than feeling better. That's an interesting take on 'outcomes'.

July 2012

Between October 2011 and July 2012 I have been in email contact with the OT who runs the peer support group and the psychiatrist at [identifiable information removed] mentioned my project in community meetings. Having professionals endorse my project and keep it alive in people's minds is of great help. I informed them about the progress of the ethics application. Service users were very helpful in refining the PIS. This was a further way of establishing relationships and building trust.

August 2012

Finally got ethics approval and can start collecting data.

October 2012

Another therapy services has come on board, which is a great addition to my project. Meeting with two service users went well and think they will want to participate.

3rd November 2012

Neither of the two new recruits came in for the interview today but then rang me and sounded very apologetic. Think there is a lot of ambivalence around and I am sympathetic but I am also a bit worried about getting the interviews done in the timeframe.

12th November 2012

First interview went really well. It was very enjoyable for me and the participant spoke very personally and openly, which was good. Quite an interesting idea came up around turning-points initiating change and the value of developing self-acceptance.

30th November 2012

The interviews are going well. Sometimes people are not attending but I am still in contact with them so I think eventually they will show up. Did one interview (P7) in which I fell into therapist/ care planning mode but discussed with [supervisor] and after looking at the transcript with her feel that I have done the right thing and had an ethical obligation to go off script. Perhaps I will try and be more neutral in subsequent interviews though.

12th December 2012.

Tried out more blank face/ neutral interviewer stance and it really affected the interaction in a negative way. I think the more open I am about my thought processes, the more openly participants speak about their experiences. It seems that there is something quite important about transparency about mental states and a bit of mentalising seems to help the interview process with this client group .

January 2013

I managed to get a fourth service on board but participant recruitment is difficult. I have eight participants so far and one person who has expressed interest but not yet consented. I have exhausted all recruitment possibilities from the three main services so might be better off moving on to triangulation with published accounts. Possibilities of recruiting more interviewees seem slim.

February 2013

Am coding data now and am torn between NVivo and paper methods. NVivo helps me engage with the data more and gives me useful lists of codes but I can't print off coded transcripts and have to click on each code separately to see the quotes it links to. The grounded theory group is really helpful though. Seems like we are all doing things slightly differently and there is always something to learn. Looked at coding with [friend] and practiced getting the action focus going. Too many of my codes are passive: being rejected, being abandoned.... Does that say something about the client group grappling with passivity/ agency or does it say something about my coding.... I don't know.

April 2013

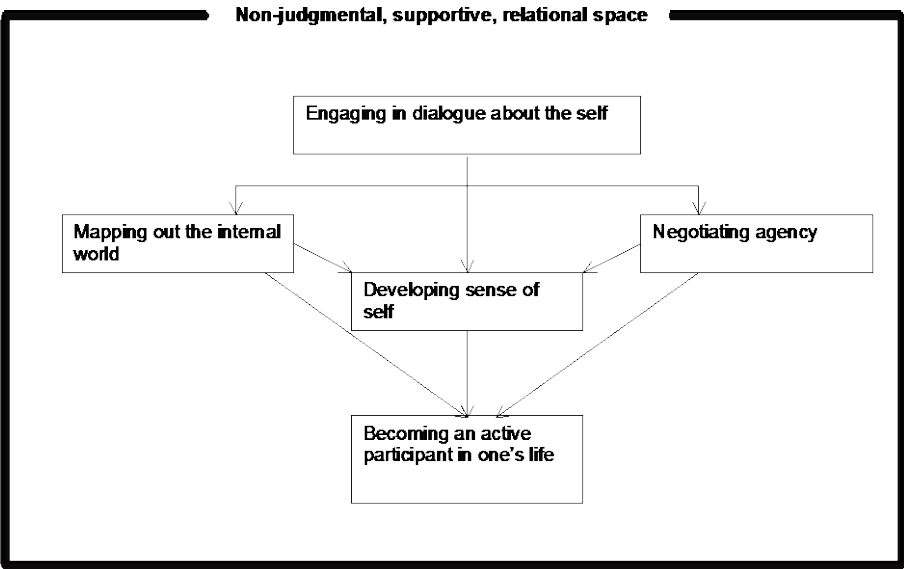
My focus has shifted completely to section A. Can't wait to get back to the data.

May 2013

I used the list of focused codes to develop initial groupings of focused codes, which could become categories and subcategories. I printed and cut out all focused codes, glued them onto post-its, and then arranged them on a plastic surface. I used speech bubble post-its to denote potential categories. I started using arrows to indicate sequences or relationships but haven't quite figured out how to do this yet. There is a temptation to lay things out in a before/ after format and at times participants' accounts seemed to suggest this. However, there seem to be lots of processes going on and different ones might shift into focus at different times.

