“What we need is to be held when we’re falling, but allowed to get on with it when we’re well”: What do individuals with a diagnosis of ‘Borderline Personality Disorder’ really need from Counselling Psychologists?

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ABSTRACT

Individuals diagnosed with ‘Borderline Personality Disorder’ (‘BPD’) suffer both psychological distress and rejection from professionals. Though the qualitative literature highlights many beneficial therapeutic qualities for this clinical group, it is unclear how they interact to facilitate processes of positive change. Such knowledge could reduce disengagement and improve outcomes. Ten participants with a diagnosis of ‘BPD’ were invited to consider the utility of different therapeutic approaches in working with ‘BPD’. Reflective Thematic Analysis was used to analyse participant narratives. Data patterns moved beyond identification of beneficial therapeutic qualities and the nature of their interactions in creating a process of positive change, to wider ‘Healing’ and ‘Harmful’ processes for participants in their engagements with services. ‘De-Othering’, ‘Someone to be There’ and ‘Giving What’s Needed’ represent ‘Healing Processes’. ‘Harmful Processes’ include ‘Lights on, but Nobody’s Home’ and ‘Corned Beef Sandwiches and Paper Suits’ (being incarcerated, stripped, handcuffed, and abandoned). This research provides a platform for this stigmatised group to express their needs from services, drawing attention to the powerful impact of psychosocial factors on mental health. The findings have major implications for counselling psychologists both for therapy, and for promoting psychologically informed practice within the team and wider services. Limitations and possibilities for future research are also discussed.

CONTENTS

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INTRODUCTION

This research thesis employs a qualitative approach to explore what individuals with a diagnosis of ‘Borderline Personality Disorder’ (‘BPD’) need from counselling psychologists and mental health services. The question asked of participants was whether a ‘being with’ relational therapeutic approach or a ‘doing to’ directive therapeutic approach would be more effective for addressing the needs of individuals with a diagnosis of ‘BPD’. This question unlocked rich narratives regarding the experiences of these individuals in their interactions with mental health services and society. What emerged were sets of processes which described ‘healing’ and ‘harmful’ ways of treating these individuals which have been shaped by numerous interacting factors including early experiences of emotional deprivation, trauma, and the ways in which people who experience emotional disturbance are treated by society.

The process of data collection was a rewarding and humbling experience for me. I felt a great sense of privilege in being able to hear my participants’ stories and to work with them to construct meaningful answers with which to address the research question. Every interview yielded rich data, with powerful, emotive stories demonstrating the strength of the human spirit in the face of adversity. With the presentation of the findings of this research, I wish to communicate these powerful experiences of suffering and adversity which individuals with a diagnosis of ‘BPD’ endure, in the hope that it will make others aware of the complex psychosocial factors which perpetuate their difficulties and offer answers as to what services can do to intervene and improve the quality of care that they provide.

Despite the long-stand stigma associated with this clinical group (Gallop, 1985, Gallop et al.,1989; Kaplan, 1986; Markham, 2003), their views and experiences of mental health services and therapy have not been ignored in the qualitative literature (e.g. Fallon, 2003; Rogers & Dunne, 2013). A wide range of topics have been explored including their evaluations of psychological therapy (Hodgetts et al., 2007; Ó Lonargáin, et al., 2017), how they understand and experience recovery (Gillard et al., 2015; Katsakou et al., 2012), what they have found helpful in treatment (Langley & Klopper, 2005), how they experience their interactions with mental health services (Fallon, 2003; Rogers & Dunne, 2013) and their experiences of being given and living with their diagnosis (Horn et al., 2007; Nehls, 1999).

However, in review of the qualitative literature on exploring clients' experiences of their treatment for 'BPD' and their perceptions of recovery, Katsakou and Pistrang (2018) conclude that the qualities that individuals found helpful were often presented as lists with little indication of how factors interact with one another to achieve positive change and how the themes relate to one another. Themes were only briefly described, only providing a thin description of client's experiences. Most studies critiqued did not explore the processes of change. Katsakou and Pistrang (2018) noted that some of the treatment characteristics identified appeared generic and did not offer a detailed picture of recovery processes in 'BPD'. This made it difficult to imagine how such generic characteristics, in the absence of other processes could play a major role in the treatment of a condition as complex as 'BPD'. They concluded that the specific mechanisms through which such characteristics promote change and additional processes that might facilitate recovery remain poorly understood.

The ongoing pressure on mental health services to keep services brief and goal-orientated has prevented therapeutic practitioners from being able to fully immerse themselves in their client's emotional experiences (Chalkley, 2015). This situation conflicts with the values of Counselling Psychology who prioritise the needs of their clients and the therapeutic relationship (Ashley, 2010; British Psychological Society [BPS], 2005). Chalkley (2015) argues that for therapy to be truly client-centred, the content of the distressing concerns that clients bring must be identified, acknowledged, analysed, and worked through. This therapeutic approach focused on the content of client experiences can be described as the humanistic approach, which highly values attention to client subjective experience, personal meaning, and self-worth in the context of an accepting and supportive therapeutic relationship (du Plock, 2010). It has been contrasted with ways of working influenced by medical models, involving the use of 'expert' knowledge to treat clients, and using strategies to promote change, or even 'cure'. This is described as 'doing-something-to' the client in therapy (du Plock, 2010).

This research aims to further illuminate the therapeutic processes which facilitate improved mental wellbeing for individuals with a diagnosis of 'BPD', by asking individuals with this diagnosis to compare the effectiveness of these two ways of working for supporting clients with a diagnosis of 'BPD'. It is hoped that the knowledge generated will build upon previous research and offer additional insights into how certain therapeutic qualities interact to facilitate positive change within the individual. Where valued qualities appear generic, it is hoped that the participants contrasting of the two ways of working will shed light on why these qualities are of particular significance for individuals with lived experience of ‘BPD’.

This research provides a platform for a group of individuals who are still highly stigmatised to express their therapeutic preferences and to have these heard by mental health professionals. Service-user feedback is essential for effective service evaluation and improved service delivery (National Institute for Clinical Excellence [NICE], 2011). It is hoped that this study will contribute to the deconstruction of this stigma and support professionals to better understand the needs of individuals with a diagnosis of ‘BPD’ and to feel more comfortable working with them. The knowledge acquired may be especially beneficial to trainee therapists who may feel anxious about supporting a clinical group who are painted as particularly challenging. It is anticipated that this understanding will enhance therapeutic outcomes and engagement. It aims to contribute to professional understanding around the best utilization of resources whilst preserving and enhancing the therapeutic alliance, enhancing team cohesion, and reducing clinical burnout.

Definition of ‘Borderline Personality Disorder’

‘Borderline Personality Disorder’ (‘BPD’) was initially defined in 1978 and was then indexed in the Diagnosis and Statistical Manual of Mental Disorders (DSM), Third Edition (DSM-III) in 1980 and in the International Classification of Diseases 10 years later (as Emotionally Unstable Personality Disorder) (Gunderson et al., 2018). The most recent revision of the diagnostic criteria for

‘BPD’ occurred in 2011 and was published in the DSM-5 (5th ed., DSM-5, American Psychiatric Association [APA], 2013). A summary of the diagnostic criteria is presented below with full description in Appendix I:

> *‘The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose borderline personality disorder, the following criteria must be met:*
>
> *A. Significant impairments in personality functioning manifest by:*
> *1. Impairments in self functioning (a or b):*
> *a. Identity*
>
> *b. Self-direction*
>
> *AND*
>
> *2. Impairments in interpersonal functioning (a or b):*
> *a. Empathy*
>
> *b. Intimacy*
>
> *B. Pathological personality traits in the following domains:*
> *1. Negative Affectivity, characterised by:*
> *a. Emotional liability*
>
> *b. Anxiousness*
>
> *c. Separation insecurity*
>
> *d. Depressivity*
>
> *2. Disinhibition, characterised by:*
> *a. Impulsivity*
>
> *b. Risk taking*
>
> *3. Antagonism, characterised by:*
> *a. Hostility*

C. *The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.*

D. *The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment.*

E. *The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma)'.*

LITERATURE REVIEW

In this chapter, a review of the literature looks at prevalence rates for ‘BPD’, the stigma of the diagnosis, theoretical understandings of the condition, a look at other factors that may contribute to its onset, issues in the relationship between individuals with this diagnosis and mental health services, two therapeutic ways of working with ‘BPD’, some of the qualitative literature in this area and the research aims and rationale.

Prevalence

‘BPD’ is present in just under 1% of the general population (Coid et al., 2006), is prevalent in early adulthood and is often comorbid with other mental health conditions (NICE, 2009, reviewed July 2018). Studies have shown that 36–67% of inpatients have a diagnosis of BPD (National Institute for Mental Health in England [NIMHE], 2003). The number of outpatients with a diagnosis of ‘BPD’ is reported to be 10-11% (DSM-IV, 4th ed., APA, 1994). In primary care, the prevalence of ‘BPD’ ranges from 4 to 6% of primary attenders (Gross et al., 2002; Moran et al., 2000). Approximately 69-80% will self-mutilate or attempt suicide while in a distressed or crisis state of mind, and 10% will complete suicide (Pompili et al., 2005). This suicide rate is 50 times higher than the rate in the general population (McKeown, Cuffe & Schultz, 2006).

The DSM-5 (APA, 2013) reports a female-to-male ‘BPD’ diagnosis ratio of 3:1. However, epidemiological studies have reported mixed findings regarding gender differences in the prevalence rates of ‘BPD’. For example, diagnostic criteria were met in roughly equal proportions of males and females across studies included in a recent meta-analysis (Mdn 56.1% female, range 49.5–63.0%; Vokert et al., 2018).

A Controversial Diagnosis

The central feature of ‘BPD’ is emotional instability (World Health Organization [WHO], 1992). Those who live with this mental health condition struggle to identify and regulate their emotions. This causes great psychological distress, and often has a detrimental effect on the individual’s personal relationships and their sense of belonging to their local community and to society (Rogers & Dunne, 2013). Family members of individuals with a diagnosis of ‘BPD’ have been found to experience chronic and traumatic levels of stress (Giffin, 2008). The emotional volatility of ‘BPD’ often results in those with the condition being emotionally rejected and stigmatized by others, including the clinicians whose insight and support is desperately desired (Aviram et al., 2006). Once a diagnosis of ‘BPD’ is received, for some individuals, this result represents a sense of hope, control and an explanation for their past and present feelings and behaviour (Horn et al., 2007). However, others interpret this outcome as confirmation that they are a ‘bad’ person or a ‘failure’ (Ramon et al., 2001). Castillo argues that there is a need for ‘‘a reframing and renaming of the concept of personality disorder’’ as the term ‘‘is so very stigmatising that it can itself compound the effects of trauma, both by reinforcing a damaged sense of self and precipitating a negative service response’’ (Castillo, 2000, p. 58).

Negative staff attitudes towards individuals with a diagnosis of ‘BPD’ have been well documented in the literature (e.g. Gallop, 1985, 1989; Kaplan, 1986, Markham, 2003, Markham & Trower 2003). Cleary et al., (2002) reported that mental health staff found dealing with this client group to be more difficult than dealing with other client groups. Lewis and Appleby (1988) found that the term ‘BPD’ evoked negative reactions in psychiatrists who perceived people with ‘personality disorders’ as less deserving of care than a control group. As a group and individually, people with a diagnosis of ‘BPD’ have been referred to as ‘not sick’, ‘manipulative’, ‘non-compliant’ (Nehls, 1999), ‘time-wasters’, ‘difficult’, ‘bed-wasters’, ‘not mentally ill’ and ‘attention seeking’ (NIMHE, 2003). Their tendency to identify some staff as ‘all good’ and others as ‘all bad’ evokes strong counter-transference emotions and conflicts within staff and can lead to ‘splits’ between staff groups (Gallop,1985).

Aetiological Factors

Theoretical Perspectives

Psychodynamic/ Object Relations Theory

In 1938, Adolph Stern described a group of patients who “fit frankly neither into the psychotic not into the psychoneurotic group” (Stern, 1938, p.467), and introduced the term ‘borderline’ to explain what he observed because it ‘bordered’ on other conditions. Otto Kernberg (1967, 1975) maintained that borderline psychopathology stemmed from ego defects resulting from the predominance of intense, pathological, aggressive impulses, caused by either biological constitutional factors or early environmental frustrations where caregivers fail to provide adequate emotional care to validate the experiences of their infant. High levels of aggression interfere with the normative developmental process of integrating disparate representations of self and significant others by disrupting one’s capacity to integrate positive and negative representations (Kernberg, 1993). The mechanism of splitting (Kernberg et al., 1989) protects the ego from conflict by dissociating contradictory experiences of the self and others. The need to keep primitive aggression from contaminating the good self and good object or caregiver leads to splitting of the ego, so that contradictory all-bad and all-good self-representations and object-representations are separated (Kernberg et al., 1989). This self-protective strategy is costly because it prevents an integrated self-concept and concepts of others from forming, resulting in identity disturbance and a pattern of all or nothing thinking, where close relationships are often viewed in extremes of idealization and devaluation. Kernberg et al. (1989) claimed that a chronic overdependence on ‘external objects’ occurs in an effort to achieve some sense of continuity in action, thought, and feeling in relation to them. Levy et al., 2006) developed Transference-Focused Psychotherapy (TFP) based on this view of development. TFP focuses on reactivating the primitive object relations of a client with a diagnosis of ‘BPD’ in a controlled setting. With support from the therapist, the client develops an increased capacity to reflectively think about thoughts, feelings, and experiences. This creates change by integrating the polarized concepts of self and others. Doering et al. (2010) investigated the efficacy of TFP compared with treatment by experienced community psychotherapists for individuals with a diagnosis of ‘BPD’. The results found TFP to be more efficacious in the domains of borderline symptomatology, psychosocial functioning, and personality organisation. There was also preliminary evidence indicating that TFP was superior in the reduction of suicidality and requirement for psychiatric in-patient treatment.

Central to object relations theory is the concept of object representation which refers to conscious and unconscious cognitive structures of significant historical interpersonal encounters with caregivers (Lerner & Ehrlich, 1994). The significant early formative relationships are internalized within the mind of the infant and affect their later experiences of themselves and others (Cardasis et al., 1997). Winnicott (1953) believed that the ability of an individual to hold consistent images or representations of valued others develops during childhood through interactions with caregivers who are caring but frustrating. The evolution of 'emotional object constancy' provides grounding, supporting the infant to achieve an increasingly stable sense of significant others, leading to a more stable sense of self (Cardasis et al., 1997). The infant's evocative memory, the skill of being able to evoke the image of the good object, especially when they are fearful, is a crucial step in the process of developing object constancy, a fixed sense of self and others which can resist fluctuations in the consistency of the environment.

Numerous theories offer explanations as to why individuals with a diagnosis of 'BPD' fail to develop object constancy. For example, it has been associated with experiences of childhood trauma (e.g. Ogata et al., 1990). It has also been suggested that the adult 'borderline' as a child was unable to properly pass through the rapprochement subphase of the separation-individuation process of child development (Mahler et al., 1975). During this phase the child experiences conflict between anxiety over caregiver-separation and drive for autonomy. This is thought to be due to their caregiver's emotional lability, which thus prevents the child from developing a stable sense of self, others, or the environment (Fraiberg, 1969; Mahler, 1971; Mahler, 1972).

Without this inner representation of a soothing caregiver, individuals with diagnosis of ‘BPD’ are unable to contain their distress. Within the boundaries of the therapeutic relationship, the therapist provides ‘limited reparenting’ in the form of an emotionally holding relationship (Winnicott, 1965), where the therapist takes the role of the significant object (initially the ‘good enough’ mother) and provides the client with a sense of safety by acting as a ‘container’ for the strong emotional storms of the client. These soothing responses provided by the therapist in response to the client’s distress are gradually internalised by the client until they form the client’s own ‘Healthy Adult’ mode (Young et al., 2003). However, the emotional needs of individuals with a diagnosis of ‘BPD’ are often so great, that they are almost always more than the therapist can address through ‘limited reparenting’ (Young et al., 2003). Celani (1994) explains that as time goes by in the life of a child who has been repeatedly emotionally rejected by their caregiver, they need more rather than less support. The consistently deprived five-year-old requires not only that his five-year-old needs are addressed, but also the neglected needs from when he was four and younger. Therefore, by the time these individuals reach adulthood and enter the therapeutic space, their emotional needs are so great that it is impossible for the therapist to meet them. This situation evokes conflict within the therapeutic relationship, where the client becomes frustrated when the therapist is unable to fully commit themselves to the role of substitute parent.

Individuals with a diagnosis of ‘BPD’ experience similar frustrations in response to their interactions with mental health services who also struggle to meet their emotional needs. Individuals with a diagnosis of ‘BPD’ have described seeking emotional support from nursing staff in A & E and on psychiatric wards when they were in distress, but their feelings were met with advice to seek out expert help, for example by contacting their psychologist (Fallon, 2003). However, participants stated that it wasn't therapy they were seeking, but just to be heard and given time and emotional support, but nurses did not see this as their role. Participants in a study by Morris et al. (2014) described mental health services within the NHS as being reactive rather than proactive regarding risk. This meant that once immediate risk to the individual had been managed, services were not concerned with addressing the emotional distress which lay beneath the risk behaviour. This meant that individuals had to continue to suffer this distress without support. Where the participants of this study were offered long-term support, they described services offered as being focused on co-ordinating care, which was considered useful but superficial and disproportionate with the levels of distress experienced, and therefore the amount of emotional and psychological support required.

Both individual therapists and mental health services are faced with a great challenge in addressing the needs of individuals with a diagnosis of 'BPD'. How can services possibly begin to support these individuals? Winnicott (1986) recognised that skilful mothers were able to understand the needs of their children (known as 'the good enough mother'), and this supported the infant to make sense of their own inner experience. This allows the needs of the infant to be linked with accurate maternal responses in their mind, so that the world is experienced as a place that is responsive and validating of their needs, and they are protected. To achieve a 'good enough' service, staff interacting with individuals with a diagnosis of ‘BPD’ must be able to validate their distress, offer emotional support and aim to prevent rather than reduce risk (Morris et al., 2014).

The research literature also demonstrates the critical importance of adopting a trauma-informed approach in supporting individuals with a diagnosis of ‘BPD’ (Ferguson, 2016). This approach reflects the understanding of the relationship between symptoms of ‘BPD’ and the early histories of these individuals which are often found to include perceived experiences of trauma, real abuse, and difficult attachments (Wilkins & Warner, 2001). The impulsive symptoms of ‘BPD’ such as self-harm in response to painful emotions are understood to be a reaction to these early traumatic experiences, which are then internalized. The expression of impulsive behaviour in adulthood can be seen as giving form to re-enactments of early traumatic relationships with past attachment figures and an attempt to communicate their needs (Wilkins & Warner, 2001). Staff awareness of the relationship between the individual’s current behaviour and past life events has been found to improve the quality of care that these individuals receive because it can prevent negative staff attitudes from developing (Fallon, 2003), and ensures that services do not collude with or reinforce negative relationships and attachments (Wilkins & Warner, 2001).

Biosocial Theory

In biosocial theory, Linehan (1993) argues ‘BPD’ is primarily a disorder of emotion dysregulation, which emerges from transactions between individuals with specific environmental influences and biological vulnerabilities over time. Biological vulnerabilities to developing ‘BPD’ include neurophysiological and neurobiological differences between individuals with a diagnosis of ‘BPD’ and the general population. Linehan (1993) states that the specific environmental influences that contribute to the onset of ‘BPD’ include an invalidating developmental context in childhood, where any expression of private emotional experiences is met with an attitude of intolerance, especially emotions which are not supported by observable events. Although invalidating environments intermittently reinforce extreme expressions of emotion, they also suggest to the child that such emotional displays are unjustified and that emotions should be managed internally and without parental support. As a result of this parental response, Linehan (1993) states that the child does not learn how to understand, label, regulate or tolerate difficult emotions. Instead, these children learn to oscillate between emotional inhibition and emotional lability.

Linehan (1993) developed Dialectical Behaviour Therapy (DBT), which includes the application of a broad range of cognitive and behaviour therapy strategies to address the problems of ‘BPD’. DBT focuses on assessment, data collection on current behaviours, clear treatment targets, and a collaborative relationship between therapist and client. It emphasises ‘dialectics’; this is the reconciliation of opposites in a continual process of synthesis (Linehan, 1993). The key dialectic is the necessity of validating the client’s emotional distress and accepting them just as they are, within a context of trying to teach them how to change so that they might engage less frequently in self-damaging acts and become better able to regulate their emotions. Examples of such invalidating environments for children who eventually develop ‘BPD’ include those where they were subjected to emotional, physical and sexual abuse (e.g. Laporte & Guttman, 1996; Westen et al.1990).