The following pictures illustrate the process of model construction, culminating in a precursor of the final model presented in the write-up:





Experiencing with new ways of being in
 the space between self and other

Appendix 12 – Example of analytic memo

Major categories are underlined and bold. **Subcategories** are bold. *Focused codes* are underlined and in italics. Initial codes are underlined.

The following examples will show how research memos helped separate out different processes and establish relationships between them. The example refers to the subcategories of **promoting connectedness**, **elaborating private mental states** and **becoming an active participants in one's life**.

Memo I

This memo shows the initial stages of my developing thinking about interpersonal space and its role in promoting reciprocity/ connectedness and agency:

“Participants describe dimensions of reciprocity in their interpersonal relationships. Reciprocity emerged in a tendency to reject others because they have been rejected or to withdraw from and avoid others in response to being misunderstood or being ignored. At the same time, there was a process of valuing reciprocity in relationships with others.

Participants actively contrasted past and present selves in the interviews.

Participants' **representations of self** shared a sense of the self as self-sacrificial rescuer and protector of others. In parallel to this view of self there seemed to be a common development of a changing view of self and relationships from self-sacrificial protector of others to an active participant in reciprocal relationships, characterised by being helped and being understood and in turn wanting to help others by understanding them.

This seemed to be linked to a parallel process of developing a more nuanced sense of agency and choice. Participants described a sense of feeling controlled by others' perceived expectations and views of themselves. They frequently indicated a deterministic view of self/ deterministic experience of self (e.g. in relation to the past, the psychiatric system). However, they also described experiences, which enabled them to gain an increasing recognition of choices. This seemed to occur when participants' were able to a) step out

of their *immersion in experience* and to **elaborate private mental processes**, b) *observe others*, *accept difference* between self and other, *compare self and other* and from this, gain self-acceptance, a sense of entitlement and feeling empowered (e.g. P4). *Distinguishing between thoughts and feelings* seemed to give increased choice as to how to respond to thoughts and feelings.”
(Research memo, 1st May 2013)

Memo II

This memo shows an attempt to summarise the focused codes from the memo above under a conceptual/ major category. The example shows that ideas of interpersonal connectedness, self-discovery and agency were present early on but not clearly articulated or conceptually developed. Initially I was not clear about the differences between them and put them together under one major category:

“**Becoming a separate yet connected self** was defined as the core psychosocial activity, which underpinned processes of change as lived and experienced by people diagnosed with BPD. **Becoming a separate yet connected self** was defined as a process by which people with a BPD diagnosis continuously work on establishing a separate sense of self, which is internally integrated and externally related. Change emerged to be an on-going process of self-discovery and of developing new ways of relating to oneself and to others.” (Research memo, 15th May 2013)

Memo III

This memo shows emerging conceptual distinctions between **connectedness**, **becoming and active agent in one’s life** and **elaboration of private mental states**, as well as emerging relationships between these:

“**Elaborating private mental states** seemed to be a particularly important change process in relation to self-destructive impulses. *Comparing self and other* on the other hand seemed to be a pertinent change process or mechanism of change regarding relationships with self and others. It seemed to be a way of trying to work out boundaries between self and other

(*accepting difference*) and of establishing commonalities (*seeing similarities between self and other*) and valued grounds for connection (e.g. not being the only one who is self-harming). One could then say that *comparing self to others* is an important change process in relation to relationships while **elaborating private mental states** seemed to give more freedom of choice in relation to self-destructive impulses. There seemed to be a general shift from passive victim to **becoming an increasingly active participant in one's life**. The general tendency of current layout is an overall *move from a static view of self* and of life to a sense of on-going process, including the recognition of personal growth and struggles.

Developing a sense of continuity or perhaps **connectedness** seems to be an on-going activity, which enabled participants to become more accepting of themselves. **Developing a sense of continuity/ connectedness** involves *building and maintaining relationships* despite *concerns about intimacy and disagreements*, and connecting up/ making links between past, present and future (*engaging with the past, living in the present, setting future goals*). This contributes to overall *self-acceptance*, which is characterised by recognition of strengths and limitations, acceptance of limitations, acknowledgement of achievements. This in turn feeds into processes of personal growth, self-development and a positive sense of self." (Research memo, 20th May 2013)