Attachment Theory

Fonagy and colleagues (Fonagy & Target, 1997; Fonagy et al., 2004) describe a process of ‘mentalization’ where children develop the capacity to interpret or make sense of behaviour in themselves and in others in terms of intentional mental states. The development of this skill requires a strong emotional bond between child and caregiver, where the caregiver supports reflective function in the child by teaching them how to recognise and make sense of their own feelings and those of others. Where this relationship disintegrates, the child will struggle to recognise key social cues in others that will lead to future interpersonal relationship problems. Fonagy et al. (1996) propose that some characteristics of ‘personality disorder’ may be rooted in childhood abuse where those individuals coped with their maltreatment by refusing to conceive of their caregiver’s thoughts and thus avoided having to think about their caregiver’s wish to harm them. By defensively refusing to attend to their caregiver’s thoughts and thus withdrawing from the mental world, the child disrupts their capacity to depict mental states in others and in themselves (Fonagy et al., 2004). The maltreated child is left operating on inaccurate impressions of thoughts and feelings, making them significantly vulnerable in intimate relationships as they struggle to comprehend the thoughts and feelings of other people and of themselves. The result is a diminished capacity to form the close affectional bonds or secure attachments required by all human beings (Bowlby, 1969, 1973, 1980). Mentalization-based treatment (MBT) (Fonagy & Bateman, 2007) is a model of psychodynamic therapy based in attachment theory which aims to enhance the individual’s capacity to represent thoughts, feelings, wishes, beliefs, and desires in themselves and in others in the context of attachment relationships. It focuses on enhancing the patient's capacity to think about and regulate mental states.

Schema Therapy

Schema Therapy was developed as an addition to Beck's cognitive therapy to address the emotional difficulties of clients who presented with more pervasive, chronic psychological disorders after cognitive therapy had not been effective (McGinn and Young, 1996). These clients held more rigid belief systems, where their patterns of thinking and feeling were deeply rooted in their cognitive structures and were widely expressed in maladaptive coping strategies (Young et al., 2003). These lived experiences were understood to be associated with an abusive childhood, where the child's basic needs were not met, and maladaptive coping strategies thus developed as tools for survival (Kellogg & Young, 2006). To accommodate the needs of these clients, who in many cases, fitted the definition of having a 'personality disorder', Young et al. (2003) discovered it was necessary to extend the duration of therapy, devote more time to exploring childhood experiences and focus more attention on the nature and strength of the therapeutic relationship. Young et al. (2003) believed that successful treatment of clients with 'personality disorders', including 'BPD', required the delivery of an integrative psychotherapy, where cognitive therapy was enhanced with knowledge and techniques from object relation and attachment theories, and from Gestalt and emotion-focused therapies.

Schema therapy is based on two conceptual models in the formulation of the client’s issues and to understand the change process (Young et al., 2003). Early Maladaptive Schemas (EMS) are pervasive and self-defeating, defective patterns of thoughts, feelings, and behaviours, which usually evolve during childhood when there is a mismatch between a child’s basic needs and their environment. On recognition of the rapid emotional shifts endured by individuals with lived experience of ‘BPD’ with simultaneous activations of several schemas, Young et al. (2003) created the schema mode model. Modes or aspects of self, describe current states rather than traits, and refer to the interaction between an individual’s schemas and their coping style. The five key modes in ‘BPD’ are the Abandoned and Abused Child, Angry and Impulsive Child, Detached Protector, Punitive Parent, and Healthy Adult modes (Young et al., 2003), and individuals will switch continually from mode to mode in response to life events. The presence of these five key modes in ‘BPD’ have been supported in the research literature (e.g. Lobbestael et al., 2005).

Young et al. (2003) describes the Healthy Adult mode as weak and undeveloped in most clients who experience symptoms of ‘BPD’. The Healthy Adult mode is initially embodied within the therapist in their emotions, reactions, attitudes, and behaviour. Over the course of therapy, this mode of being is gradually internalised by the client. The Healthy Adult mode allows the client to protect and nurture their Abandoned Child, set limits on the behaviour of the Angry and Impulsive Child, and teach them more appropriate ways of expressing feelings and getting needs met, to overcome and expel the Punitive Parent, and to gradually replace the Detached Protector (Young et al., 2003). Interventions include limited reparenting, emotion-focused experiential techniques (including imagery work, dialogues, and letter writing), cognitive restructuring and education, and behavioural pattern breaking. These interventions are used during the three phases of treatment known as bonding and emotional regulation, schema mode change, and development of autonomy. In awareness of the fact that clients with lived experience of ‘BPD’ can trigger the therapist’s own schemas and emotional issues, schema therapists are encouraged to reflect on what is evoked for them in therapy (Young et al., 2003; Kellogg & Young, 2006). Through this process of self-analysis with the insight of their supervisor, they can understand and control their countertransferential reactions. The effectiveness of Schema Therapy to address symptoms of ‘BPD’ has been demonstrated in both the quantitative (e.g. Nordahl & Nysæter, 2005; Giesen-Bloo et al., 2006) and qualitative (e.g. Tan et al., 2018) research literature.

Enactment

The term ‘enactment’ has been subject to varying uses and definitions since it was first described in psychoanalytical literature (Jacobs,1986). An enactment occurs in the therapeutic space when historical emotional scenarios for both client and therapist that have been buried in the unconscious due to the intolerable emotion that they evoke, are repeated within their interactions in the therapeutic space (Maroda, 1998). The analytical dyad unconsciously performs real or fantasised traumatic situations from the past because of the impossibility of externalising these scenarios, or unconscious fantasises linked to them, through spoken or written expression of their meaning and the emotion they evoke (Cassorla, 2001). This means that the inter-actions between the therapist and client are often of a regressive nature. Busch (2006) proposes that enactments are defences that are activated once painful transference feelings are experienced by the client as dangerously close to consciousness, and this leads to a specific countertransference reaction in the therapist. An unconscious interpersonal process unfolds where in the countertransference, the therapist adopts a role to help protect the client from a dangerous thought or feeling, thereby supporting their defence.

Cassorla (2001) argues that the basis of enactment is projective identification (Bion, 1959; Klein, 1946), where parts of the self are split off and projected on to another person, and that object is mobilised by the projected contents in a bidirectional process between client and therapist. Intolerable feelings are projected from one member of the analytical dyad to the other, where the receiver identifies these feelings as their own and this triggers them to react in a reciprocal manner. The painful feelings evoked in the therapist are understood to be ones with which they identify and can keep them under the client’s control (Cassorla, 2001). In review of the literature describing examples of mutual enactments (e.g. Maroda, 1998), Struthbridge (2015) notes that the therapist’s response could be related to both the therapist’s unique personal history and the client’s repetitive affective patterns.

Individuals with a diagnosis of ‘BPD’ are known to ‘act out’ feelings which they cannot represent, and often require long-term therapeutic intervention to develop mentalisation capacity before they are able to directly address their difficulties (Ruggiero, 2012). There is conflict over the desire to fuse with the object which is an experience that was lacking in their relationship with their primary caregiver, yet there is also fear of the risk this poses to their identity. Through the process of projective identification (Klein, 1946), powerful countertransference is elicited within the therapist (e.g., anger and a desire to rescue the client) which is understood to represent the projection of the client's primitive uncontrolled feelings which have failed to be processed by their original caregivers, and therefore cannot be re-introjected by them in a more containable form (Holmes, 2004).

Fonagy and Bateman (2007) hypothesise that when a child is denied the opportunity to develop a self-representation through their caregiver's mirroring, they internalise the non-contingent image of the caregiver as part of their self-representation (Winnicott, 1956). If the caregiver is experienced as abusive, the child's self-representation becomes a torturing, alien self-representation which must be expelled because it is persecutory and not true to the child's primary experience (Fonagy, 2000). Fonagy (2000) explains that for the self to be coherent, the alien parts require externalisation through projection on to the other, so that they are seen as part them and can then be attacked. The power of the projections pulls the therapist into the historical role of the 'bad' object (Gabbard and Wilkinson, 1994). The countertransference disrupts their ability to function as a secure base who can accurately reflect their state of mind, thereby recreating historical trauma of interactions with a care giver who was unable to fulfil the individual's emotional needs (Holmes, 2004).

Though enactments may erode therapeutic progress or create an impasse, they also hold potential clues which may explain the client's difficulties with their capacity for thinking and offer insight into the destructive functioning of their inner world (Cassorla, 2008). To develop this insight and resume progress, the therapist must recognise the enactment and identify barriers to their own capacity to describe the client's actions and experiences. For the client's primitive feelings to be understood and represented as thoughts rather than actions, Ruggiero (2012) emphasises the importance of analysis of the countertransference and self-analysis in relation to the client (Bollas, 1987).

Re-enactments of past traumas can also be found within interactions between individuals with a diagnosis of 'BPD' and mental health services. Wilkins and Warner (2001) describe how patients with a diagnosis of 'BPD' who have endured similar chaotic experiences of early family relationships and trauma, and share related emotional needs are pushed together on hospital wards. These environments are regarded as chaotic with the replaying of family dynamics, sibling rivalry and power struggles with staff. This leads to staff becoming the desired carer and the hated abuser, resulting in patients engaging in impulsive behaviour to communicate their needs.

As children, when these individuals verbally or behaviourally expressed distress in response to experiences of trauma and abuse, this was often met with unheard, dismissive, or punitive responses from caregivers, signifying the message 'you're bad/ not important', (Wilkins & Warner, 2001). 'BPD' symptoms such as self-harm can therefore be understood as a reaction to early relationships with care givers, perceived trauma, and experiences of abuse, which are then internalized. These symptoms are a direct consequence of what was communicated to them by their early caregivers. As staff can become entangled in these re-enactments without the resources to reflect on them, patients' attempts to communicate their needs through their behaviour pass unacknowledged, thus repeating historical responses of denial and disbelief from their care givers. Wilkins and Warner (2001) stress the importance staff understanding of the relationship between a patient's experience of early traumatic relationships and their re-enactment in relation to their behaviour. This can improve relationships between staff and patients by reducing defensive staff behaviour and the number of harmful re-enactments played out.

Neurophysiological and Neurobiological Factors

Research studies have found neurophysiological and neurobiological differences between individuals with a diagnosis of 'BPD' and the general population that might further explain the emotional lability present in 'BPD'. NICE guidelines for 'BPD' (2009) indicate that the brain's neurotransmitters contribute to the regulation of impulses, aggression and affect. Research indicates that some people with a diagnosis of 'BPD' suffer from brain injuries or abnormalities in serotonergic, adrenergic, or cholinergic function. Reduced serotonergic activity may inhibit a person's ability to control destructive urges (e.g. Cornelius et al., 1989; Hollander, 1994). Evidence of structural and functional deficit in brain areas central to affect regulation, attention, executive function, and self-control have been reported in the brains of individuals with a diagnosis of 'BPD'. For example, Rusch et al., (2003) found a significant volume reduction in the area of the basolateral amygdala among patients with a 'BPD' diagnosis compared to healthy controls.

Trauma

Examples of invalidating environments which might contribute to the later onset of symptoms associated with ‘BPD’ include subjection to traumatic events, including emotional, physical and sexual abuse (e.g. Ogata et al., 1990; Westen et al., 1990). It has been reported that the incidence of physical and sexual abuse is significantly greater among women who have received the ‘BPD’ diagnosis than women with other types of ‘personality disorders’ (Laporte & Guttman, 1996). Zanarini et al., (2000) discovered that 84% of people with ‘BPD’ retrospectively described experience of biparental neglect and emotional abuse before the age of 18. It was also found that emotional denial of their experiences by their caregivers was a predictor of the onset of the disorder. It has been documented that traumatic experiences are ubiquitous in clients with ‘BPD’, and that there is a significant overlap in symptoms of ‘BPD’ with complex post-traumatic stress disorder (Mosquera & Steele, 2017).

Luyten et al. (2020) argue that complex trauma has been suggested to play a key role in explaining the severe problems with self and identity in patients with a diagnosis of ‘BPD’. They believe that the negative impact of complex trauma should be considered within a broad framework emphasising continuous interactions between environmental factors (attachment environment, relationships with peers and the sociocultural context) and biological factors. These interactions disrupt the evolutionarily pre-wired human capacity for social learning and salutogenesis (i.e. the ability to benefit from positive social input) by damaging effects on the capacity for epistemic trust (being open to receiving social communication that is personally relevant and of generalizable significance).

When trauma disrupts the capacity for epistemic trust, this leads to impairments in the capacity for attachment and the related capacity for social cognition or mentalising, (Luyten et al., 2020) The loss of these systems closes off the individual from the social world, leaving them feeling isolated, and no longer able to engage in social learning. They lose the ability to 'recalibrate' the mind or readjust it to adaptively process adverse life events.

Gender and the Social Construction of 'Borderline Personality Disorder'

The relationship between gender and the 'BPD' diagnosis is highly contentious. Although the DSM-5 (APA, 2013) reports a female-to-male 'BPD' diagnosis ratio of 3:1, the results of recent epidemiological studies are less conclusive. For example, data from the National Epidemiologic Survey on Alcohol and Related Conditions study (Grant et al., 2008), showed no gender difference in 'BPD' rates (around 6% for both genders). However, a second report based on the data revised the diagnostic algorithm to require that 'personality disorder' criteria were associated with distress/impairment and reported that 'BPD' was significantly more prevalent among women (3.02%) than among men (2.44%). A study conducted using data from the Collective Longitudinal Personality Disorders Study, a prospective examination of 'PDs' in treatment-seeking adults, found that women (72.92%) represented a higher proportion of 'BPD' diagnoses than men (27.08%). Upon reflection of the varied results found in recent epidemiology studies, Kalpakci and Sharp (2017) suggest that differences in methodology, including sample type and assessment approach, whether interview or self-report measures are used, are likely to contribute to the mixed findings regarding gender differences in rates of ‘BPD’. NICE guidelines for ‘BPD’ (2009) state that in community samples, the prevalence of the condition is roughly equal between genders. However, in services there are a greater number of women. Widiger and Frances (1989) report that ‘BPD’ patients who appear in treatment settings are 70 to 77 percent female. Kalpakci and Sharp (2017) propose that treatment-seeking behaviour is associated with the female gender, which may account for the higher percentage of women with a diagnosis of ‘BPD’ in clinical settings.

Several theories have attempted to explain the gender difference in ‘BPD’, including the influence of gender stereotypes (Nehls, 1998). Renzetti & Curran (1995) argue that the socialization process of young children is reflective of gender stereotypes, where boys and girls are socialized into separate and unequal genders. Boys are taught skills that are highly valued in society such as independence and problem-solving abilities, whereas girls are taught dependence and domesticity, which society devalues (Renzetti & Curran, 1995). It has been argued that when the stereotypical female behaviours of demanding and dependent behaviour are displayed by adult women, this will increase the likelihood of a ‘BPD’ diagnosis (Becker, 1997; Gunderson & Zanarini, 1987). Studies indicate that when comparing men and women with ‘BPD’, men were more likely to present with comorbid substance abuse, schizotypal, narcissistic, and anti-social personality disorders, while women presented with post-traumatic stress disorder and eating disorders (Johnson et al., 2003; Zlotnick et al., 2002).

Simmons (1992) argues that the psychiatric classification that an individual will be diagnosed with will be influenced by gender. Anger in women suggests

‘BPD’, but in men it suggests ‘anti-social personality disorder’. Horsfall (2001) claims that gendered assumptions are embedded within psychiatric knowledge, and that ‘BPD’ is ultimately a gendered construct born from a classification system that is itself a social construction. Gaines (1992) contends that psychiatric classification is culturally constructed and expresses an underlying ethnopsychology of the ideal self. He believed the psychiatric classification systems are attempts to describe during particular historical times, “a particular culture’s unconscious ethnopsychological assumptions” about what constitutes the ideal self, Other, and the modes of experience and activity that indicate abnormality.

Butler (2004) explores what it might mean to undo restrictively normative conceptions of gendered life or what it means to ‘become undone’ by the power of society in relation to being socially accepted as a human being. She argues that a normative conception of gender can undo one’s personhood, undermining the capacity to persevere in a liveable life. Butler explains that the social norms that constitute our existence carry desires that do not originate with our individual personhood. Our chance of continued existence as an individual person is fundamentally dependent on these social norms. The traits that are considered ‘desirable’ by society are culturally dependent and change with the progression of society. If a person embodies traits that are recognised and valued by society as desirable, then that person will be recognized as fully human and powerful. If the individual cannot achieve recognition by conforming to society’s norms, then they will become powerless and socially isolated.

Relationships with Mental Health Services

NICE guidelines for the recognition and management of ‘BPD’ (2009) state that the extent of the emotional and behavioural problems experienced by people with ‘BPD’ varies considerably. Some individuals can maintain relationships and employment, but others experience repeated crises and are frequent users of psychiatric and acute hospital emergency services. Individuals with ‘BPD’ have sometimes been excluded from health or social care services because of their diagnosis, possibly due to lack of staff confidence and skill in this area (NICE, 2009). NICE guidelines for ‘BPD’ (2009) state that it is the community mental health services that should be responsible for the routine assessment, treatment, and management of people with ‘BPD’. However, the NIMHE (2003) indicates that only those who suffer the most significant distress or difficulty will be referred to secondary services and explains that as with all forms of ‘mental disorder’, the majority of people with a ‘personality disorder’ who require treatment will be cared for within primary care. People with a primary diagnosis of ‘personality disorder’ are frequently unable to access the care they need from secondary mental health services, and specialised ‘personality disorder’ services are rare.

It appears that for many people diagnosed with ‘BPD’, their lives have been a repeating pattern of emotional neglect and invalidation from those from whom they desperately seek to be heard and understood. Even some clinicians have been reported as being weary of this group for fear of manipulation or emotional burn-out (Aviram et al., 2006; Fallon, 2003; Markham, 2003). This pattern is even repeated by mental health services (Markham, 2003). Johnstone and Dallos (2013) describe a typical relational re-enactment, where the client attempts to address the unmet attachment needs and unresolved trauma from their early life through the services of their mental health team. When this approach fails because the service is not designed to fulfil this need, the team's empathy for the client gradually develops into frustration at the client's lack of progress. By becoming unwilling or unable to provide further support, the team unconsciously repeats the client's early experiences of emotional rejection.

Within mental health services, there is a continuing pressure to offer effective therapeutic intervention to reduce psychological distress within a limited time frame in order to minimise the time a client spends on the waiting list and the financial cost to the organisation for providing this service. Where mental health services for 'BPD' are available, there are only sufficient resources for those who are experiencing the most acute psychological distress (NIMHE, 2003). Individuals with 'BPD' still experience difficulty in accessing treatment services that have the length of time and skill available for the individual's key treatment goals to be met (Katsakou et al., 2012). Chalkley (2015) describes how the significant pressure on practitioners to keep their therapeutic work short and highly structured has prevented them from being able to immerse themselves in the content of their clients concerns, because of the need to achieve particular goals within a limited time frame. However, despite these ongoing restrictions, Counselling Psychologists have an obligation to stay true to the needs of their clients and to provide a platform from which their voices can be heard. The demands on mental health services should not be at the expense of the provision of a supportive therapeutic relationship (Ashley, 2010). As client knowledge of therapeutic practice increases, so does their expectations of their therapist to meet their individual needs rather than present them with standard manualised interventions. Chalkley (2015) argues that for therapy to be truly client-centred, the content of the distressing concerns that clients bring must be identified, acknowledged, analysed, and worked through, always using the client's own words for their description of their emotional distress. This therapeutic approach focused towards the content of client experiences can be described as the humanistic approach, which highly values attention to client subjective experience, personal meaning and self-worth in the context of an accepting and supportive therapeutic relationship (du Plock, 2010).

Two Contrasting Therapeutic Approaches

The humanistic approach is the philosophy in which Counselling Psychology is based (Strawbridge & Woolfe, 2003). Du Plock (2010) states that counselling psychologists who adopt this humanistic approach in therapy which highly values the healing potential of the therapeutic alliance can be said to be practising an approach of 'being with' the client in therapy. Du Plock (2010) contrasts this with ways of working more influenced by medical models, which involve the use of 'expert' knowledge to treat clients and use strategies to promote change, or even 'cure'. This is described as an approach of 'doing to' the client in therapy. Steffen (2013) explores how a 'being with' approach based on humanistic values can be integrated into therapeutic work with clients diagnosed with 'BPD' in contemporary health care settings, and some of the dilemmas which can present themselves to counselling psychologists when working solely from this stance. Practising a humanistic approach validates the individual experiences of the client, and this process helps to prevent their identity from becoming lost within the ‘BPD’ diagnosis. However, Steffen (2013) argues that there are occasions when practising such an approach in response to the needs of a client with a diagnosis of ‘BPD’ could be interpreted as unhelpful, invalidating and, in times of crisis, could be seen to be dangerous to the wellbeing of both client and therapist. Such occasions would include communicating the humanistic belief in the client’s self-actualising potential for growth when the client views themselves as fundamentally flawed. When a client is in crisis and is contemplating suicide, by practising a ‘being with’ approach based only on empathy and validation, this can confirm their experience of themselves as unworthy of being protected and cared for, and that suicide is a viable option (Steffen, 2013).