Appendix 13 – Full list of focused codes

1. Hitting “rock bottom”
2. Using relationships to affect change
3. Taking time to change
4. Building self-confidence
5. Asserting oneself
6. Learning about the self
7. Seeing similarities between self and other
8. Comparing self and other
9. Accepting self
10. Choosing one’s family
11. Valuing non-judgmental attitude
12. Fearing rejection
13. Anticipating judgement
14. Working with conflict
15. Withdrawing from others
16. Avoiding others
17. Struggling to survive
18. Struggling with loneliness
19. Feeling contained
20. Belonging to a group
21. Feeling connected
22. Having a secure base
23. Challenging long-held beliefs about self and other
24. Engaging with difference
25. Engaging with conflict
26. Acknowledging vulnerability
27. Feeling judged
28. Taking positive risks
29. Sharing self with others
30. De-masking/ falling masks
31. Valuing talking therapy
32. Trusting therapist
33. Overcoming fears of being with others
34. Testing relationships
35. Linking relapse to starting therapy
36. Struggling to settle
37. Settling down
38. Hiding parts of the self
39. Presenting self as rescuer
40. Presenting self as victim
41. Deterministic view of self/ deterministic experience of self
42. Relinquishing façade
43. Going along with others
44. Pleasing others
45. Linking change to experiences in groups
46. Contrasting past and present
47. Relinquishing public presentations of self

48. Revealing self to others
49. Exploring selfhood
50. Grappling with agency
51. Valuing dialogue
52. Changing through dialogue
53. Rejecting diagnosis
54. Grappling with diagnosis
55. Worrying about stigma
56. Not being taken seriously
57. Engaging with the past
58. Developing new perspectives
59. Welcoming challenge
60. Accepting difference
61. Experimenting with identity
62. Shifting static view of self
63. Feeling supported
64. Offering advice
65. Giving feedback
66. Getting advice from others
67. Advising others
68. Valuing reciprocity
69. Experimenting with new behaviours
70. Engaging with new information
71. Relating differently to self
72. Changing view of self
73. Using feedback
74. Practicing assertiveness
75. Building skills in therapy
76. Individualising
77. Developing new parts of the self
78. Recognising limitations
79. Empowering the self
80. Elaborating private mental states
81. Immersion in experience
82. Feeling overwhelmed by emotion
83. Distinguishing between thoughts and feelings
84. Distinguishing between urge and thought
85. Coping with anger
86. Putting things in perspective
87. Focusing on today
88. Tolerating mixed emotions
89. Acknowledging mixed feelings towards self and others
90. Widening sense of choice
91. Creating space for agency
92. Observing others
93. Learning from others
94. Moving on
95. Struggling with endings
96. Avoiding endings
97. Working through ending

- 98. Acknowledging loss
- 99. Becoming an active participant in one's life
- 100. Drawing on helpful memories
- 101. Taking action
- 102. Taking pleasure in creativity
- 103. Having a purpose
- 104. Taking responsibility
- 105. Taking control
- 106. Accepting on-going struggle
- 107. Recognising self-sabotage
- 108. Recognising needs
- 109. Relating to the opposite sex in a new way
- 110. Struggling with intimacy
- 111. Building and maintaining relationships
- 112. Getting on with others
- 113. Helping others
- 114. Creating opportunities for self-discovery
- 115. Seeking help
- 116. Recognising limitations of therapy
- 117. Living in the present
- 118. Setting future goals
- 119. Feeling confident about the future

Appendix 14 – Categories, subcategories and focused codes in the final model

A table follows, relating focused codes to subcategories and categories.

Category	Subcategory	Aspects of subcategories	Focused codes
Turning-points			Hitting "rock bottom" Using relationships to affect change Struggling to survive Taking time to change
Core process	All of the below		Taking time to change
Service-user valued outcomes of core change process			Asserting oneself Building self-confidence Accepting self Feeling connected
1) Laying foundations	Providing connectedness		Seeing similarities between self and other Struggling to settle Trusting therapist Having a secure base
	Balancing containment with exposure to conflict		Avoiding others Withdrawing from others Anticipating judgment Working with conflict Building and maintaining relationships Struggling with loneliness Feeling contained Challenging long-held beliefs about self and other Engaging with difference Engaging with conflict
	Engaging with therapy		Fearing rejection Feeling judged Belonging to a group Valuing non-judgmental attitude Choosing one's family Overcoming fears of being with others Testing relationships Linking relapse to starting therapy Settling down