In order to fulfil a therapist’s duty of care to their client, a more directive, ‘doing to’ approach can sometimes be necessary to ensure client safety and to protect the therapist’s boundaries and the healing potential of the therapeutic relationship. However, Milton (2001) argues that where suicidal ideation and behaviours are a recurring theme in therapy, a ‘doing to’ approach should not be followed so adherently that there is no therapeutic space to allow a client-focused exploration of meanings and functions of the suicidal material. In review of the theoretical model of DBT to support clients with ‘BPD’, Hadjiosif (2013) recognises that although the validation strategies practiced in DBT allow a collaborative stance between therapist and client, and a holistic acceptance of the client as a worthy human being whose thoughts and actions make sense, DBT remains a manualised approach whose delivery can become invalidating to clients who do not buy into its theory and culturally embedded assumptions. Steffen (2013) concludes that both a humanistic approach of ‘being with’ and a more directive approach of ‘doing to’ have their contributions to make in enhancing the mental wellbeing of someone with a diagnosis of ‘BPD’, and that the most effective therapeutic models, such as DBT, will skilfully move between these two approaches to most effectively address the needs of the client. In order to stay grounded within the client-centred humanistic foundation of counselling psychology, it is important that this debate be extended from within the discipline to those personally affected; to individuals with a diagnosis of ‘BPD’ who have come into contact with mental health services.

Asking individuals with a diagnosis of ‘BPD’ about the potential benefits and shortcomings of the two approaches would be of great value to therapists because it would highlight what makes a positive change for them, so time and resources could be invested in the training and application of the most beneficial approaches. The information gathered might also shed valuable insights into how to enhance the quality of the therapeutic alliance. This is critical for clients who struggle to trust (Langley & Klopper, 2005), and for therapists who are under pressure to complete therapy within a set timeframe.

Qualitative Studies in ‘Borderline Personality Disorder’

As noted in the Introduction, qualitative research has attempted to provide a platform for individuals with a diagnosis of ‘BPD’ to express their views and describe their experiences on a range of topics. These include the lived experiences of ‘BPD’ (e.g., Ntshingila et al., 2016), experiences and understandings of being given the diagnosis (e.g., Horn et al., 2007), understandings of ‘recovery’ from ‘BPD’ (e.g., Katasakou et al., 2012), experiences of therapy for ‘BPD’ (e.g., Hodgetts et al., 2007) and of mental health services (e.g., Fallon, 2003). However, as concluded by Katsakou and Pistrang (2017) in their meta-synthesis of findings from qualitative studies exploring clients’ experiences of their treatment for ‘BPD’ and their perceptions of ‘recovery’, studies do not always present their themes with detailed description and psychological meaning, following a strong analytic narrative, and an explanation of how themes might relate to each other to inform the phenomenon under study. I have sampled the following research studies in ‘BPD’ as they raise issues of method and interpretation that I believe are key to this piece of research.

Rogers and Dunne (2013) reported the findings of a semi-structured focus group with 7 service-users with a diagnosis of ‘BPD’ who were under the care coordination of a specialist ‘personality disorder’ service as part of a service development project. The aim was to specifically explore their experiences of the Care Programme Approach whilst under the care of a community mental health team within the National Health Service. Authors provided detailed information about the process of recruitment and the procedure, including the list of questions asked of participants. Such detail offers a sense of transferability (Lincoln & Guba, 1986), allowing the reader to evaluate the potential of applying the results to other contexts and participants.

However, significant detail was missing in the analysis section. Authors merely stated thematic analysis (TA) was used with the use of Braun and Clarke’s (2006) article which details each stage of the analysis process to ensure it was performed accurately. Braun and Clarke (2006) and Holloway and Todres (2003) argue that it is important that researchers are transparent in declaring the theoretical position (their epistemological and other assumptions) of their analysis, and that the specific approach to TA is made clear. Rogers and Dunne (2013) did not specify which form of TA they were using or discuss the epistemological assumptions that shaped their analysis. They also did not describe their process of analysing the data. Attride-Stirling (2001) states that researchers need to be clear about ‘how’ they conducted their analyses, as reporting the techniques used serves to enhance the value of their interpretations and allows their work to be evaluated. Providing this information also assists other researchers who wish to engage in related projects in the future.

Though researchers describe using a qualitative design, quality criteria and techniques applied to ensure it reflected quantitative rather than qualitative standards. Researchers emphasised the importance of ensuring that their analysis was as objective as possible and used interrater percentage agreement to assess reliability of the themes. As qualitative research values subjectivity, evaluation of the ‘trustworthiness’ of research is considered a more suitable criterion of quality than reliability and might be assessed using the technique of member checking (Braun and Clarke, 2013).

Though a good balance was struck between analytic narrative and data extracts supporting claims made, the findings were listed as eight individual themes without subthemes or visual representation of the themes as a thematic map. The narrative identified patterns across the data, but it was necessary to study the text closely to identify links between themes. A restructuring of the themes, presented in a thematic map would likely assist the reader to better understand how they link together to form a coherent meaningful synthesis of what was expressed by the participants. For example, ‘Progression versus Consistency’ (wanting progression but craving staff consistency and fearing rejection from services that might result from progression) was connected to ‘Moving On from Services’ (moving on to the specialist service seen as positive because of increased involvement in care but evoked fear around discharge, leading to feelings of abandonment and rejection). These might have been better understood as subthemes under a main theme; ‘Relationships with Services’.

In summary, analysis of this research highlights the importance of being transparent in declaring the theoretical position of one’s analysis and the specific approach to the method applied. It also draws attention to the importance of detailing the analysis process so that this may be repeated by other researchers, applying qualitative quality criteria to qualitative research, and presenting your results clearly to the reader (including having themes and subthemes which are presented visually), so clear links can be made between the themes.

Gillard et al. (2015) conducted a qualitative interview-based study with six individuals purposively sampled from a specialist ‘personality disorders’ service to explore understandings of ‘recovery’ from the perspectives of people with lived experience of ‘personality disorders’. Throughout their article, Gillard et al. (2015) demonstrate clear ownership of their own perspectives (Elliot et al., 1999), which were harnessed to enhance the quality and utility of the findings produced for the benefit of both individuals with a diagnosis of ‘personality disorder’ and the clinicians who support them. The researchers engaged in discursive practice to co-produce understandings of ‘recovery’ that responded to the lived experience of ‘personality disorders’ and were of applied relevance to practitioners. The research team (a university-based researcher, service user researcher with lived experience of ‘personality disorder’ and a clinical researcher with experience of working in ‘personality disorders’ services) adopted an interpretive, collaborative approach to their study where researchers were jointly involved in carrying out interviews and analysing interview data. This approach was designed to ensure that data collection and analysis were not shaped predominantly by the priorities of a particular researcher, therefore, providing a form of triangulation (Lincoln & Guba, 1986) which enhanced the trustworthiness of the findings produced.

To ensure that the analysis was informed by the interpretations of all members of the research team, a thematic analysis process was developed in several stages where researchers shared the tasks. Each stage of the analysis process was described in the text and listed in a table alongside details of the team members involved at each stage, making the process transparent to the reader. Commitment to a rigorous analysis was reflected in the presentation of a table which demonstrated theme development and refinement. The first theme, ‘The lived experience of personality disorders’, and its’ component sub-themes, provide the context with which to make sense of the second theme, ‘Understandings of recovery in the context of lived experience of personality disorders’, and its’ component sub-themes. Clear links between themes were consistently interwoven within the analytic narrative and supported with a significant number of participant quotes. Themes were also depicted as diagrams to support the reader to make sense of how researchers interpreted the relationships between themes. This allowed the findings to be presented as a coherent and meaningful psychological concept (Morrow, 2005), offering an understanding of ‘recovery’ which is specific to lived experience of ‘personality disorders’.

This study reflects the value of the researcher presenting clear ownership of their perspective on the research topic and seeking the perspective of other researchers through triangulation which enhances the trustworthiness of the findings produced. The study also displays its quality through demonstrating engagement in a rigorous analysis and presenting clear links between themes within a strong analytic narrative supported by vivid participant quotes.

Lonargáin et al. (2017) conducted a study to explore how adults with difficulties associated with ‘BPD’ experience intensive out-patient Mentalisation-Based Treatment (MBT). Seven adults recruited from three NHS Trusts were interviewed, and the data was analysed using interpretative phenomenological analysis (IPA). In the study’s design section, the researchers were attentive to detailing the paradigm which underpinned their research and the philosophical assumptions which informed it (Morrow, 2005). They explained what IPA is, its’ intellectual heritage, the type of research it is used for and why it was an appropriate choice for their research. There was a clear fit between the research question and the design and philosophical assumptions which underpinned it.

To achieve transferability, the researchers provided information regarding participant inclusion criteria and where they were recruited from. They also listed details of therapist training and supervision, and the process of recruitment, receiving ethical approval and data collection. The text states that the first author conducted, recorded, and transcribed all the interviews, and analysed all the data. The researchers explain exactly how the data was analysed. However, the only credibility check discussed was the use of a reflective diary by the first author around the time of the interviews and analysis phase to highlight and bracket potential biases and assumptions, and to reflect on each interview to enhance interview performance. As there is no mention of the analysis being checked by the other researchers or the participants, in addition to discussion of the reflective diary, it would have been helpful to have information reflecting ownership of the researcher’s perspective (Elliot et al., 1999; Morrow, 2005). By sharing the researcher’s theoretical orientations and personal anticipations, their experience with the topic and qualitative methods, and any assumptions and biases they bring to the study, this supports the reader to interpret the researcher’s data and understanding of them, and to consider possible alternatives.

Analysis of participant data resulted in four main themes and twelve sub-themes. The first two themes regarding the challenges of engaging with group therapy and the importance of developing trust in therapeutic relationships, though part of participants’ experiences of MBT, had also been described in studies exploring the experiences of service users with lived experience of ‘BPD’ for other therapeutic modalities (e.g., Hodgetts et al., 2007; Langley & Klopper, 2005), and thus were not specific to experiences of MBT. The number of themes and length of the titles made it confusing and difficult to grasp what the core experiences were for service users engaging with MBT. Themes read as shallow summaries listing all participants had discussed, rather than capturing a deeper, meaningful psychological concept relating to their experiences of MBT. The analytic narrative accompanying each theme was often brief, with few quotes, often reduced to quoting key words rather than full participant quotations.

The key issues this study highlights are the importance of having a clear fit between the research question, the design and the philosophical assumptions which underpin it, and being transparent about these details and why they fit together. This study draws attention to the need for multiple methods to check credibility, having an appropriate number of themes so that the core findings are clear to the reader, and ensuring that each theme is representative of a deep and meaningful concept that is well evidenced, rather than a shallow summary of participants' narratives.

Morris et al.,(2014) conducted a study to explore the experiences of individuals with a diagnosis of 'BPD' of accessing adult mental health services to better understand which aspects of contact with services can be helpful or unhelpful. Nine participants were recruited though voluntary sector services. They engaged in semi-structured interviews and the data was analysed using inductive thematic analysis. Researchers demonstrated sensitivity to context (Yardley, 2000, 2008) by explaining that though previous research had explored the topic under investigation, it had not been revisited since the introduction of UK government guidance (NIMHE, 2003) to address the issue of deficits in quality of care received by individuals with a diagnosis of 'BPD'. They also discussed some of the challenges faced by individuals with a diagnosis of ‘BPD’ when they have tried to access care e.g., negative experiences of being diagnosed (Horn et al., 2007).

In the Methods section, detailed information was provided regarding participant inclusion criteria and demographics. Researchers were transparent in describing their study’s design as qualitative using inductive thematic analysis, and their epistemological stance as ‘critical realist’. The interview schedule was shared in the appendices to make the reader aware of the topics covered and the analysis process was described, though this was brief. Sensitivity to context (Yardley, 2000, 2008) was also reflected in the researchers’ decision to consult with members of an internet service-user group prior to commencing the research, to ensure the interview schedule was an appropriate tool for understanding service users’ experiences. The researchers were very thorough in their implementation of techniques to increase the trustworthiness of the findings. These included the use of a reflective diary, negative case analysis, member checking and triangulation via the analysis of two transcripts being corroborated by the second researcher.

Analysis of the data resulted in the development of three themes which were ‘The diagnostic process influences how service users feel about BPD’, ‘Non-caring care’ and ‘It is all about the relationship’. As described by the researchers, themes were ‘interconnected’, but links between them could have been made more explicit to demonstrate a more meaningful understanding of what was being expressed by participants, and to make sense of the findings as a psychological concept. All themes highlighted the importance of mental health professionals treating service users as people and prioritising the development of a trusting therapeutic relationship. The analysis for each theme provided a strong narrative with rich detail to explain its meaning. However, there were only three themes with no sub-themes, where most participant quotes were reduced to key words rather than full quotations. Additional detailed participant quotes could have been interweaved into the text to better evidence the themes and give participants’ a stronger voice. In summary, this study emphasises the importance of showing sensitivity to the research context, having multiple techniques to increase the trustworthiness of the findings, and the importance of making explicit links between themes in the analysis and evidencing points made with sufficient participant quotations.

Following review of the above research literature, I conclude that my own research must be transparent in declaring the theoretical standpoint from which it makes sense of the data and the specific method of analysis applied. It must provide a detailed description of data analysis and include multiple credibility checks. I must take ownership of my perspective on the research topic, and the themes and subthemes produced must be clear and reflective of deep, interlinking, and well-evidenced psychological concepts.

RESEARCH RATIONALE, AIMS AND DEVELOPMENT OF THE QUESTION

Research rationale

Although the use of qualitative studies to explore the beliefs and experiences of individuals with a diagnosis of ‘BPD’ have been established in the literature, some of which discuss what factors individuals have found useful in therapy, as Katsakou and Pistrang (2017) conclude, it is still unclear how individual beneficial therapeutic factors work together to form a process of positive change for the individual. Studies have focused on individual’s evaluations of recent therapeutic interventions that they have received and their experiences of those, rather than inviting them to reflect on two therapeutic ways of working, and to share their views on what they think would be helpful for supporting individuals with a diagnosis of ‘BPD’ in therapy.

By extending the debate around the strengths and weaknesses of the ‘being with’ and ‘doing to’ approaches in their capacity to support individuals with a diagnosis of ‘BPD’ from the professional arena to experts by lived experience, it was thought that this would be a successful way to elicit rich detail about how processes of positive change are achieved, in a manner very much aligned with the values of Counselling Psychology. By asking individuals with a diagnosis of ‘BPD’ to share their opinions on these approaches and by asking what is helpful to provide in therapy, the knowledge gathered will not only give a voice to a group of people who are still stigmatised by services which will hopefully contribute to service evaluation and influence future service delivery, but by specifically exploring their thoughts on two therapeutic approaches, it is anticipated that this will provide more detail about how processes of positive change in therapy are achieved.

Research Aims and the Development of the Research Question

The research question asked of participants at interview was whether they thought a relational ‘being with’ approach or a directive ‘doing to’ approach would be most effective for supporting clients with a diagnosis of ‘BPD’. This question aimed to uncover more about what this clinical group found useful in therapy, how to improve the quality of the therapeutic relationship, how to improve support in crisis and to find other ways to improve service delivery. It aimed to build on previous qualitative research in attempting to find out more about the facilitative processes of positive change in therapy for individuals with a diagnosis of ‘BPD’. As a result of some initial interviewing and engaging in a literature review, I formulated a set of questions which informed the research interviews which are listed in the next chapter. However, upon analysis, there emerged a mismatch between the research questions and the data produced, so it was necessary to develop the research question.

When analysing the complex data that this question generated, it emerged that the original research question no longer did justice to the depth of material and what participants were trying to tell me in their narratives. What they were describing was something much deeper than a simple binary choice between therapeutic approaches. They were informing me of their deep, complex needs from therapy, Counselling Psychology, and mental health services as a whole.

Participants were asking services not to treat them as everyone else had done by listening to them, being there for them and responding to their needs. They also expressed some of the highly damaging ways that they had been treated by society which put them at significant risk. It became clear that the question the research was asking of its data was ‘What do individuals with a diagnosis of “BPD” really need from Counselling Psychologists? And how can we begin to undo all the ways in which everyone who should have cared for them has let them down?’

In prioritising the voices of those with lived experience, it is hoped that their views will be reflected upon by therapists in relation to how they work with this group and will be considered by services in terms of future interventions offered, so that individuals with a diagnosis of ‘BPD’ receive a better experience of therapy and services, with the delivery of therapy that is meaningful for them. It aims to draw professionals’ attention to the impact of psychosocial factors on the mental health of individuals with a diagnosis of ‘BPD’, how services can prevent the repetition of historical traumas and provide a better quality of care which addresses their complex emotional needs.

The research aims to challenge the stigma surrounding ‘BPD’, to support therapeutic practitioners to address the fears or negative assumptions they may hold about this clinical group and improve the quality of relationships that they have with them. For trainee therapists, this research aims to help prepare them for work with a clinical group that they might have been told are challenging to work with, and to support them to build a strong therapeutic relationship within what may be a time-restricted intervention. It is anticipated that this research will generate knowledge about what therapeutic factors individuals with a diagnosis of ‘BPD’ find useful, and it is hoped that this information will support therapists to make the best use of the time and resources available to them, and hopefully to avoid clinical burnout.

In this chapter, I have discussed the prevalence of ‘BPD’, controversies regarding the diagnosis, some of the theoretical understandings of the condition and other factors that are believed to contribute to its onset. I have described two ways of working with individuals with a diagnosis of ‘BPD’ in therapy, reviewed some of the related qualitative research and stated the research rationale, aims and development of the research question. In the next chapter, I will describe the study’s design, method, theoretical framework, data collection and analysis process, issues of quality and reflexivity.

METHODOLOGY

In the previous chapters, I presented the definition of ‘BPD’ and discussed its’ prevalence, theoretical understandings, bio-psycho-social factors, psychological interventions, and their success. I described the two therapeutic approaches under scrutiny, reviewed the qualitative literature, highlighted this study’s contribution, and concluded with its’ rationale and aims. I will now describe the study’s design, provide my rationale for the chosen methodology and relate these choices to the values of Counselling Psychology. This is followed by details of the method and concludes with reflexivity.

Design

The study’s design was strongly influenced by my values as a counselling psychologist in training. Counselling Psychology embraces both the identities of the ‘scientist-practitioner’ and ‘reflective practitioner’ in their attempts to explore the human condition (BPS, 2020). Attention is paid to the development of phenomenological models of practice and enquiry in addition to that of traditional scientific psychology (BPS, 2005). Strawbridge and Woolfe (2010) describe how Counselling psychology emphasises the subjective experience of clients and the need for helpers to engage with them as collaborators, seeking to understand their inner worlds and constructions of reality. Application of these values is essential for working with individuals with a diagnosis of ‘BPD’ as they are known to have felt misunderstood (Nehls, 1999). A cross-sectional qualitative approach was implemented to obtain rich accounts of participants’ views. Reflexive Thematic Analysis (Braun & Clarke, 2006; 2019) was the chosen method because the research question sought to explore participant’s opinions at a deeper level.

What is Reflexive Thematic Analysis?

Braun and Clarke (2006; 2012) describe Thematic Analysis as a method for systematically identifying, organising, and offering insight into patterns of meaning (themes) across a data set in relation to the research question. This allows the researcher to recognise and make sense of shared meanings and experiences. It is now known as Reflexive Thematic Analysis (RTA) because of the centrality of researcher reflexivity (Braun et al., 2018).

RTA provides a method of data analysis but does not prescribe methods of data collection, the theoretical position or epistemological or ontological frameworks (Braun & Clarke, 2013). This gives flexibility to select the theoretical and epistemological approach most appropriate for the research question. RTA was judged to be a suitable method for data analysis as the research question concerns participants' opinions. I wanted to prioritise my participants' voices which meant taking a primarily inductive or 'bottom-up' approach towards data coding and analysis, where themes identified are strongly linked to the data themselves (Patton, 1990).

As I understand 'BPD' as a social construction, the theoretical framework for the analysis is critical constructionist in orientation. Critical qualitative research takes an interrogative stance towards the meanings expressed in the data and uses them to explore some other phenomenon (Braun & Clarke, 2013). Constructionism understands meaning and experience to be socially produced and reproduced, rather than existing within individuals (Burr, 1995). Social interactions between people are given structure and content by the culture in which we live, by our society’s economic conditions, and by the power relations in which we are embedded (Burr, 2015). Constructionist analysis works to unpick the surface of ‘reality’, by identifying the hidden concepts, assumptions and meanings which underpin the surface content of the data (Braun & Clarke, 2013).

In the earlier phases of analysis, initial themes developed represented semantic or surface level themes (Boyatzis, 1998). Over time, with greater immersion in the data and related literature, theme identification progressed from semantic to a more latent level (Patton, 1990). Latent themes are interpretative, where there is an attempt to theorize the significance of the patterns and their broader meanings and implications (Braun & Clarke, 2006). The final analysis generated both semantic and latent level themes.

My approach to RTA is consistent with the values of Counselling Psychology as the data-driven inductive approach to analysis reflects engagement ‘with subjectivity, intersubjectivity, values and beliefs’ and ‘seeks to know empathically and to respect first person accounts as valid in their own terms’ (BPS, 2005). Its critical constructionist framework is aligned with the values of counselling psychology in that it understands knowledge to be ‘co-constructed’ (BPS, 2020), aims at ‘the exploration, clarification, and understanding of clients’ worldviews, underlying assumptions, and emotional difficulties that emerge out of our interaction with the world and others”.

Role of the Researcher in the Research Process

In RTA (Braun & Clarke, 2019), as the researcher I am positioned as active in the process (Braun & Clarke, 2006). Though a degree of bracketing may be achieved (Morrow, 2005), I accept it is not possible nor desirable to fully free myself of my prior beliefs (Heidegger, 1962; LeVasseur, 2003). I take ownership of my beliefs around ‘BPD’ and make these visible to the reader for evaluation of their impact on knowledge produced. In RTA *(*Braun & Clarke, 2019), my role is central to knowledge production, where themes are produced at the intersection of my theoretical assumptions, analytic resources and skill, and the data.

This union between the data provided by the participant and the theoretical knowledge and analytical skill contributed by the researcher in the co-construction of knowledge is mirrored in the relationship between a Counselling Psychologist and their client. Counselling Psychology understands knowledge as co-constructed through relational practice, where practitioners bring aspects of themselves to their work, derived from their training, wider knowledge and lived experience, (BPS, 2020*).*

Rationale for chosen Methodology

In planning this research study, various methodological approaches were considered in terms of their relevance to the research question.

The decision to apply qualitative rather than quantitative methods

A qualitative methodology was selected to ensure the data collection environment was one where participants could share their opinions freely, without being constrained by the often predetermined categories listed within quantitative data collection methods (Braun & Clarke, 2013). Barker et al. (2002) state the linguistic data collected in qualitative approaches can give the researcher rich, deep, and complex information, sometimes referred to as ‘thick description’, (Geertz, 1973). Other benefits of qualitative approaches include the ability to ‘give voice’ to a group of people or an issue, its flexibility and attention to meaning (Braun & Clarke, 2013).

A qualitative synthesis study by Berry and Hayward (2011) demonstrates that qualitative research can provide a detailed understanding of clients’ lived experiences of therapeutic interventions and illuminate their perspectives on their goals and what is useful to them. The importance of obtaining service-user feedback regarding their experiences of mental health services has been highlighted within the literature (Omeni et al., 2014; NICE, 2011; NIMHE, 2003). Service-users with a diagnosis of ‘BPD’ have been included in such service evaluations (e.g. Lamont & Dickens, 2019; NICE, 2009). Previous research discusses the significance of service-users with a diagnosis of ‘BPD’ being involved in the care planning process, and the detrimental impact of being excluded from decisions made regarding their care (Fallon, 2003; Rogers & Dunne, 2013).

Continued commitment to acquiring service-user feedback is critical in maintaining a sense of collaboration between services and their recipients. The ability of services to understand and respond to this feedback can improve people's experience of services and support the effective use of resources (NICE, 2011). The use of qualitative methods to explore issues relating to individuals with a diagnosis of 'BPD' have been well established in the research literature. These include the application of Poetic Analysis (Chugani, 2016), Grounded Theory (Fallon, 2003) and Interpretative Phenomenological Analysis (Hodgetts et al. 2007).

Rationale for utilizing RTA

This research journey has undergone many adaptations before coming to the final research question and methodological framework presented here. Unexpected twists and turns in the journey prompted reflection on suitability of methods used and whether the research question accurately captured the key message expressed by participants.

The original research question ('Understanding the "Recovery" Journey from "BPD": how do individuals make sense of their experiences before and after therapeutic intervention?') sought to gain insight into the lived experiences of individuals with a diagnosis of ‘BPD’ at different life stages; including life pre-therapy, experiences of therapy and life post-therapy. Addressing this question required the gathering of participants’ personal narratives of their life-story, and so the use of individual interviews was the obvious choice of data collection approach. A version of Wengraf’s (2001) Biographic-Narrative Interpretive Method (BNIM) was adapted for use in the pilot study as it was expected to evoke rich narratives within an informant-led process. The interview procedure involves three sub-sessions (Wengraf, 2001; 2004). The interviewer begins with a single narrative interview question (SQUIN), inviting participants to tell their life story. Sticking strictly to the sequence of topics raised and the words used, the interviewer then asks for more narratives and concludes with more non-narrative questions. The method of analysis was undecided, but different types of narrative analysis (e.g. Murray & Sools, 2014) or the BNIM interpretation procedure were under consideration. Pilot interviews elicited rich data, but one participant reflected that she found it difficult to stay focused due to the lack of structure. During a research review, it was suggested the research question should have a clearer focus and simpler method. The research question was changed; inviting individuals to reflect on the utility of relational and directive approaches in addressing the needs of clients with a diagnosis of ‘BPD’ and to share what therapeutic factors they found helpful.

I felt narrative interviewing was useful for research with participants with a diagnosis of ‘BPD’ because it shifts power in the participant-researcher relationship by giving control to the participant, reducing the interviewer’s role to active listening. This builds trust and thus has a direct influence on data quality.

In selecting an alternative methodology, I wanted the flexibility to adapt what was used to integrate the spirit of narrative interviewing to ensure participants felt heard.

My understanding of the ‘BPD’ diagnosis as a social construction required a methodology which could analyse data through a constructionist lens. I wanted an approach which would prioritise participants’ voices. Grounded Theory (GT) (Glaser & Strauss, 1967) is an approach to qualitative research focused on constructing theory from data (Charmaz & Henwood, 2008). Through systematic coding of the interview material, categories are identified at a low level of abstraction and then building up to more abstract theoretical concepts (Barker et al., 2002). The ‘constant comparative method’ is used where categories are checked and adjusted against the following data (Strauss & Corbin, 1990; Madill et al., 2000). Data collection and analysis is simultaneous, where developing theory guides the sampling strategy (Barker et al., 2002). Analysis results in the development of one or more core categories which capture the essence of the phenomenon. A constructionist version of GT was developed by Madill et al. (2000).

However, GT is concerned with social and social psychological processes within particular social settings (Charmaz, 2006). The pilot studies drew my attention to social processes that impacted upon the wellbeing of individuals with a diagnosis of ‘BPD’. However, my revised research question had a psychological rather than social focus, therefore, GT did not feel suitable. Additionally, Braun and Clarke (2013) warn a complete GT analysis is very time consuming, therefore, not feasible for a research project constrained by time and resources. These factors along with theory-development not being an aim of the research resulted in GT not being selected.

RTA was chosen because its' theoretical flexibility meant compatibility for use within a constructionist paradigm. Braun and Clarke (2006) provide clear guidelines for conducting the analysis, of which I had previous experience and felt could be achieved within the timeframe. RTA was also judged to be a good choice because it can usefully summarize key features of a large body of data, and or/ offer a 'thick description' of the data set (Braun & Clarke, 2006). TA has already proved to be successful in analysing qualitative data in 'BPD' research (e.g. McSherry et al., 2012). However, a disadvantage is it does not allow the researcher to make claims about language use.

Pilot interviews demonstrated rich data could be elicited with individuals with a diagnosis of 'BPD' through individual interviews with a broad opening question to elicit narrative, allowing participants to feel heard. The information gathered would also provide insight into the psychosocial context in which participants' experiences were based. The flexibility of TA supports a wide range of data collection methods (Braun & Clarke, 2013) and was therefore considered an appropriate choice for analysis of data collected by semi-structured narrative interviews.

Data Collection

Development of the Data Collection Approach

In consideration of the hostile responses that individuals with a diagnosis of ‘personality disorder’ have described from mental health services in response to their help-seeking (NIMHE, 2003) and the emotive nature of the research topic, I felt it was essential that the data collection approach constructed would support the development of a trusting alliance between myself and my participants. A semi-structured interview was appropriate because it facilitates rapport between researcher and participant; allowing the researcher to gain a detailed picture of a participant's beliefs about a particular topic (Smith, 1995). The method’s flexibility permits asking additional spontaneous questions in response to topics shared by the respondent which might be relevant. As discussed above, the broad opening question to elicit narrative was retained as it handed control to participants, allowing them to feel heard, whilst informing me of the psycho-social context of their experiences which informed their opinions. This was followed by further questions regarding the therapeutic factors participants found helpful.

The Data Collection Approach

The data collection approach consisted of three items. Participants initially received an electronic copy of the research advert (see Appendix B), which described the topic of interest and invited them to share their opinions. At interview, participants were asked to complete a demographics questionnaire

(Appendix F). Finally, participants engaged with a semi-structured interview schedule (Appendix G) consisting primarily of open questions (plus additional questions in response to topics of interest) concerning:

- What were participants opinions about what has been beneficial and what could be improved in their therapy?
- Of the two approaches, which did participants think was more effective in addressing symptoms of ‘BPD’?
- What did participants think was the role of a Counselling Psychologist in supporting clients with a diagnosis of ‘BPD’?
- What did participants think were the strengths and weaknesses of the two approaches?
- How did participants think each approach would affect an individual’s feelings towards their therapist and the therapeutic relationship?
- Which therapeutic approach did participants think was best when a client was in crisis?

The interview schedule was developed following guidance by Braun and Clarke (2013). Due to the sensitive nature of the research topic and the emotional vulnerability of the participants, care was taken in the sequencing of interview questions. More personal questions were asked in the second half of the interview after I had established an alliance with each participant. More neutral questions were asked towards the end of the interview to ground participants in preparation for ending.

Method

Participants

Sampling considerations*:*

Participants were a purposive and opportunistic sample. They consisted of individuals with a diagnosis of ‘BPD’, connected to the service-user led ‘personality disorder’ company, Emerging Health Community Interest Company (see Emerging Health Letter of Agreement – Appendix A). Through a process of snowball sampling, individuals were invited to recruit others meeting inclusion criteria to participate.

Inclusion criteria

To be considered eligible to participate, individuals were required to be over the age of eighteen and to have received a clinical diagnosis of ‘BPD’. This information was declared by participants in completion of the demographics questionnaire.

Exclusion criteria

Individuals were not recruited if they required support to communicate in English. The interview schedule was designed to produce rich and detailed accounts of complex issues relating to lived experience of ‘BPD’ and opinions on therapy. Therefore, it was deemed necessary to recruit participants who could converse freely in English to acquire first-hand accounts of these issues, so depth of meaning could be secured. Participants were not considered eligible to participate unless ‘BPD’ was their current diagnosis. An enquiry to participate was received by an individual who had previously received a diagnosis of ‘BPD’, but this had since been adapted to ‘Complex Post-Traumatic Stress Disorder’ (Hodges, 2003). As the research question sought to specifically explore opinions of individuals with a diagnosis of ‘BPD’ to better understand their preferences for therapy, it was felt necessary to only include individuals who currently had this diagnosis.

Participant Information

Due to the depth of focus into participant data to yield richly descriptive accounts, Thematic Analysis typically requires a small number of participants (Braun & Clarke, 2013). Ten participants volunteered to take part in this research study, after a sample of ten to twelve were searched for. This sample size met Braun and Clarke’s (2013) recommendation of 10-20 interviews for a research project of this nature. All interviews produced detailed accounts, ranging from 71-163 minutes in duration. This allowed a broad range of perspectives to be covered so that recruiting additional participants would have been unlikely to add any new themes to the data. The sample size was also considered appropriate considering the labour-intensive nature of qualitative analysis (Barker et al., 2002), the timeframe within which data collection needed to be completed; and limitations in resources available. A summary of participant information is detailed in Appendix J.

Procedure

Ethical Considerations

Ethical approval was obtained from the University of the West of England Faculty Research Ethics Committee. Each stage of the research process was conducted under the guidance of the British Psychological Society's (BPS) Code of Ethics and Conduct (2009 & 2018) and the Code of Human Research Ethics (2014).

Consent Process

Informed consent:

The BPS Code of Ethics and Conduct (2009) and Code of Human Research Ethics (2014) stress the importance of ensuring participants are given ample opportunity to understand the nature, purpose, and anticipated consequences of research participation, so that they may freely give informed consent to the extent that their capabilities allow. Although participants recruited had all received a diagnosis of 'BPD', and so would have experienced vulnerability in their mental wellbeing, their ability to consent for themselves was already demonstrated by their having consented to join and participate in a service-user led self-help organisation.

Upon receiving the research advert, individuals interested in participating contacted me for more information and to organise a meeting. I provided a copy of the participant information sheet (Appendix C) at this point, to allow participants enough time to reflect on the research question and what was expected of their participation before deciding whether to take part. The participant information sheet gave details of the background and purpose of the research, what was involved in participating and contact details of support services. Upon meeting, participants received a hard copy of the participant information sheet to read again. They were given time to process this information and were encouraged to ask questions. Once they confirmed that they still wished to participate, they received a copy of the participant consent form (Appendix D) to sign. This form stated the participant had been given information about the research and what their participation involved, and that this had been understood. The participant consent form also stated participation was voluntary.

Right to withdraw

Participants were informed both in the information sheet and the consent form that they would be able to withdraw from the research prior to and during the interview without having to give a reason. They were also made aware that they had the opportunity to withdraw part or all of their interview material from the research for up to one month after the interview had taken place.

Confidentiality

Participants were made aware verbally and through the research documentation that all information they provided in their individual interviews was confidential. They were informed of limits to confidentiality, where duty of care to participants might override confidentiality, such as in the case of disclosure of potential risk of harm to the participant or to another person, or if I was under legal obligation to disclose information. Before giving consent, participants understood that although extracts of their data might appear in written reports and oral presentations of the research, confidentiality and anonymity would be maintained by changing all identifiable information and by giving a pseudonym to any data used.

Recruitment

An advert for the research was designed which described the topic under investigation, participant inclusion criteria and my email address. Individuals were invited to contact me if they were interested in participating. I sent the advert to the director for Emerging Health. As stated in the Letter of Agreement from Emerging Health, the director used the company's mailing list to facilitate participant recruitment by forwarding an email with the attached research advert to individuals connected to the company with a diagnosis of 'BPD' who might be available to participate. The email invited individuals to read the research advert and to contact me if they wished to share their views. They were also asked to forward the research advert to anyone else in their social network that met inclusion criteria and might be interested in participating. The research advert informed potential participants they would receive a ten pound 'Love to Shop' voucher as a gesture of appreciation for their time. This incentive to participate was strongly recommended by the director to ensure participants felt valued for their time and contribution to the research. I initially felt hesitant to comply with this request due to concerns about how it might affect the nature of the research, and that it might suggest that there is no other value in being a participant (Braun & Clarke, 2013). These concerns were shared in supervision, and I reflected on the need to be mindful of how the incentive might affect the interview dynamics.

The BPS Code of Human Research Ethics (2014), p.20-21 emphasises the importance that participation is not coerced in any way, but states that it is acceptable for 'reasonable recompense' for the time and costs of participating to be offered. The director's suggestion of a £10 voucher meets Braun and Clarke's (2013) advice of keeping the recompense small and practically orientated. The BPS's Code of Ethics and Conduct (2009) p.19 states that researchers should:

> *"Refrain from using financial compensation or other inducements for research participants to risk harm beyond that which they face in their normal lifestyles".*

Although recompense details were included in the research advert to demonstrate participant value and to support recruitment, the risk assessment evaluated risk to participants as low when control measures were included to alleviate any emotional distress evoked as a result of participating. Once individuals made contact, I was able to provide further details of the research, including the information sheet and was able to answer any queries. For those wishing to proceed, I arranged an interview for a time and location convenient for them. This initial contact began the process of developing a rapport with participants.

Interview Process

Most participants were interviewed face-to-face individually in hired rooms in public locations which could all be accessed safely, including youth centres and university buildings. One participant chose to be interviewed virtually using Skype. Two participants in a relationship requested each other's presence during interviews for emotional support if needed. Verbal consent for this decision is recorded on their transcripts. Of the two participants interviewed as part of the pilot study, one gave consent via email for their interview material to be included in the data analysis, and the other consented to be interviewed again using the new interview schedule as well as including her previous interview material in the data analysis (Pilot Participant Consent Form – Appendix E).

Upon arrival to the interview, all participants received a hard copy of the information sheet which they were asked to read and were encouraged to ask questions. They were reminded that they did not have to answer any particular questions and had the right to withdraw any or all of the information they provided at any time within a month of participation without giving a reason. If participants were happy to proceed, they were then asked to read and sign the consent form. They then completed a demographics questionnaire which included information such as their age, gender, employment status, social class, and ethnicity. The questionnaire also enquired about their history of mental health, including which professional provided the 'BPD' diagnosis, comorbidity, whether they have received therapy specifically for 'BPD', what therapy this was and its' duration.

Participants then took part in an audio-recorded semi-structured interview using an electronic digital recorder borrowed from my university. Once this was finished, participants were invited to share their experiences of having engaged with it. I then checked in with each participant about how they were feeling after being interviewed, reminding them of the sources of support provided on the information sheet. Participants were then asked to read the debrief sheet (Appendix H) which explained the purpose of the research and its broader aims in contributing to the literature on ‘BPD’. A space was made to discuss this information and to answer any questions before thanking participants for their contribution.

Risks and Risk Management

The BPS Code of Human Research Ethics (2014), p.13 describes risk as:

> *“The potential physical or psychological harm, discomfort or stress to human participants that a research project may generate”.*

These guidelines state that researchers need to consider the costs to the individual participant in comparison with the potential benefits to society, and that striking this balance can be difficult. Research into counselling risks different possibilities of harm, including information about clients being disclosed, painful feelings being restimulated, the relationship of trust with the therapist being damaged, and where former clients are interviewed about their experience of therapy, the interview itself may awaken a need for further counselling (McLeod, 1998).

By engaging in the interview, there was a possible risk participants might experience emotional distress as a result of reflecting on and answering some of the interview questions. Although risk was assessed to be relatively low, I integrated the following control measures into the research to protect participant wellbeing:

- I received regular supervision from my university throughout each stage of the research process to ensure any problems were avoided or resolved quickly to protect participant wellbeing.

- Participation was conducted through a process of informed consent where participants were fully informed about the nature of the study, that participation was voluntary and that they had the right to withdraw from the interview at any time.
- Participants were encouraged to take the time to process the information and ask questions to ensure they understood the purpose of the research and what would be involved before deciding whether to participate.
- Participants were made aware that they did not have to answer any specific questions if they did not want to.
- The information sheet forewarned participants that because the interview would involve an in-depth discussion of a highly emotive topic, there would be a possibility that participation would evoke feelings, so participants were able to better prepare themselves for the emotional impact of participating.
- The information sheet listed some of the discussion topics, so participants were able to reflect on their feelings around these issues, and to consider whether they felt comfortable to discuss them before giving consent.
- The information sheet included the contact details of three organizations trained in providing specialist mental health support, so participants had an immediate resource of containment if they became distressed following the interview if needed.
- I used my clinical skills to monitor participant wellbeing during the interview. Breaks were provided when necessary.

- None of the participants became distressed. However, if they had, the session would have been paused and the participant would have been given the opportunity to have a break, continue or withdraw. If they had chosen to withdraw, I would have offered a debriefing session to alleviate distress before they left and would have encouraged them to seek professional support.
- Participants were made aware of the circumstances in which I had a duty of care to break confidentiality. This course of action would only have been taken for legal reasons or to prevent harm. Knowledge of these circumstances meant participants were aware of the potential consequences of the information they chose to share, so could make informed decisions about what they chose to disclose.
- I asked each participant about their feelings following the interview to explore whether they felt distressed and required additional support (as advised by Barker et al., 2002). Although some reported feeling drained, none reported distress significant enough to require professional support. If distress was detected, participants would have been referred to the organizations listed on the information sheet or their general practitioner. No participant became distressed following participation. Preparing a support structure in case it was required created emotional containment for participants and myself. This allowed us to engage more deeply in the research process and thus construct data of a richer quality.