	De-masking		<ul style="list-style-type: none"> Hiding parts of the self Taking positive risks Sharing self with others Hiding parts of the self Deterministic view/ experience of self Relinquishing façade Relinquishing public presentations of self Presenting self as rescuer Presenting self as victim Going along with others Pleasing others Revealing self to others Struggling with intimacy Relating to opposite sex in a new way
2) Exploring selfhood and agency	Promoting dialogues about self		<ul style="list-style-type: none"> Worrying about stigma Not being taken seriously Grappling with diagnosis Rejecting diagnosis Valuing talking therapy Valuing dialogue Changing through dialogue Developing new perspectives Comparing self and other Contrasting past and present Engaging with the past Learning about the self Acknowledging vulnerability Exploring selfhood Welcoming challenge Engaging with the past
	Providing transitional space		<ul style="list-style-type: none"> Shifting static view of self Accepting difference Changing view of self Observing others Comparing self and other

			<ul style="list-style-type: none"> Linking change to experiences in groups Contrasting past and present
	Scaffolding new behaviours		<ul style="list-style-type: none"> Getting advice from others Giving feedback Advising others Valuing reciprocity Offering advice Building skills in therapy
	Experimenting with 'new ways of being'		<ul style="list-style-type: none"> Grappling with agency Using relationships to affect change Using feedback Engaging with new information Individualising Experimenting with new behaviours Developing new parts of the self Recognising limitations Observing others Experimenting with identity Feeling supported Relating differently to the self Changing view of self Practicing assertiveness Empowering the self
	Elaborating private mental states		<ul style="list-style-type: none"> Putting things in perspective Focusing on today Feeling overwhelmed by emotion Distinguishing between thoughts and feelings Distinguishing between urge and thought Tolerating mixed emotions Coping with anger Acknowledging mixed feelings towards self and others Widening sense of choice Creating space for agency Observing others

			Learning from others Being immersed in experience
3) Consolidating/ 'Moving on'	Processing ending		Struggling with endings Avoiding endings Working through ending Acknowledging loss
	Becoming an active participants in one's life	Drawing on therapy experiences	Taking action Drawing on helpful memories
		Making space for enjoyment	Taking action Taking pleasure in creativity Creating opportunities for self-discovery
		Becoming a mental health advocate	Taking action Valuing reciprocity Having a purpose Helping others
		Taking responsibility	Taking action Taking responsibility Accepting on-going struggle Recognising self-sabotage Recognising needs Living in the present Taking control Seeking help Recognising limitations of therapy Living in the present Setting future goals Feeling confident about the future

Appendix 15 – NRES closing summary**DECLARATION OF THE 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 that gave a favourable opinion of the research (“the main REC”) 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:	Connie Geyer
Address:	Dpt of Applied Psychology, Canterbury Christ Church University Salomons Campus at Tunbridge Wells Broomhill Road, Southborough TN3 0TG
Telephone:	07507 146 162
Email:	Cg237@canterbury.ac.uk
Fax:	

2. Details of study

Full title of study:	Personal experiences of change over time in people diagnosed with Borderline Personality Disorder (BPD): a grounded theory
Research sponsor:	Canterbury Christ Church University
Name of main REC:	NRES Committee
Main REC reference number:	

3. Study duration

Date study commenced:	13 September 2012
Date study ended:	27 July 2013
Did this study terminate prematurely?	No <i>If yes please complete sections 4, 5 & 6, if no please go direct to section 7.</i>

4. Circumstances of early termination

What is the justification for this early termination?	
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5. 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?	<i>e.g. Safety, difficulties recruiting participants, trial has not commenced, other reasons.</i>

6. 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.	
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7. Final report on the research

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

Signature of Chief Investigator:	
Print name:	Connie Geyer
Date of submission:	28 July 2013

Appendix 16 – R&D summary

This has been removed from the electronic copy.

Appendix 17 – Cover sheet for journal submission

Running head: *Experiences of change*

Discovering 'new ways of being' in interpersonal space: A grounded theory of change of people diagnosed with borderline personality disorder

Connie Geyer*, Sarah Dilks, and Anne Cooke

¹Canterbury Christ Church University

²South London & Maudsley NHS Foundation Trust

³Canterbury Christ Church University

Word count (exc. figures/tables): 7913

*Requests for reprints should be addressed to Connie Geyer, Salomons Campus, United Kingdom

Appendix 18 – Practitioner points as required by journal

Practitioner points:

- Regardless of therapeutic allegiance, clinicians can promote service user-valued changes by providing interpersonal opportunities for self-discovery and experimentation with new behaviours and ways of being.
- An evolving secure base function appears to provide an important context for change processes. This suggests that rapid and full discharge from services might not be conducive to promoting increasingly self-generated processes of change in people diagnosed with BPD.
- A dialogic, co-constructive setting appears to facilitate the core change process while expert-driven approaches might undermine it.

Appendix 19 – Author guidelines

perimental designs.