Transcription

Audio recorded interviews were transcribed verbatim to produce ‘orthographic’ transcripts (Braun & Clarke 2006, p.88) capturing the level of detail necessary to engage in RTA. Transcriptions included paralinguistic information such as noting when participants laughed, sighed, paused, used non-verbal utterances (e.g. “umm”) and reported speech. Words that were emphasised by participants were underlined. Punctuation was added to extracts from the interview quoted in the analysis section to enhance the readability of spoken data (Braun & Clarke, 2013). Each transcript was checked against its’ original audio recording to improve accuracy (Braun & Clarke, 2006). My process of becoming ‘immersed’ in the data began with transcription and checking transcripts with original audio recordings (Morrow, 2005, p.256).

Data Protection

All research data, whether written, electronic, or audio-recorded, was securely kept in accordance with guidelines from the Data Protection Act (1998; 2018), BPS Code of Human Research Ethics (2014) and the BPS Practice Guidelines (2017). Transcripts were anonymised by removing any identifiable information and by giving participants pseudonyms. All paperwork completed by participants (consent forms and demographics questionnaires) were securely stored in a locked filing cabinet which only I had access to. All electronic and audio-recorded data were stored confidentially on password-protected USB pen drives, used on a password-protected computer only available to me. Data was shared where necessary with my supervisor.

Data Analysis

Braun & Clarke’s (2006) six-phase approach to RTA was used to systematically identify, organise, and offer insight into patterns of meaning across the data set (Braun & Clarke, 2012). The initial phase began with transcription of the interview recordings. This supported the process of immersion in the data to allow me to become familiar with the depth and breadth of the content. Following transcription and checking transcripts against the recordings for accuracy, I read and re-read each actively, by searching for meanings and patterns within and across the interviews, noting my initial thoughts in a column adjacent to the transcript entitled “Open Codes” (Charmaz, 2006). I then read through each data item and created a list of codes to identify and provide a label for each feature of the data that was potentially relevant to the research question (Braun & Clarke, 2012). Codes were recorded in a third column entitled “Focus Codes”. My first attempt at coding produced descriptive/ semantic codes, only reflecting a summary of participant meaning (e.g. “Not Feeling Heard”). However, over time, with greater engagement with the data and literature, I became able to recognise deeper patterns of meaning across the data set and connect these with relevant theory. Codes created then came to reflect the underlying assumptions behind what was said, thus becoming more interpretative or latent in nature (e.g. “Impact of Attachment Style”).

To avoid missing anything potentially relevant to the research question, I thoroughly coded the entire data set (Braun & Clarke, 2006). This resulted in the development of many codes reflecting issues relevant to participants’ experiences of mental health services and therapy. Not all codes were relevant to the research question at the time regarding helpful therapeutic factors. However, they alluded to the context which explained why the codes relating to helpful therapeutic factors were so important to participants. At this point, I realised participants' narratives were informing me of much deeper issues regarding their experiences of social injustice and how these influenced their needs from therapy and mental health services. Codes are presented and explained in relation to the process of their theme and their significance in addressing the needs of individuals with a diagnosis of 'BPD' in the analysis section. Flow diagrams presented in Appendix M depict the process of each theme, where codes cluster together to form the different stages of each process. Extracts were coded inclusively (relevant surrounding data was kept to preserve context) and as the code list developed, each new extract was checked against it to see if other codes applied. Existing codes were sometimes modified to incorporate new extracts. Upon completion of coding, I checked all coded extracts against the final code list to ensure all applicable codes for each extract had been documented. The code list was typed into a Word document, and all coded data extracts were copied into this under their relevant codes. In the third phase, codes were sorted into themes. The name of each code was written on a separate piece of paper so codes could be moved around on the floor in exploration of how those with shared meaning might cluster together to form themes. Once codes were sorted into theme-piles, an initial thematic map was drawn which depicted relationships between overarching themes and subthemes within them (see Appendix L). Some codes were developed into themes. Those that did not belong anywhere or no longer seemed relevant formed a 'Miscellaneous' theme and were eventually discarded.

Over time, the thematic map underwent several revisions as my engagement with the data set gradually shifted from surface-level awareness to a deeper level of understanding. Although the initial thematic map captured important themes, one overarching theme was not relevant to the research question asked at the time, so was dismissed. Themes presented in the second map appeared to address the research question. However, closer inspection indicated some of the sub-themes were under-developed as they presented summaries of data domains as 'themes' (Clarke & Braun, 2018), which lacked shared meaning. Recognition of this lack of coherence prompted return to earlier phases of the analysis to delve for deeper meaning to find the core concepts which connected participants' narratives. This process supported the reorganisation and refinement of codes into themes, resulting in greater clarity and distinction in the stories each theme told. Overlap was then recognised between two themes, so one was collapsed into the other. Once the thematic map had been finalised, all coded data extracts relevant to each theme were collated within a separate Word document.

The fourth phase was a process of quality checking by reviewing and refining potential themes. All collated extracts for each theme were read to check they formed a coherent pattern. To check the validity of individual themes in relation to the data set, all transcripts were re-read to assess whether themes (and thematic map) accurately captured the meanings present within the data. The fifth phase concerned making sure all codes within each theme worked together to form a process which related to the overall 'story' told by the data and addressed the research question (now recognised as concerning participants' needs from mental health services). This involved re-using paper code labels, moving them around on the floor to make sense of how codes cluster together in a particular order to form different stages which made up the process of each theme. Codes were moved to another theme or discarded if they no longer fitted. Theme names were then finalised, and the names chosen used participants’ language or a concise statement or imagery which captured the theme’s essence.

In the final phase, the analysis was written up as a report (see ‘Analysis’ section below). It addresses the research question from the perspective of each individual theme and describes the ‘overall story’ that is told about the data from the narrative framework created by the relationships between all themes. To help the reader with the complexity of the data, an evocative approach involving storytelling, narration and quotation was adopted. The most vivid extracts from each theme were selected and organised into a coherent account, which accompanied by analytic narrative, told each theme’s story. This narrative described and interpreted the meaning of each extract and used this interpretation to make an argument to address the research question.

Considerations of Quality in Qualitative Research

Several measures were integrated into the research to ensure a high standard of quality and rigor. In her guidelines for ensuring trustworthiness in qualitative research, Morrow (2005) explains that qualitative research embraces multiple standards of quality, known variously as validity, credibility, rigor, or trustworthiness. Certain standards are understood to transcend all qualitative research paradigms, such as attention to subjectivity and reflexivity. However, Morrow (2005) also argues that criteria for trustworthiness in qualitative research are closely tied to the paradigmatic underpinnings of the particular discipline in which a particular investigation is conducted.

For research based on a constructionist epistemology, Patton (2002) identified triangulation; the “capturing and respecting multiple perspectives” (p.546) as an important component of quality. Each interview transcript, complete with open and focus codes, including reflective notes on the interview process was shared with my supervisor for discussion and feedback. This encouraged me to reflect on interview dynamics, the possible influence of any assumptions on the interview process and analysis, and the development of codes and themes. My supervisor also supported me to take a step back from the intensity of each interview encounter, to explore how the issues discussed related to broader societal issues around living with a severe and enduring mental health condition in western society and the difficulties in trying to access support. This insight improved the overall quality of the analysis by allowing me to make better sense of the data, so that themes identified and discussed were an appropriate representation of participants’ narratives. It also prompted reflection on the potential impact and importance of the research as regards how it might contribute to positive social change for individuals with a diagnosis of ‘BPD’ (Yardley, 2000).

Morrow (2005) also emphasised the extent to which participant meanings are understood deeply (described by Patton, 2002, as *verstehen*) and the extent to which there is a mutual construction of meaning (and that construction is explicated) between and among researcher and participants as important for constructionist research. Morrow (2005) states that understanding participant constructions of meaning depends on multiple factors, including context, culture, and rapport. I used my active listening skills as a trainee counselling psychologist to develop a good rapport with participants. This supported a deep understanding of participant meanings. Where there was uncertainty, I sought clarification to ensure shared understanding. By beginning the interview with an open question about the participants' life history, I had the opportunity to understand the culture and context in which participants' meanings were constructed and how these issues may have impacted on the data.

Participants were asked to consider whether a more relational or directive therapeutic approach was best in addressing the needs of clients with a diagnosis of 'BPD'. Despite the difficulty in separating participants' realities from my interpretation of them, I had a responsibility to learn from my participants how well my interpretations reflected their meanings. This was to ensure that participant meanings were fairly represented (Morrow, 2005). Braun and Clarke (2013) describe member checking as the practice of checking one's analysis with one's participants. The information sheet informed participants that they would be offered a copy of the report before submission to acquire feedback, and that if requested the findings would be amended. Following preliminary data analysis, participants received a summary report of the findings, including an initial thematic map and an explanation of each of the themes. Three of the ten participants responded and validated this report, providing feedback which was reflected on and integrated into the results and discussion sections of the final report. Finally, repeated reference to Braun & Clarke (2006) 15-point checklist of criteria for good TA supported me to engage in a thorough analysis of the data and produce a detailed and well-evidenced report of the themes.

REFLEXIVITY

Etherington (2004) states that academic research has traditionally been viewed as an impersonal activity, where researchers have been expected to approach their studies objectively. Researcher subjectivity was judged to be a contaminant to the quality of the research. Quantitative research holds the realist view that there is a single reality or truth 'out there' in the world, and that it is the purpose of the researcher to use objective research methods to uncover that truth (Sukamolson, 2007). However, the worldview underlying qualitative research is subjectivist, arguing that there is no pre-existing objective reality that can be observed by humanity. Sukamolson (2007) explains that the process of human observation of reality changes and transforms it, so that it is at least in part constructed by human beings and their observations. Therefore, truth can only be relative.

Shaw (2010) states that as beings based within a social world, the ways in which we make sense of our experiences are bound by time and place. This means that we experience and interpret the world from a particular perspective, and we can never fully escape this subjectivity. Therefore, qualitative analysis is inherently subjective because the researcher is the instrument for analysis (Starks & Trinidad, 2007). They inevitably bring their assumptions, values, interests, emotions and theories or their preconceptions to all stages of the research process (Tufford & Newman, 2012). These preconceptions influence how data are gathered, interpreted, and presented.

To attempt to manage researcher bias, qualitative researchers attempt to approach their studies reflexively (Morrow, 2005). Dowling (2006) describes reflexivity as essentially a process of self-critique by the researcher to examine how her/his own experiences might or might not have influenced the researcher process. Reflexivity supports a deeper insight into the research and ensures that the focus remains on the research and its participants (Patnait, 2013). It was important for me to participate in a process of “personal reflexivity” (Wilkinson, 1988). This involves reflecting on the prior assumptions I may have held about the topic of interest and the factors which motivated me to explore this area in the first place. Etherington (2004) concludes the researcher’s interpretations can be better understood and validated by readers who are informed about the position they adopt in relation to the study, and by their explicit questioning of their own involvement. This process enhances the trustworthiness of the findings and outcomes of the research. This section aims to make transparent to the reader the preconceptions and motivations which shaped the research process so they may judge the quality of the findings presented.

To reduce the severity of the potentially damaging effects of one’s unacknowledged preconceptions and to increase the rigor of one’s study, some researchers engage in a process of bracketing (Tuffman & Newman, 2012). This concept originated within the phenomenology tradition. Husserl (1913/ 1931) believed that understanding lived experiences requires ‘direct seeing’ which exceeds sensory experience. It does this by looking beyond one’s natural perspective; beyond one’s constructions, preconceptions, and assumptions to the essences of the experience being explored, and this allows one to obtain knowledge (Gearing, 2004). This process is reached through bracketing, which is described by Gearing (2004, p.1430) as:

> *"the scientific process in which a researcher suspends or holds in abeyance his or her presuppositions, biases, assumptions, theories, or previous experiences to see and describe the phenomenon".*

I used a reflexive journal to keep an ongoing record of my experiences, reactions, and the identification of my preconceptions around the research as they emerged (Ahern, 1999; Morrow, 2005). However, because I only began my journal during the data collection process, instead of from the study's inception as recommended, I acknowledge that this delay in reflexivity allowed my preconceptions to interfere with my engagement with participants during pilot interviews. The journal and supervision following pilot interviews brought my preconceptions into awareness; supporting me to bracket these during the remaining interviews. Rolls and Relf (2006) discussed how consecutive interviews on sensitive and emotion-laden material can have a cumulative, adverse effect on the researcher, who may subconsciously adopt the uncomfortable feelings experienced by the participant. My lack of clinical experience with 'BPD' resulted in me feeling slightly overwhelmed by the feeling of sadness I felt as a counter-transferential response to hearing one of my pilot interviewee's narratives. The journal was a safe place for me to process uncomfortable feelings evoked at different stages of the research and to learn from them.

During the pilot interviews, the lack of structure within the original interview schedule and my lack of experience in conducting qualitative interviews resulted in the process mirroring that of therapy, rather than research (Dickson-Swift et al., 2006). The challenge for most qualitative interviewers who also practice therapeutically is to manage the slippery slope on which boundaries between research and therapy may be confused (Haverkamp, 2005). Throughout journaling and supervision, I reflected on my struggle to transition from therapist to researcher. At the beginning of this transition, I experienced internal conflict at hearing repeating narratives around trauma and rejection and struggled to withhold the emotional support I was accustomed to providing. Guidance from supervision and insight about my preconceptions gained through journaling supported me to reflect on the differences between the two roles in preparation for the remaining interviews. I considered how I might harness my clinical skills as a therapeutic practitioner to build a trusting alliance with each participant which would support them to feel safe enough to share their stories. Though this approach was necessary to elicit rich data, to ensure the safety of participants, it was necessary to balance this with clear boundaries based on the limitations of the researcher-participant relationship. The focus of this approach was collaboration with participants in constructing answers to the research questions rather than the provision of emotional support.

The analysis phase can be a challenging time for a Counselling Psychologist to bracket the core values and beliefs of their discipline (BPS, 2005). Researchers need to examine their preconceptions carefully, as failure to do so can unconsciously influence the way in which they can hear, ignore, and overemphasize certain aspects and disregard other aspects of participants' narratives (Berger, 2015; Tuffman & Newman, 2012). To assist me to bracket my preconceptions to prevent them from skewing my interpretation of the data, I integrated reflective notes with my open codes which were written alongside the transcript. These notes (also known as ‘memos’, Cutcliffe, 2003) allowed me to reflect on the nature of my relationships with participants, to clarify my thoughts about themes present and to identify triggers to the surfacing of my preconceptions. Studying and reflecting on the interview process supported me to recognise important shifts in interview dynamics, such as moments of realisation for participants, which provided valuable insight into the key communications behind their narratives (Glaser, 1998).

During pilot interviews, I became aware of assumptions I held around ‘BPD’ and therapy, which differed from the beliefs of my participants and occasionally interfered with the process of data collection. Through engaging in reflexivity, I recognised that these assumptions mostly developed from my training and clinical practice in Counselling Psychology (BPS 2005;2018) and are identified as follows:

- The psychiatric classification ‘borderline personality disorder’ should be approached critically as it is socially constructed.
- Therapy is always beneficial to the client, and long-term relational approaches are considered more effective than short-term directive and manualised approaches.
- Receiving the ‘BPD’ diagnosis always makes the individual feel labelled and stigmatized.

When redesigning my interview schedule, I considered how the philosophy of Counselling Psychology can shape all stages of the research process. To manage this potential influence on data collection, my supervisor reviewed the new interview schedule. Amendments were made to question wording to ensure they did not unintentionally predispose participants towards a certain perspective or outcome, based on the unexplored perspective of the researcher (Tuffman & Newman, 2012). As a trainee counselling psychologist, I acknowledge that the values of my discipline shape the lens through which I make sense of the data. In counselling psychology, the therapeutic relationship is considered the main vehicle through which psychological difficulties are understood and alleviated (BPS, 2020). This belief may have drawn me to overly attend to codes which when collated, created the theme “Someone to be There”, reflective of the therapeutic relationship. Though benefits of directive approaches were acknowledged in the coding stage of the analysis process, this did not give rise to the creation of a corresponding theme. I understand that if the data had been analysed by a researcher from a different background, other themes may have been privileged.

In considering my position relative to my participants, I recognise that though I share some traits with many of them (being a white female with a history of emotional regulation difficulties), I have never experienced ‘BPD’. Therefore, I class myself as having outsider status. Berger (2015) claims that studying the unfamiliar offers several advantages. As the researcher is ‘ignorant’ and the participant is the ‘expert’, it is an empowering experience for them (Berger & Malkinson, 2000). This is important in the study of marginalized or otherwise disadvantaged population groups, such as those with a diagnosis of ‘BPD’. However, concerns have been expressed as to whether a researcher who has not shared participants’ experiences can understand and convey them, even when reflexivity is used as a vehicle for making the research process visible (Pillow, 2003).

Across the research process, there were several experiences which evoked uncomfortable feelings within me. These included the first assessment of research progress and the early stages of data analysis. Upon reflection, I identified a sense of parallel process with my participants. In recognising the connection between my feelings and theirs, I felt pulled closer to them and a sense of insider status. Once I detected parallel process, I made a space between myself and the research to process these feelings before proceeding. As time passed between these early research stages and the latter interviews, I came to a deeper understanding of the different use of self as researcher and self as therapist which supported me to contain myself and my participants. This was an emergent property as the research unfolded.

Personal Interest

I once volunteered in an eating disorders support group, where several attendees reported receiving the ‘BPD’ diagnosis and being dismissed from services without support or were placed on a long waiting list for DBT. One attendee announced:

> *“I felt like the psychiatrist was calling me a slag!”*

Bearing witness to this individual’s sense of rejection and shame sparked a desire within me to explore this area further in my training so that I might one day be able to better support individuals with this diagnosis through my clinical practice.

Though I have never received the ‘BPD’ diagnosis, in my teenage and early adult years, I struggled with emotional regulation and used maladaptive coping mechanisms to manage my feelings. I felt ‘othered’ for my difficulties and need for support. These experiences nurtured an affinity within me for this clinical group.

Professional Interest

Across my training placements, I have come across many ‘BPD’ cases where individuals were described negatively by staff due to their perceived excessive demands on services. It appeared individuals were often discharged despite still engaging in high-risk behaviour. This made me curious about their life experiences following discharge. I have not yet worked therapeutically with ‘BPD’. It has been highlighted that this lack of clinical experience might be advantageous. Without having to bracket potentially negative experiences of working with ‘BPD’, I was then able to engage with participants from a more neutral standpoint. I felt this research question was relevant to my clinical practice because its’ aim was to contribute to a positive therapeutic alliance between staff and service-users by providing a platform for service-users to express their therapeutic preferences. This would support staff by offering other avenues to strengthen the therapeutic alliance.

There was a sense of unease when selecting participant quotations to illustrate my interpretations because the data generated addressed not only participants’ opinions about therapy, but also their feelings around important issues within mental health services in general. Some of the most powerful extracts that seemed applicable to the themes concerned general experiences of services, rather than those specific to the therapeutic relationship. Therefore, these extracts had to be discarded. This often felt frustrating because of my drive as a counselling psychologist to wish to contribute to service development and to reach out to those who might be able to intervene. These feelings mirror the ‘borderline’ experience of having to fit in, of not being heard, and the internalisation of conflicts that are social in origin. Processing this frustration with my supervisor supported me to remain focused on addressing the research question. However, there was shared recognition of the importance of these stories and the feeling that they should be preserved to inform future policies concerning patient wellbeing.

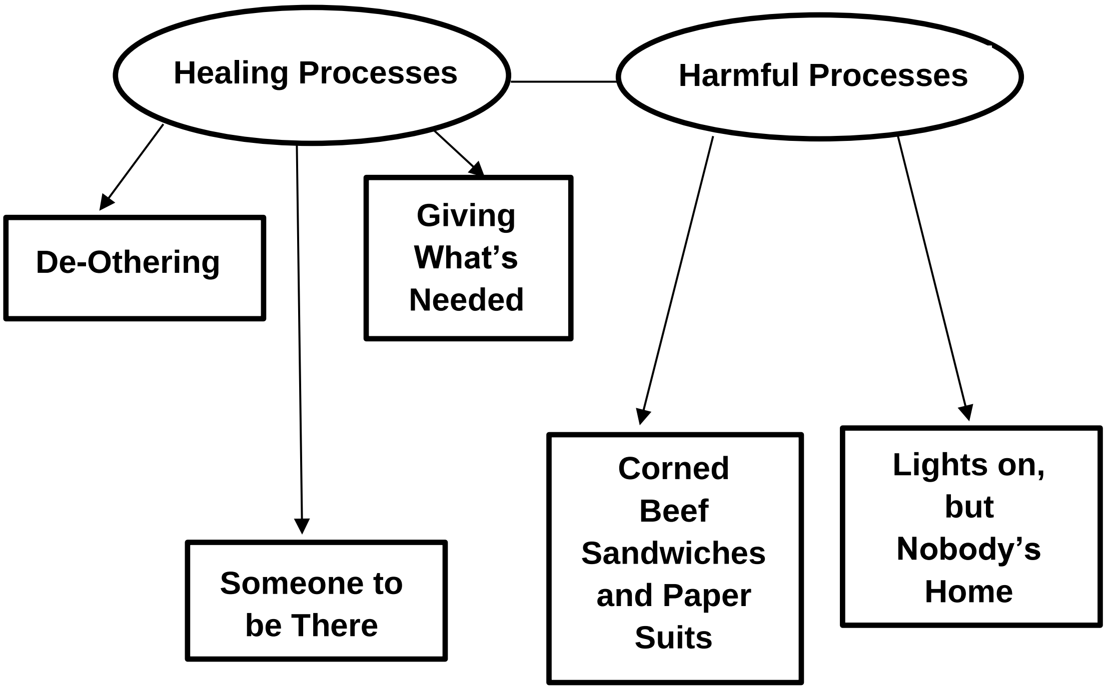
I acknowledge that I am a white well-educated middle-class woman, and that it was necessary to reflect on how these privileges might impact upon my relationships with my participants. Although participants were informed of my experience of working in a mental health setting, I presented my position towards the research as that of a naïve student, eager to learn from those with lived experience. In addition to emphasising participants as the experts in their experiences, I used my skills as a trainee counselling psychologist to build a strong collaborative relationship with each participant to try and balance the power dynamics between us. Participants committed themselves to the interview process; sharing rich accounts of their life history as well as their opinions on which therapeutic factors they found helpful. Understandably, participants reported that engaging with the interview was emotionally draining, but felt it was important to share their views.

In this chapter, I have discussed the research design, method, theoretical framework, process of data collection and analysis, and reflexivity. In the next chapter, I will present the research findings as themes illustrated with participants quotes and will interpret the meaning of these in relation to the research question.

ANALYSIS

In the previous chapter I described the study's design, method, theoretical framework, alignment with the values of Counselling Psychology, rationale for the chosen methodology, process of data collection and analysis, and I reflected on my position in relation to the research. In this chapter, a detailed description of all themes constructed from the analysis is presented, direct quotations from the transcripts illustrate their essence and evidence their relevance in addressing the research question. This is followed by interpretation of data leading to the thematic maps around which the research findings are organised. Two overarching themes, each with multiple sub-themes were constructed from an in-depth analysis of the data using Reflexive Thematic Analysis and are presented in Figure One below.

Figure One



To enhance the reader’s understanding of the meaning that each participant makes of their beliefs and experiences, a vignette of each participant’s background is listed in Appendix K to provide further context for how the themes emerged. Flow diagrams demonstrating how codes clustered together to form different phases of the process of each theme are presented in Appendix M.

Overarching Theme 1: Healing Processes

The first overarching theme details ‘Healing Processes’ received and experienced by individuals with a diagnosis of ‘BPD’ from therapists and mental health services in general. In this context, the word ‘healing’ refers to the following Cambridge Dictionary (2021) definition:

> *“The process in which a bad situation or painful emotion ends or improves”*

The emphasis is on improved wellbeing not ‘recovery’ from ‘illness’. The individual is accepted as they are and is supported to achieve a better quality of life. Exploration of participant’s evaluations of the two therapeutic approaches unlocked deeper issues concerning the need for counselling psychologists to reverse the effects of repeated experiences of rejection by caregivers, society, and mental health services towards individuals with a diagnosis of ‘BPD’. It is evident from the data that Counselling Psychologists have the skills and a responsibility to make a significant contribution to these healing processes. They can achieve this in their therapeutic relationships with clients and by providing information about client needs to their multi-disciplinary team; supporting them to practice a consistent, client-centred, and holistic approach to care. Participants described various therapeutic interventions which formed a process of ‘de-othering’, supporting them to feel ‘normal’. The importance of having ‘Someone to be There’, particularly at the beginning of therapy and during crisis was emphasised. Participants varied in their preference of therapeutic approach in session and during crisis. They stressed the seriousness of recognising individual differences in reaction to ‘BPD’ symptoms, and the requirement for counselling psychologists to practice a ‘Giving What’s Needed’ approach, by adapting their way of working to the individual and their circumstances.

Subtheme 1a: De-Othering

All participants described experiences of feeling like an outcast. These may have been evoked from emotional neglect by caregivers, being bullied, abusive relationships, being dismissed by services or a feeling of rejection by society for failing to meet its standards. Participants described several therapeutic skills by professionals involved in their care which they found beneficial. Each contributed to dismantling the individual’s feelings of ‘otherness’ and promoted a sense of feeling ‘normal’, accepted and valued. Sarah described the relief she felt upon entering therapy, and finally feeling accepted as she was:

> *Sarah: “Um, I think it helps for the trust.*
>
> *Interviewer (I): Mmhmm. Yeah.*
>
> *Sarah: And the, the feeling validated and feeling that it’s okay, to not be in the right place.*
>
> *I: Yeah.*
>
> *Sarah: Okay to be upset, it’s okay to be angry, it’s okay to… want to feel like you want to give up and die. Um… and… you’re not gunna… you kind of accept that and you’re gunna go with it, and you’re not gunna try and change. I’d had enough people trying to change how I am, and trying to change how I, I feel and how I fit. And society as, as a general, you almost have to fit in to. Um…*

> *you're expected to, I dunno, if you go into work, you're expected to not bring your personal life in, not bring… an argument that you just had a boy, with your boyfriend. Um… if you're seeing, with customer-based thing you're expected to put a smile on and everything's okay and you're really happy. Um… but you don't have to do that in a therapy kind of environment. You can actually almost be real with the person" (pg.49).*

Society has repeatedly given Sarah the message that there is something 'wrong' with her that must be changed. Her examples demonstrate society's demand for emotional control. Therapists must counter feelings of social ostracism by demonstrating unconditional acceptance of the client. This is essential for trust:

> *Sarah: "I spose the client builds up trust… Because they know, or, for me… um, I know that it doesn't matter how I come, how I turn up to a, a meeting, um, that they're gunna be able to work with me whatever, and there's not conditions on it" (pg. 36).*

Acceptance is imperative because it allows the therapeutic relationship to be experienced as safe and non-judgemental and this encourages trust.

Where individuals have felt pressure to change, there is a risk that practising a purely 'doing to' approach might be interpreted as further evidence that they are 'faulty', resulting in deeper feelings of alienation:

> *Stephanie: "… CBT "You know it's just your thoughts… catch your thoughts, change your thoughts" and I feel like hitting them! Like, I don't have a choice over this, it's not just me needing to think positively, it's not, it's hardwired I don't connect with people easily, and it goes wrong easily, and it's not under my control. So, I don't really want therapists where they try and change me anymore, because I had a childhood where they were constantly trying to change me and correct me", (pg. 121).*

Acceptance must be practiced before encouraging change, otherwise there is a risk of repeating historical rejections. The client must receive emotional validation which supports self-acceptance:

> *Louis: "… My emotions havn't ever really been validated as such… So, having someone say, "Oh I can see that you're upset" or um, you know, "Let's explore this more", or, um, "Its okay to be sad, you know, what you've been through is difficult and sadness is an appropriate response to that". Like that, that was just really different for me to hear, but I think it was really important for me to hear those things. Um, because that in itself kind of led me to think, yeah ok, like actually being sad is okay" (pg. 23).*

Permission to feel one's emotions normalises them and supports containment.

Several participants noted they did not receive information about their condition and Counselling Psychology can address this:

> *Sarah: "… helping them to understand why they've got the diagnosis that they've got. Um… if they don't understand it in the first place…That helped me… at the start… a lot", (pg.27).*

For Cathy, information:

> *"gives you power. It gives you the ability to understand what's happening" (pg. 52).*

Having an explanation of the relationship between an individual's experiences and their diagnosis provides an understanding which supports control over one's world. This process continues through therapy where clients are supported to make sense of feelings in relation to experience:

> *Louis: "I think it was helpful though because it felt like it was about getting a formulation that made sense to me, and that's what I really needed. I really needed someone to, to kind of acknowledge the experiences that I'd had and help me make sense of them… And how they related to my current experiences" (pg. 16).*

Collaborative formulation acknowledges life experiences and validates the impact of these on the client's feelings.

Exploring the individual's relationship with their diagnosis was considered meaningful. Some participants rejected the diagnosis, finding it useful to deconstruct it to identify which symptoms accurately reflected their experiences:

> *Louis: "…the psychologist that I was seeing when doing DBT was like, "Well let's look at the other diagnoses and see the ones that you don't fit", like, and, and that was quite a helpful thing cause it kind of made me see that maybe I was thinking of myself in those terms so much that I was actually giving myself extra difficulties". (pg. 56).*
>
> *"… the idea of like having a personality disorder, where it places the blame on the individual for having a disordered personality when it's like actually it's a consequence of all these really shitty experiences. Um, I kind of almost reject the label a bit more now" (pg.57).*

Diagnosis deconstruction included identification of comorbid mental health issues requiring separate intervention:

> *Lexi: "… at the time, I maintain my issues were very low mood and social anxiety. But he saw that someone had written 'BPD' at some point and that's all he talked about, and all he wrote in his report. He kept using the singular. Like saying 'Borderline Personality Disorder', and saying singular, like singular things that implied that's the only thing he thought I had… Um, so I think maybe identifying whether the, whether there's other things… that need a separate… like treatment, (pg. 35).*

Others embraced the diagnosis as a useful explanation for their experiences:

> *Debbie: "I actually quite like the fact I've got those labels because I can understand now why I behaved in the way I did" (pg.45).*

Whilst holding their discipline's values, a counselling psychologist must support clients "*to reach a position that feels comfortable for them*" (Louis, pg. 58).

Knowing one’s therapist was associated with improved engagement, and could be assisted with the careful delivery of minor therapist self-disclosure:

> *Sarah: “… the CPN kind of mentioned something about um, when she’s has a really stressful day, she’ll go out and buy a load of kitkats, and binge on kitkats, um, which was quite funny at the time, but at the same time as well like… “Thank you!” like, I know you struggle too, and you have bad days, and, and… some things impact you”, (pg.38).*

When the therapist shares a small personal detail, this gently tilts the power dynamic towards a more balanced position between therapist and client. Staff vulnerability teaches individuals they are not so different from others. Insight into how others process their emotions help the client to understand and process theirs. However, participants stressed the use of clinical judgement to determine what was ethical to share.

Therapists must be mindful of the impact of the length of the therapeutic intervention on client wellbeing. An intervention without a clear endpoint may perpetuate the belief that the individual will always be dependent on services:

> *Louis: “… if you’re kind of in things that are kind of just ongoing like you know, like drop-in art therapy or, or like a therapeutic community that is actually for quite a long period of time, then there is that sense of like you, you’re just, you’re in it, potentially forever, and I don’t think that’s a helpful thing” (pg. 62).*

If an intervention is too long, this may result in overattachment to the therapist and the loss of one’s belief in their ability to become independent:

> *Lexi: “… there’s a need… for a bit of detachment and maybe in, maybe having the time limit is also a bit helpful… in that I’m not like, it’s giving the message to the service-user, or whatever they get called these days of like, “I’m not going to be your friend. I’m not going to be your mother. I’m just going to for 20 sessions work through and… having that distance, because ultimately you do have to fix yourself”, (pg.25-26).*

Longer term work with a fixed endpoint gives the client time to work through their issues, but also reinforces boundaries and motivates the client to focus on their goals. Individuals with a diagnosis of 'personality disorder' are also described as having 'complex mental health needs'. From analysing their narratives, it transpired that their primary need from therapy is quite simple. The highly trained counsellor must get used to the idea they are just 'someone to be there'.

Subtheme 1b: Someone to be There

This theme captures what participants say is needed from the therapeutic relationship, and how needs develop. Initially, the therapist must 'go the extra mile' to encourage engagement and gain trust. This creates a sense of feeling cared for. As the client learns emotional containment, therapist reliance gradually reduces, and autonomy is achieved. Individuals simply want someone there:

> *Deanna: "I want someone to care, and that person will care... Um, and that person will be there…", (pg. 48 & 49).*

What is most important to individuals with a diagnosis of 'BPD' is having a consistent source of support who will allow them to feel heard:

> *Stephanie: "I always feel better and more relaxed when somebody's actually just listened to what I've said", (pg. 186).*

Having someone there who will properly listen to their experiences allows individuals to feel cared for:

> *Debbie: "…knowing that somebody is there caring, or willing to care for the fact that they're gunna sit there and listen…", (pg. 94).*

This is particularly significant for this client group because of historical ‘othering’ experiences within a broad range of psychosocial environments across their lifetimes. The ‘being with’ approach is centred around emotional containment which is critical because of the emotional intensity that these individuals endure:

> *Stephanie: “I would desire a therapist who would understand the depth and the power of the difficult emotions that I go through”, (pg. 165).*

Therapists must be robust and prepared to travel to uncomfortable territory to demonstrate that such emotions can be processed safely.

The therapeutic relationship is nurtured when individuals recognise that the staff member supporting them is prepared to go ‘the extra mile’ to meet their needs:

> *Sarah: “… if I’d brought something up that he didn’t quite understand, he would go away between sessions and research it… to me that was just brilliant because it was, he was willing to learn, he was willing to go out of his way to, to understand”, (pg.83).*

To go the extra mile is to recognise the individuals’ needs and be willing to offer the time and effort to address them. This means going beyond basic service provision. For example, when an individual is going through an episode of crisis, the staff member supporting them may offer more frequent contact to ensure their safety until the crisis has passed:

> *Deanna: “For example, like if I said “Awe, I feel like doing this”, and then we got through that, and then they said “Okay, well, I’ll come and see you tomorrow and then I’ll see how you are and then if not, then we’ll think of a plan”, (pg. 87).*

Participants described the benefit of having someone there to support them to contain their distress safely, to check in the following day, and put plans in place to keep them safe if required. Having the flexibility to provide additional support when it is needed allows the individual to feel safe and cared for:

> *Cathy: "…I started to see a CPN. He was amazing. Um… I had him for 8 years and… he knew me inside out, to the point that I could phone him up at, you know, during working hours, but I did have his mo – private mobile number, if I really needed it. And he would drop everything and come, and he would spend whatever time he could with me", (pg. 14 & 15).*

Though it is important to preserve professional boundaries, individuals with a diagnosis of 'BPD' greatly benefit from staff actions which indicate they are a priority. Investment of staff time communicates hope that life can improve and validates their struggle to trust and to share their feelings:

> *Sarah: "Um… and as I said, sometimes we could be sat for a good four, five hours…uh on one evening and… it could take me… I'd scoot around stuff. I would avoid subjects. I would talk about service, service stuff um… for an hour, just because I didn't want go to the deep stuff, but having that time to,… to do that… and still knowing that she wasn't gunna kick me out after two and a half hours, or two hours, one hour, um, helped me to relax", (pg. 52).*

When staff go the extra mile by providing the amount of time that the individual needs, this allows them to feel seen and heard. They are put at ease when provided with a safe open space to share their feelings at a pace that is comfortable for them. Such commitment to their care is often contrary to their previous treatment and nurtures a feeling of being worthy of support.

A sense of collaboration between client and therapist was highly valued:

> *Stephanie: "Give me the information and we go on the journey together", (pg.190).*

Collaboration is an additional therapeutic tool which attempts to begin to undo the damage inflicted by a rejecting society. It communicates to the client that they are valued experts by experience, with important insights to contribute to the therapeutic process. The strength of the therapeutic relationship is a major factor for achieving progress, where the implementation of relational skills encouraged engagement:

> *Louis: "… a lot of it is about the relationship you have with the person you're working with", (pg.23).*
>
> *Alex: "…it makes the experience more pleasant, so you'll keep going back, and you'll keep working through", (pg. 41).*

These factors support clients to feel comfortable which encourages return, improving likelihood of progress.

In working with individuals with a diagnosis of 'BPD', multiple barriers can impede progress which therapists need to consider in preparing for and committing to intervention to protect potential ruptures to the therapeutic alliance. It is paramount to reflect on the client's personal relationships and previous relationships with services and how these have affected them. These experiences must be considered when building the relationship and preparing for ending. Abrupt endings with trusted figures negatively impacted upon wellbeing:

> *Rachel: "…she thought that they probably hadn't put two and two together, and I definitely should not have been seeing her at the same time ((laughs)). Um, um, even though I still maintain that it wasn't doing any harm… it annoys me because the, the two things were not interacting. But I know, it's the rules…so ((sighs))… I will do as I'm told.", (pg. 19 & 20).*

Loss of a significant attachment figure can evoke deep feelings of powerlessness which will likely impact upon future engagement. Knowledge of the client's relational history should inform and shape preparation for future endings:

> *Debbie: "… you know when you start when your end date is. Because if you don't do that, then you'll go along quite merrily, and all of a sudden, your end date comes up and with personality disorders, if nothings put like that, no boundaries are put in like that, you can, you can go into one hell of a crisis", (pg. 27 & 28).*

Endings must be discussed from the beginning of an intervention to help to prepare for and manage potential feelings of abandonment.

Asking for help and engaging with treatment were considered challenging for multiple reasons:

> *Alex: "… we just don't understand how to ask for what we need. So, we think, "Oh, if I cut really badly then they'll understand I'm in crisis", (pg. 79).*

Some participants described a struggle to articulate their emotional needs. This is a likely consequence of being raised in an environment deficient in emotional mirroring which would have supported them to communicate their emotional needs. It is critical that therapists recognise self-destructive behaviour as an expression of emotional pain and not 'attention-seeking' and that they respond compassionately. Seeking support and engaging in treatment was also difficult because individuals had trained themselves to supress their emotions to function:

> *Charlotte: "… it was difficult as well to um, to vocalize some stuff because you, you know, to get, to get on… that's how it feels, to get on, you have to kind of just ignore all the things that you're feeling and cover them up", (pg. 94).*

The thought of surrendering these coping strategies and engaging with one's emotions was considered terrifying and potentially a risk to one's safety.

An essential component of the creation of a secure base with whom one could engage was trust:

> *Cathy: "… I was able to explore things with because I trusted them. I felt safe. I knew that they were gunna deal with the information I gave them, um… in a confidential way", (pg. 59).*

Though individuals often struggle to trust because of their experiences of abuse and mistreatment, this can be encouraged by the provision of a safe space and confidentiality. Trust in one's therapist is affected by their availability. Brief work was considered futile as it does not offer sufficient time to develop trust:

> *Cathy: "…if somebody is gunna say to you, you've got 5 weeks, we are going to do all this in 5 weeks – not gunna happen, because a) I'm not gunna trust you enough because you're leaving me in 5 weeks", (pg.44).*

Ample time is required to feel safe enough to sit with uncomfortable emotions and to trust the therapist to hold them as they do so. Frequency of support required is dependent on where the individual is in their 'healing journey'. Initially, more consistent care is required:

> *Charlotte: "… this is where it's different to any other therapy, for somebody, for a patient like me, you need to be able to contact your therapist and know that they will respond to you", (pg. 33).*
> *"…a constant support, I think. You know, where you know somebody's there that you can keep using, just not for one hour a week or you know, whatever it is – to help you try and process it, to help you try and understand it", (pg. 41).*

It is critical that support can be accessed beyond the therapeutic hour to assist them to process their emotions safely before they can achieve this independently. Individuals with a diagnosis of 'BPD' endure many experiences which put them at significant risk of causing themselves harm when enduring acute distress. These include emotional intensity and fluidity, impulsivity, and the tendency to engage in risky behaviour. Therefore, support must always be accessible when required.

When presenting in crisis, individuals need immediate emotional and sometimes physical containment:

> *Cathy: "… what we need is to be held when we're falling; but allowed to get on with it when we're well", (pg. 26).*

Contrary to stereotype, participants stated they only needed to be held by services briefly until crisis had passed. Once they felt safer, they wanted to be able to resume control. Cathy's description also reflects the pattern of care required for this client group. Support must be intensive in the beginning and during crisis, but as soon as individuals are able, independence should be encouraged. The holding of clear boundaries supports this process:

> *Debbie: "…boundaries put into place, um, you know, if it's an hour, it's an hour. And during that hour, no matter how somebody tries, you've got to say, "time's up", (pg. 69-71).*

Boundaries protect staff wellbeing and provide containment and reduce feelings of dependency for the individual. Learning skills for emotional regulation also promoted independence:

> *Stephanie: "…it is really useful to learn those and different coping skills and so… So, I do think that has to come into it… So, people can go and live their lives and don't become too dependent", (pg. 179).*

Participants stressed the importance of taking responsibility:

> *Charlotte: "…I wanted a fix so it was, you know, my therapist is "I want a fix – and they will fix it". Um, now I have a better understanding…. I want help and support … and ways… to help develop ways between us that my understanding grows, my understanding of how to cope develops", (pg.83).*

As self-understanding develops, individuals realise there is no easy solution but through collaboration with services, they can learn to respond adaptively to their feelings. The therapeutic relationship validates the client's unique needs; recognising that support must be tailored to 'give what is needed'.

Subtheme 1c: Giving What's Needed

Though participants found value in both relational and directive approaches, it was concluded that therapeutic needs vary depending on the individual, their present circumstances, and stage of their 'healing journey'. Therapeutic needs were recognised to evolve over time with developing self-awareness. Staff working within mental health services need to be skilled in determining a client's needs and adaptable in delivering the type of support required in the moment. The lived experience of daily intense, rapid fluctuations in negative moods was thought to be a critical factor influencing the type of care required from services. Participants stressed professionals needed to understand the implications of living with these experiences:

> *Deanna: "I change so quickly, I'm like a remote control… one minute I'm okay, one minute I'm not", (pg.45).*

Rapid shifts in emotion trigger fast transition from baseline to crisis. This means services need to be readily available and willing to respond immediately to keep the individual safe:

> *Cathy: "… we need that time at that point. By the time we get through any of the referrals, we're fine", (pg. 35).*

Crisis episodes are experienced as relatively short periods of time. The longer the wait from seeking support to receiving it, the more intense and distressing crisis becomes. Invalidating responses from services following help-seeking were seen to exacerbate crisis.

In planning sessions, therapists need to be flexible in their expectations of the client because of the impact of emotional intensity:

> *Cathy: "… we don't know what we're gunna be like day to day… you spend so much time building up to your next session… That by the time you get there… it's like I can't, you can't physically, can't take any more in, you need to do the "Baa-aaa" sort of thing", (pg. 50 & 51).*

A therapist may intend on delivering a structured session, with psychoeducation and skills to teach the client how to regulate their emotions. However, the build-up of a client's emotions may be so intense, that they are unable to engage with the material and instead require a safe space to offload and support to contain and process how they are feeling:

> *Sarah: "I could go to a session and… just be numb… and really depressed and, and not accepting of anything… and he understood that, and he was able to just be with me in that… and get me to try and talk about what was going on for me at that moment… he was able to work with me through those and not… when I was in that really bad place, not kind of say "Well, let's try and work on this skill", (pg. 48-49).*

Therapists must be willing and able to acknowledge the client's emotional state, how it affects their capacity to engage and adapt their support style to meet what is needed in that moment. Individuals' struggle to make sense of their thoughts and strong emotions make it difficult to recall session content, highlighting the importance of record-keeping and the therapist remembering to return to significant material when the client is more stable:

> *Charlotte: "I'd like to know that the stuff that I talk about is actually documented somewhere… that all these things I'm talking about, I really struggle to understand if they are meaningful… I'd like to know at some point, you know, "You said this… this actually means this", (pg. 40).*

Acute emotional distress also impairs the ability to learn new skills for emotional regulation and to remember to use them in crisis:

> *Cathy: "… we need reminding… what's in that toolbox, because it's not because we don't wanna use it, it's because we've gotten so distressed, we've forgotten it is actually there", (pg. 54).*

Participants stressed skills must be practiced with the therapist to ensure they are accessible when needed, and that the therapist will need to remind them of these until their application has become instinctive.

Therapists must be attuned to the fact that individuals with a diagnosis of 'BPD' have diminished emotional resilience:

> *Louis: "…things might happen in a person's life and if they've got BPD they might not be able to cope with them in, in the same way as someone without the diagnosis", (pg. 52 & 53).*

This means they are likely to need more time and support to process difficult events and feelings than other client groups, because of the lack of an internal secure base for self-soothing and their impaired capacity to mentalise. Many individuals with a diagnosis of 'BPD' have endured multiple traumatic life events and wish for these to be validated in therapy:

> *Stephanie: "… there maybe needs to be more acknowledgement of that with borderline people, that we've been traumatized by something or lots of things, and, and then having difficult lives too, adds to it", (pg. 160-161).*

Therapy awakens the distressing effects of trauma and therapists must be trauma-informed and trained to contain these issues appropriately:

> *Charlotte: "…the more that you start to unravel a condition like this, the more crap and muck is gunna turn up that you are gunna start feeling more unraveled before you're gunna start feeling any better, (pg. 33).*

This means that individuals will require a significant amount of support at the beginning of treatment and during difficult episodes because of the emotional impact of processing trauma and having to do so without the use of previous harmful coping strategies. Access to care needs to be consistent to support this process.

Participants advised adapting one's interactional approach to compliment client attachment style:

> *Alex: "… you might wanna stand back a bit from someone who might develop romantic feelings for previous therapists, but you might wanna get closer to somebody who resists you getting closer…", (pg. 72 & 73).*

Firm boundaries must be maintained to prevent rupture to the relationship and encourage independence for anxiously attached clients. Therapists should try to get closer to the feelings and 'go the extra mile' to gain the trust of those who are more avoidant.

Individuals want to be recognised by the professionals who support them as unique not as just another 'borderline' person:

> *Cathy: "… we are so different, all of us, you can't fit us into a box", (pg. 53).*

Generalised assumptions regarding their experiences and choices for the best course of intervention were considered unhelpful. Each person and situation are unique, thus require an individualised response. Therapists must utilise their clinical judgement to accurately assess client needs:

> *Sarah: "they should be able to… determine where the client's at… And whether they have the capacity at that time to take on skills", (pg. 24-25).*

Appropriate timing is critical as a mismatch between intervention and client motivation results in wasted resources:

> *Debbie: "… you might not be ready for therapy either. There's people that have gone into it and left after two weeks cause it's been too intense", (pg. 69).*

Clients need to be ready for change to fully engage. The wrong therapy at the wrong time can even be harmful:

> *Louis: "… when I did end up having a bit of sort of psychodynamic therapy only for like a few sessions, it wasn't structured in a very safe way. I disclosed a lot of stuff and then became completely overwhelmed and ended up inpatient", (pg. 15).*

Clinical judgement regarding the suitability of an intervention must be applied continuously to protect client wellbeing.

When reflecting on of the usefulness of both the relational and directive approach, participants concluded that a 'giving what's needed approach' is what is best:

> *Charlotte: "… you need, um, both strategies, um. I think maybe sometimes it's heavier one way than the other depending on the person that you're dealing with or the patient or what they need… you could have a session where… you have this dual between patient and therapist, um, you know where you both come up with… a plan together, or you know, talking about it and talking about your experiences and how that made you feel… But then the next time, it might make you, or later, it might make you feel so crappy, that then you need someone to go, "Okay, so now you're gunna…", (pg. 43-45).*

What approach is needed and when depends on the individual. Participants appreciated session content being tailored to what was personally relevant for them:

> Lexi: *"… It wasn't, didn't follow that structure at all. It was like "Okay, you seem to be um, struggling with emotional regulation right now, let's, let's, let's do some of the emotional regulation", (pg. 46).*

Problems arose when therapists were inflexible and overly attached to a particular way of working:

> *Deanna: "… I suggested about a diary and um the rating thing, and um he said "What do you want to do that for?" (laughs). Um… so then it was like, "Oh", you know, not like, "Oh, that's a good idea", (pg. 78).*

Rigidity and defensiveness in response to client need echoes historical experiences of invalidation, increasing likelihood of disengagement.

To make therapy more client centred, participants suggested therapists ask their clients about any previous experience of support for their mental health to learn more about what they find helpful or unhelpful:

> *Lexi: "…I was able to talk about what wasn't helpful before… she knew not to do the "Counsellor Voice", (pg. 65 & 66).*

Using this knowledge to tailor one's approach to the client can support the development of the therapeutic relationship. The 'harmful' processes which individuals with a diagnosis of 'BPD' can experience in their interactions with mental health services will now be described, with suggestions for their disintegration.

Overarching Theme 2: Harmful Processes

The second overarching theme details ‘Harmful Processes’ received and experienced by individuals with a diagnosis of ‘BPD’ from therapists and mental health services in general. Participants described rejection, punishment, and neglect by those responsible for their care. This affected trust and engagement in future interactions. Understanding a client’s history should go beyond life events and personal relationships to include developing insight into their past encounters with mental health and adjoining services (e.g. police, accident and emergency, social services, housing and prisons for men with a ‘BPD’ diagnosis) to gain an understanding of how these impacted upon them. This awareness is essential for the growth and protection of the therapeutic relationship. If the therapist is aware of the likelihood of these experiences and shares them with colleagues to inform intervention, then hopefully this will prevent future rejections. ‘Corned Beef Sandwiches and Paper Suits’ represents the stigma attached to the ‘BPD’ diagnosis, where individuals are not only judged as bad people who are responsible for their difficulties but are rejected and punished as if they were criminals. Participants spoke of not feeling heard and being ignored when crying for help. ‘Lights on, but Nobody’s Home’ captures the experience of being invisible to services and the tragic consequences of this.

Subtheme 2a: Corned Beef Sandwiches and Paper Suits

This theme represents the shame and torment when suffering is met with punishment and rejection. Society's message is fault lies within the individual who is beyond help. Even in therapy, participants report judgement and withdrawal of care. Historical interactions with services must be known to inform intervention and improve care. Individuals are made to feel they are bad, manipulative and attention-seeking:

> *Lexi: "… I'd talked about how I just was feeling really, really impulsive, and was worried I was going to do something really bad on an impulse and I didn't want to do that cause it would hurt people. And she just turned around and said, "Hmmm. You're not gunna kill yourself, are you? And if you do, it will just be to spite people", (pg. 9 & 10).*

They were made to feel they were the problem. The diagnosis was not understood as a condition in requirement of care, but a manifestation of bad behaviour, and at worst, of criminality warranting punishment through incarceration, feeding feelings of shame and low self-worth:

> *Alex: "… I would sit in a police cell, often cuffed at the wrists and ankles, for up to 3 days. Um, they would put me in clothes that I couldn't tear, it, paper clothes. They'd take my clothes away, my underwear, my bra. Um, and the only thing I'd be offered to eat every, three times a day I'd be offered a corned beef sandwich. And that was all I was offered for three days. So, for three days I ate nothing", (pg. 8).*

Being in crisis often led to a section 136 and detainment in a police cell. Although deemed necessary for safety, confinement, isolation and having their clothes replaced with paper suits was experienced as humiliating and punishing at an already frightening time.

Participants felt discriminated against because of their diagnosis:

> *Cathy: "…I became very aware very quickly, that because of the diagnosis… um… nobody listened, nobody wanted to know", (pg. 9).*

The stigma of the diagnosis meant professionals kept their distance. Emphasis was placed on taking responsibility with a tone indicating that they were at fault and able to control their behaviour:

> *Deanna: "… just their attitude and tone and it's, it's like the sort of like blaming me sort of thing, and it's like "Well, you know what to do if you want to get better", (pg. 32).*

Participants recognised their lifetime cycle of trauma being repeated within their interactions with services:

> *Cathy: "… we need people to understand that we're not attention-seeking and we don't deserve to be abused by somebody else because we've got this diagnosis", (pg. 76).*

Some participants felt professionals were attuned to their emotional vulnerability, giving them power to refuse care. Stigma associated with the diagnosis gave professionals permission to patronise and dismiss them, leaving them feeling unworthy of support:

> *Charlotte: "… this was just – "No, sorry, computer says no, that's it. Get out. Goodbye. We're not even gunna support you with it. Um, we're just gunna wait for it to happen. And laugh at you along the way, cause I had one psychiatrist say to me "Oh, what are you always going to be suicidal? Let's be serious"…. "That's really helpful – thanks!", (pg. 15).*

Instead of understanding their self-harming behaviour as a method of managing emotional pain, professionals interpreted this as 'attention-seeking':

> *Sarah: "…Um… "Why have you been so stupid to self-harm? You're using up all our, all our resources when there are people out there who have genuinely hurt themselves", (pg.54).*

Individuals were judged as selfish for using resources when they had self-harmed. They felt a burden and believed services wanted rid of them:

> *Stephanie: "…she said, "Well, secondary services make you low, make you feel worse, they might not be the place for you". And I said to her, "Well, where else am I supposed to go with a serious mental health condition but secondary mental health services? Aren't you the people I'm supposed to go to?" And she was telling me that maybe I didn't belong there! And I was like, "What you mean is, you can't handle it!", (pg.162).*

Participants had the impression they were deemed too complex and demanding for services, which meant staff would try to find a way to push them out.

Even when therapy was available, it was not always free from society's judgement:

> *Charlotte: "… she made me feel like it was all my fault, and I was blamed for it. And it just added to the negativity of you know, "This is just my bag, my bad bag of, you know, my lot of life", (pg. 90).*

When a client feels judged by their therapist, historical rejections by caregivers are re-enacted. This reinforces society's message that they are flawed and that there is no hope for them. A sense of being judged and shamed is also evoked when staff panic and withdraw support in reaction to intense emotions:

> *Cathy: "…cause when we suddenly melt down, it's like, "Woah, what did we do?" So instead of saying, "Okay, we're gunna hold you"… they back right off. Um, they make you feel ashamed of how you are and why you struggle", (pg. 32).*

Therapists need to be nonjudgmental and robust in response to intense emotions, so clients feel contained. Defensiveness in therapists can lead to misuse of power, where their own therapeutic model is utilised as a defence against the client:

> *Stephanie: "I took an advocate… just I want somebody there. And then her interpretation was that, "Oh, so you want somebody there like a mother to look after you?", and I said "Well, no, no. I just want someone whose there". Like a reference point, cause my mind goes, slides all over the place… And she just, she was going, "Oh, but do you ack, acknowledge that, you know, people have these childhood emotions and things?", "Well, yeah". But that wasn't what I meant, but her, cause she's a psychologist, her immediate interpretation of that. But I felt belittled by that. I'm not looking for a mum, I don't want that. And then she, then she analysed my reactions and said, "Oh, but you reacted quite strongly to that didn't you?" I said, "Well, yes 'cause you didn't…" She, it had to be my stuff", (pg. 143-144).*

When a therapist feels threatened or experiences strong negative counter transference reactions, there is a risk that their responses will be harmful to the client.

Even when support was offered, timed interventions with focus on the achievement of set goals could trigger feelings of failure:

> *Lexi: "… the biggest issue would be feeling like a pressure to get better in line with expectations. Even if there's not a time limit on it, if there's like clear like, "You'll do X, Y, Z. By the end of it, we want you to not self-harm anymore, to not misuse alcohol, blah, blah, blah. And then someone feeling like they've failed if they're not ready yet…", (pg. 41).*

Participants felt they were inherently flawed when they could not meet the standards and expectations set for them by the therapist and society. They lost hope when support offered was ineffective:

> *Alex: "… sometimes the manual isn't always right – what works for one person doesn't work for everybody. Um, it could lead the client to believe ideas about themselves that they're untreatable… it's quite demoralising if you go to someone for help and that you don't get that help. Or you do get that help but it doesn't work, and then you're like, well the problem's me, but it's not always… but the problems with the help you were offered", (pg. 51-52).*

Therapists need to acknowledge individual differences and explain that one approach will not work for everyone. Discussing the theory and research behind an approach and supporting them throughout setbacks was thought helpful for motivation and avoiding feelings of failure:

> *Stephanie: "… explain the theories and the percentage rates so that they don't feel they've failed if they can't stand up to this, you know, commitment they've made to some, yeah, the, the new therapists need to know that everything melts and everything just flows away inside of us, borderline people. It all just… thoughts and emotions. So, you know, yeah, you can make a commitment to something, but it will melt away. They need to understand that. And so they're not, it's not that somebody can't stick to that commitment, don't punish them for it.…", (pg. 217-218).*

A therapist's ability to engage in reflective practice was considered essential for the protection of the therapeutic relationship and achievement of progress:

> *Stephanie: "… a lot of therapists, they think they're it, they think they are knowledgeable and they sit there, "I know what's happening, you don't", and it's actually therapist-centred therapy, it's therapy… it's counsellor-centred counselling. It's therapist-centred therapy. It's about them! That's been my experience for the main… they need reflexive self-awareness, and the ability to make amends as most people do", (pg. 129-130).*

When a therapist is non-defensive and demonstrates willingness to learn from their mistakes, this shifts the power balance and strengthens the alliance. Therapists and mental health services need to be aware of these historical interactions with services, for them to be integrated within the client's formulation to inform understanding of their issues and improve the quality of care provided. Hopefully, this awareness will enhance the therapeutic relationship and repair trust. Individuals are not only harmed by services when seen and then punished or rejected, but equally harmed when never seen at all.

Subtheme 2b: Lights on, but Nobody's Home

The 'BPD' stereotype depicts an attention-seeking individual who has no issue asking for help. However, participants described learning to their hide feelings for survival, only seeking help when necessary. Under-resourced services result in distress going unseen unless accompanied by obvious risk. Therapists must look beyond the surface, reassuring clients that their feelings are sufficient for care. An under-resourced stepped care model suggests 'risk leads to recognition':

> *Rachel: "… maybe I've just had some bad experiences, but um… I've just… like… um… times when um… I've… um… overheard nurses making … comments about like… my overdose not being particularly impressive", (pg. 54).*

The language used by staff invalidates Rachel's distress by suggesting that the level of harm she had inflicted upon herself to manage her distress was unworthy of their time. The model of care available suggests to individuals that support will only be provided to those who are most at risk. This message is internalised, reinforcing the urge to self-harm in response to emotional distress or even take a gamble with their own lives:

> *Deanna: "… And then it's like, the only way they listen to me is if I say "Oh, stuff it, I'll go and take an overdose". And then the next minute they're calling the police to do a welfare check because they've made me angry because I don't feel they're taking me seriously", (pg.37).*

When individuals do not feel heard or understood by services, they feel driven to drastic action in a desperate attempt to communicate their needs and receive care. One's emotional distress is judged to be insufficient alone to be considered worthy of care. However, if individuals present to services having self-harmed, they are judged to be attention-seeking and wasting resources, and are then turned away or treated with hostility:

> *Lexi: “And then it’s very self-perpetuating with, for BPD. Like there is, I, I feel there is a, a lot of judgment on someone who has BPD… Um, and people often think that they attention-seek or do behaviours to get attention, and then the services perpetuate that by not listening. And to get, to be noticed and for people to take you seriously, you have to have hurt yourself, so they end, you end up accidentally getting sucked into that, I think. And thinking that the worst damage you do, the more ill you are and the more support you’ll be given”, (pg. 23 & 24).*

Lexi describes the ‘BPD’ stereotype as an individual who engages in specific behaviours to get ‘attention’ from others. This seems to imply that whatever assistance is being sought from others is self-indulgent and unnecessary. When others read their behaviour in this way, detaching it from their unmet emotional needs and trauma, in the context of an under-resourced and overwhelmed service, it is understandable that the individual would receive judgment. This then permits their dismissal, thereby relieving pressure on the service. To avoid dismissal, individuals feel they must present with a higher level of risk to qualify for care:

> *Lexi: “… the system forces us to be the stereotype… With regards to like, the worse you hurt yourself, the more support you get. And that the person probably didn’t start out…feeling like… they had to self-harm to prove how unwell they were, that’s often… a product of the system”, (pg. 68).*

Symptoms associated with ‘BPD’ such as self-harm and suicidal behaviours are exacerbated through rejection from services. For individuals with a diagnosis of ‘BPD’, their interactions with the mental health system and wider society actively trigger further deterioration in their mental health:

> *Alex: “They were trying to invalidate the experience of going to A & E in the hope that I would stop going. And in a way that was kind of effective, I mean I did go less. But when I went… I would have done more serious things to make them take note. And I would of, it*

> *became a scary place to go. Um… interactions with the mental health team that were quite stand-offish, felt like I wasn't human. Um… it reinforced "No one cares about me. I'm empty. I'm invalid. Nothing I do matters". I think it in, it in, enhanced the depressive tendencies… And the suicidal ideation and the self-harming. It all just intensified when they took that approach… Because I just kept, I just kept doing more, and more, and more, and more to make them notice me", (pg. 35-36).*

Alex's words reflect how powerful and damaging service responses can be in worsening an individual's symptoms of 'BPD', potentially putting their lives at risk. Though services are under pressure to meet the demands of a high volume of patients, they need to recognise that their attitude of rewarding risk and dismissing distress inflicts greater harm and chaos for both sides.

Many individuals are unable to receive care from their service because of the lack of resources:

> *Sarah: "…It's so small because the population within "Newbridge" that have BPD is so large… they've gotta firefight so they've only got a small service, so the window to get in is really small, but you have to be almost extreme BPD to get into that service, and everybody else outside that's not really extreme…*
>
> *Cathy: We don't get anything", (pg. 34-37).*

A lack of resources results in only the most severe cases being supported. Again, this system evokes a sense of feeling unworthy of care, diminishing the validity of one's emotional distress. Where support is available, it is restricted to risk management:

> *Cathy: "… it's always been more of a case of firefighting. There isn't the support you need… to actually start moving forward", (pg.26).*

There is only intervention to manage immediate risk to the individual, such as attending to self-harm wounds and teaching basic emotion regulation strategies.

Few resources are available to address the underlying issues behind the self-harm. Participants felt resources could be saved and suffering prevented if support were offered sooner:

> *Lexi: "… when someone's a little bit mentally unwell, they get nothing or… six sessions of counselling and then it takes until they're like super, super unwell for anyone to pay any attention. And if there was just better intervention earlier… it wouldn't get to that stage where it needs, lots and lots and lots of time and resources", (pg. 20 & 21).*

If participants had been able to access therapy, they repeatedly reported experiences of not feeling heard by their therapist:

> *Stephanie: "… I said to her about um, "I feel like I'm standing by the railway line, and the train is going past, and I don't even have a platform to help me get on the train"… and she turned round and said "Oh, that's not a very useful analogy, let's try something else", (pg. 105-107).*

Historical experiences of not feeling heard by their caregivers were re-enacted within the therapeutic space. Their emotions are invalidated, and their distress remains invisible:

> *Stephanie: "… I was crying and crying and crying… I couldn't stop and then she just said something like "Well, at least you can write poetry", and I just flipped", (pg.84).*

A life cycle of trauma is again repeated as even therapists fail to recognise and engage with the depth of emotional turmoil they are in. The mental health professional is responding to them, yet is blind or perhaps unwilling to acknowledge the extent of their distress. The lights are on, but nobody's home. In a case of serious neglect, a client's life was left at risk:

> *Deanna: "I took the overdose and I told him just before we started the session, huh! And for some reason, he just continued with the session… and then I was quite sort of angry at him 'cause I said,*

> *"Well no, you should have cancelled it and just got me to hospital", (pg. 25-28).*

The therapist's agenda took priority over their client's safety. Even when the client is directly communicating risk, this is ignored or goes unseen by the individual who holds a duty of care towards them. Their cries for help continually go unheard.

The inability of professionals to recognise distress can be particularly damaging when they fail to contain trauma:

> *Sarah: "… if you don't have the, the time and the skills to close the box properly, then don't. Just don't open it in the first place. Or… you… the client, you know the client doesn't have the skills to close it properly, don't open it – because they can sit with that box the whole, if you see them on a weekly basis, they will sit with that box open for a whole week… And it can do so much damage", (pg. 67 & 68).*

The lack of clinical skills to properly repack traumatic memories can place individuals at great risk of further harm. Not only do therapists working with this client group need to be extensively trained in working with trauma, but knowledge and application of trauma-informed care must circulate all services in which they present. Experiences of feeling neglected and uncared for were evoked across services:

> *Rachel: "… it would just be nice to feel like um… they cared how I was… and I think um… it would probably have made a difference if, um… in some of those situations, they didn't um, refer me to the crisis team when they definitely should of done. Um… in one of those situations, they probably shouldn't have let me leave, um, let alone actively discharged me. Um… but… it happened". (pg. 57)*

The extent of their distress and level of risk repeatedly went unnoticed. It was felt that professionals did not really understand what it was like to live with the symptoms of ‘BPD’, they were unable to show empathy with their lived experiences:

> *Debbie: “… it ended up in A and E and ended up back in the psychiatric hospital and it was all because they didn’t phone at the time they said. But then again, I don’t think the Crisis Team know anything about personality disorders. They don’t know the feelings that people have, the abandonment that people have”, (pg.61 & 62).*

Staff working with individuals with a diagnosis of ‘BPD’ need to be mindful that they experience strong feelings of abandonment, and that plans need to be put in place to manage those feelings as much as possible. Timekeeping, reliable attendance at appointments and consistent communication are all vital for ensuring the client feels secure and contained.

Living with the debilitating effects of emotional intensity and fluidity, coupled with invalidating responses to help-seeking has resulted in many individuals developing a mask to hide their inner pain. They explained that this was essential so that they could suppress their emotions and continue to function:

> *Charlotte: “… I changed how I appeared and presented outwardly to get on with stuff, and to survive, which meant that when I went to see people to get help, I presented far too well… and to them that meant that there was nothing wrong with me”, (pg. 93-94).*

Unfortunately, this mask became another factor contributing to professionals’ blindness to the severity of their distress:

> *Stephanie: “… the supervisor, said to her “Do you think maybe she should come into hospital?”, but the counsellor said “Oh, she’s alright” but I’m a meditator, I present quite well. I think I should have been in hospital at that point, I actually think that I should have gone in, and I think that counselor let me down”, (pg. 54-55).*

This is not the image associated with individuals with a diagnosis of ‘BPD’. Professionals need to be aware that not all individuals express their distress openly, and that they need to be aware of the potential of a mask and to probe more deeply to gain an accurate picture of the individual's mental state. Though deterioration can be difficult to detect, each client has their own signs that they need additional support:

> *Sarah: "I wasn't able to verbally say "I'm not doing well". My way was, "I've not had a shower for a whole week", pg. 34 & 35.*

Therapists must come to know these signs to be able to accurately assess and manage risk. The threats to the wellbeing of these individuals presented in this theme may be overcome with basic relational principles of allowing the individual to be seen and heard, and by validating their feelings:

> *Alex: "… when I was treated with validation, the behaviours went down… because… I didn't need to prove to anyone that I was sick. And I didn't need to… I, I didn't have to keep upping my game to get a reaction", (pg. 34-36).*

Simply by validating the distress and reassuring individuals that they do not need to self-harm to be considered worthy of care, the cycle of 'risk leads to recognition' is broken as the harmful behaviour is no longer required as they feel heard and safe.

Final Comments

Analysis of the components which constitute each of these processes powerfully demonstrate the influence of psycho-social factors on the mental health of individuals with a diagnosis of ‘BPD’. Life experience, resilience, and clinical skill, particularly in working with trauma are essential qualities to work in this area. However, having an extensive range of complex clinical skills are not what this group of individuals are asking for from Counselling Psychology. Their narratives represent a call to society to be seen, heard, and treated as fellow human beings. This plea for compassion cuts to the core of Counselling Psychology values. We have a duty to hear and respond, both individually and as part of the wider group to which we contribute.

This chapter has presented each of the themes representing the needs of individuals with a diagnosis of ‘BPD’ from Counselling Psychology, using examples from participants’ narratives to explain each stage of the theme as a process which may be healing or harmful to them. In the final chapter, the key elements of these processes reflecting the support needs of individuals with a diagnosis of ‘BPD’ will be related to existing theory and research literature. Their implications for Counselling Psychology will then be considered from the perspectives of the different roles Counselling Psychology offers to the running of mental health services.

DISCUSSION

Following on from the analysis and interpretation of themes, in this final chapter, key elements of each theme will be discussed in relation to the theoretical and research literature. Implications of the themes for Counselling Psychology are then explored from the perspective of the different roles Counselling Psychology offers to the running of mental health services. Finally, limitations of the research and suggestions for further research are shared, ending with the study's final conclusions.

De-Othering

> *"…I made him uncomfortable. He didn't understand me and he rather held it against me. I wanted to assure him that I was just like everyone else" (Camus, "The outsider",1942, pg.65)*

"De-Othering" powerfully demonstrates the impact of social and cultural factors on mental health. Repeated experiences of rejection left participants feeling ostracized. Mental health services must acknowledge and validate the impact of this neglect. Whilst practicing acceptance and supporting clients to understand their experiences, Counselling Psychologists have a duty to challenge 'othering' discourse. This is not easy when 'othering' is well established within the caring profession. Peternelj-Taylor (2004) describes the use of language by staff in forensic environments which depersonalizes patients (e.g. 'monsters'), casting the individual in the role of the other. Canales (2000) defines othering as engaging:

> *"with those perceived to be different from self – the Other" (p.16).*

This engagement is perceived to be negative and exclusionary (Peternelj-Taylor, 2004), and has a direct impact on the creation and maintenance of the therapeutic relationship (Evans, 2000; Peternelj-Taylor & Johnson, 1995). Care may not be individualized, not sufficiently supportive and may not consider the client's psychosocial needs (Corley & Goren, 1998).

As a discipline based in humanistic values, Cooper (2009) argues Counselling Psychology is well placed to address othering. Values relevant to "De-Othering" include prioritizing the client's subjective and intersubjective experiencing (Orlans & Van Scoyoc, 2008), as they have not been heard. Counselling Psychologists must show commitment to a democratic, non-hierarchial client-therapist relationship. This communicates to the client that they and the therapist are equals. The client must be understood as a socially- and relationally-embedded being, including an awareness that the client may be experiencing discrimination and prejudice (Orlans & Van Scoyoc, 2008). This awareness must center all interactions and interventions because it dispels the idea that problems are located within the individual. Without this understanding, it is impossible to form an accurate and complete formulation of the factors influencing their experiences; thus, compromising the development and delivery of the most effective intervention. Cooper (2009) states these values can be located in Levinas's (1969) concept of 'Welcoming the Other'. This emphasises honouring the Other, in all their otherness. Counselling Psychologists have a responsibility not only to practice these values, but to encourage colleagues to follow so clients are treated compassionately and receive consistency in their care.

The importance of acceptance is emphasised in person-centred therapy for clients with a diagnosis of 'BPD' by Quinn (2011). He describes the facilitative mechanisms provided by the therapist to support positive change in the client, and process mechanisms which describe how the client improves. Process mechanisms of change begin when the client perceives minimal therapist attitudes of conditions of worth. Rogers (1959) outlined a theory of personality development which claims 'conditions of worth' of a traumatic nature were the general influence resulting in the 'borderline' client's personality formation. Therefore, it is the reversal of these conditions of worth as unconditional positive self-regard that underlies the process of change, or the self-actualization of the person. This is achieved when the therapist adopts an attitude of unconditional positive regard (UPR) or 'radical acceptance' (Linehan, 1993) towards the client. By consistently accepting the client, the client is gradually able to integrate the therapist's positive regard into their own self-concept and can then begin to own this idea of themselves as being worthy. Without continued therapist UPR, positive integration is less likely to occur, thus an attitude of radical self-acceptance cannot emerge (Quinn, 2011).

Participants spoke not only of society's unwillingness to accept them, but its' insistence on strict emotional regulation, forcing individuals to wear masks to hide inner pain. Jones (2009) argues 'personality disorders' are problematic for a culture that has privileged rational thought and has assumed emotions belong to a separate and less significant domain. This value placed on rationality is thought to have developed during 'the Enlightenment' period, where the hallmark of humanity became the ability to use reason to control the emotions (Foucault 1967, Hodgkin 2007). Wouters (1999) describes how the evolution of society has brought about a rise in internal forms of social control, which follow from the increase in the standard of morality and from the increased necessity in all social relationships of developing a more reflexive and flexible self-regulation. Jones (2009) argues such ‘disorders’ are becoming more visible within society because these individuals have not been equipped with the skills required to achieve the demanded standards of reflexivity and self-regulation. Bringing into the client’s awareness this detrimental influence of society could support the querying of their condition as something for which they are entirely responsible. Countering society’s influence by listening and validating supports the client’s transition from ‘other’ to equal.

Someone to be There

In supporting individuals with a diagnosis of ‘BPD’, therapists and the surrounding team need to make an initial commitment to consistently responding to distress with validation and support to contain and process feelings; allowing the individual to feel held. This assists the healing of wounds inflicted by past attachments, allowing the internalisation of a secure base, promoting future independence. Participants struggled to engage due to past rejections and lack of time to develop trust in their therapist and process their issues. However, having someone available who would listen, care and could be trusted, could then become the secure base required for engagement.

The significance of feeling cared for and being heard for people with a diagnosis of ‘personality disorder’ was found in a study by Castillo et al., (2013) investigating the process of ‘recovery’. Langley and Klopper (2005) found participants with ‘BPD’ identified trust as essential for the establishment and maintenance of a therapeutic alliance. Their findings echo those presented here that intervention without trust would fail. Conditions for trust included clinician availability, trying to understand by listening, and caring, which allows a feeling of being held, creating safety. Nehls (2001) explored case management services from the perspective of clients with a diagnosis of ‘BPD’, finding participants valued caregiver availability. Case managers were experienced as available on a day-to-day basis long-term if required. When compared with the weekly therapeutic hour, case management services were described as the more valuable intervention. Nehls (2001) concluded that through the relationship with a caregiver, collaborative working promotes self-sufficiency, and reduced service input.

Participants’ narratives call out for a secure base to contain their feelings, especially in crisis. Winnicott (1965) described a holding relationship, where the significant object (initially the ‘good enough’ mother and now the therapist or mental health worker) acts as a ‘container’ for the strong emotional storms of the client. This reassures the client that the therapist is there to help them to retain control and will assume control on their behalf for their safety. The temporary transfer of control in crisis to the professional was expressed as being particularly significant for participants.

As well as containment, participants expressed the importance of continuity of care. Object representation refers to conscious and unconscious mental schemata of significant past interpersonal encounters (Lerner & Ehrlich, 1994). The ability to hold consistent representations of significant others develops during childhood through interactions with caregivers who are caring but frustrating (Winnicott, 1953). This ‘object constancy’ anchors the infant, allowing an increasingly stable sense of significant others and themselves which can withstand environmental changes (Cardasis et al.,1997). Being able to evoke the object's image, especially when feeling anxious is essential. Some believe the adult 'borderline' as a toddler was unable to properly cross the rapprochement subphase (conflict between need for autonomy and anxiety over caregiver separation) of the separation-individuation process because of the caregiver's emotional lability, thus hindering object constancy (Mahler, 1971; Mahler, 1972; Fraiberg, 1969). Regular service contact provides vital constancy and continuity for individuals who lack this relational experience.

The gravity of continuous care from a secure base for individuals with a diagnosis of 'BPD' is explained in the literature describing the link between relational behaviour in 'BPD' and disorganised attachment (Holmes, 2004). Main (1995) argued that the caregiver of a 'disorganised' child is herself a sufferer of unresolved loss and trauma. Caregiving triggers painful childhood memories which hinder the ability to provide a secure base for the infant. An approach-avoidance dilemma with the caregiver ensues; an inner conflict also experienced by the 'borderline' adult, who has a yearning to be close, but a fear which pulls them away.

The story of Feli the goose (Fischer-Mamblona, 2000) demonstrates a fearful attachment response can be overcome. Feli was reared in isolation, missing the critical period of seeking contact and becoming attached, known as imprinting (Lorenz,1935). She had no mother to turn to as refuge from danger, so her escape behaviour was expressed in erratic running. At various developmental stages, Feli experienced conflict between the urge for attachment and to escape. Fischer-Mamblona (2000) believed without an early attachment figure, fear overpowers motivation to attach, dominating behaviour and blocking attachment. Feli's was able to unblock her attachment behaviour when given ducklings who were independent, but insistent on being close to her. Over time, she habituated to them, and her escape motivation diminished as attachment formed. Fischer-Mamblona connects this to therapy where a 'climate of trust' (p.19) develops through slow habituation between client and therapist. Ongoing interaction and familiarity over time, reduces fear and allows a new attachment to form and earlier trauma to be resolved.

Giving What's Needed

This theme serves to remind those working with individuals with a diagnosis of 'BPD' to see the individual and not the stereotype, no matter how maladaptive their attempts to communicate their need for support might be. It draws attention to the need for professionals to develop a deep understanding of the debilitating impact of 'BPD' symptoms on quality of life, and how they affect client engagement in therapy and their needs from mental health services. The unique needs and circumstances of the individual must inform all aspects of their intervention.

Individuals with a diagnosis of 'BPD' experience a range of intense dysphoric affects (Lieb et al., 2004) and mood reactivity (Koenigsberg et al., 2002), with rapid, fluid movement from one interpersonally reactive mood state to another. Participants feel services should be flexible and quick to respond when needed because of the rate at which emotions can escalate into crisis. They felt professionals did not comprehend the risk of living with such emotional distress, resulting in inconsistent care. The need for flexibility is supported by Fallon (2003) who interviewed clients with a diagnosis of ‘BPD’ about how they experience their contact with mental health services. It was found that services need to be developed that are accessible and flexible to the needs of this group because of their experiences of affective instability and impulsivity.

Traumatic events interweaved each narrative, supporting the suggestion that trauma is causally linked to increased vulnerability for ‘BPD’ (de Aquino Ferreira et al., 2018; Bandelow, 2005; Westen, 1990;). Participants stressed the importance of all staff working with individuals with a diagnosis of ‘BPD’ having an understanding of the impact of trauma on mental health. Such specialised care needs to be consistently accessible to keep the individual safely contained as they process traumatic memories, to avoid returning to self-destructive coping strategies. Ferguson (2016) argues for a trauma-informed approach to working with ‘BPD’ (e.g. Adults Surviving Child Abuse, [ASCA], 2012), which recognises the underlying complex trauma for many with this diagnosis. This approach asks, ‘What happened to you?’ rather than ‘What is wrong with you?’, (Kezelman & Stavropoulos, 2012; ASCA, 2012; Mental Health Coordinating Council, 2013), framing symptoms within a context of meaning and hope rather than individual pathology.

The disorganised attachment style associated with ‘BPD’ (Holmes, 2004), coexists with the other three attachment categories. Lyons-Ruth and Jacobvitz (1999) observed infants with disorganised behaviour show mostly anxiousambivalent, but also avoidant and secure attachment styles. Understanding a client's attachment style offers a perspective into how they relate to others, including the therapist, how emotion is regulated, and how memories are retrieved (Sable, 2004). Participants advise therapists to tailor their interactional approach to complement how their client behaves in relationships. Strict boundary-setting was thought beneficial for anxiously-attached clients at risk of over-attaching to their therapist. Progress with avoidant clients means finding a way to obtain greater emotional proximity to them. This might be achieved by demonstration of the therapists' trustworthiness through their availability, provision of a safe space or commitment to a client-centred approach.

Participants wished to be recognised as individuals with their own unique needs. Cunningham et al.'s (2004) explored client perspectives of the effectiveness of DBT in treating 'BPD' and their findings support those presented here that participants recognise the value of both relational (acceptance/ validation) and directive (change/ problem-solving) approaches, concluding a balance of both is required. However, support needs vary according to the specific needs of the individual, their presenting circumstances and stage of their 'healing journey', as needs change over time with increased self-awareness. Skilful use of clinical judgement is required to accurately assess client needs. This finding was also evident in Cunningham et al.'s (2004) study regarding the graded approach staff utilise when responding to client crises. Client familiarity with skills and crisis intensity determined the directiveness of staff responses to encourage autonomy.

If a therapeutic intervention is designed to facilitate change, the client must be ready for change for the intervention to be successful. This finding is supported in both the qualitative and quantitative literature (Cunningham et al., 2004, Hodgetts et al., 2007, Soler et al., 2008). Participants felt it was essential that professionals used their clinical judgement to ensure the delivery of the right therapy at the right time for the individual client. A mismatch between intervention delivered and the client's motivation for change would not only waste valuable time and resources but could also put the client at risk. Treatment must be tailored to the individual to best address their needs and to ensure their safety.

Corned Beef Sandwiches and Paper Suits

Sadly, the emergence of this theme evidences the reality that long standing negative attitudes towards individuals with a diagnosis of 'BPD' continue to circulate our mental health systems. Society's condemnation is even played out within the therapeutic space, where participants felt judged for not meeting expectations and cries for help were often met with dismissal from defensive therapists. Participants felt judged as 'bad' and 'manipulative' people, and felt others believed their presentation was their fault, their condition was untreatable, and their behaviour was 'attention-seeking'.

In one of the earliest qualitative studies with individuals with a diagnosis of 'BPD' (Nehls, 1999), participants described being misunderstood and mistrusted by mental health professionals, especially in relation to self-harm which was misinterpreted as 'manipulative' and 'attention-seeking' rather than a method of controlling emotional pain. This was considered harmful as it maintained prejudice, prevented the underlying reasons for self-harm from being addressed and hampered the development of the therapeutic alliance. Concerning staff attitudes, Millar et al., (2012) interviewed 16 clinical psychologists about their experiences and perceptions of working with clients with ‘BPD’. These clients were seen as different, manipulative, having limited capacity to change and evoked negative feelings within the psychologist, such as feeling overwhelmed, frustrated, and having a sense of low self-efficacy. However, clients were also seen as likeable, evoking desirable feelings like empathy, and psychologists were aware of this negativity and were willing to explore the reasons for it.

Ociskova et al. (2017) assert that the stereotyped imagery of psychiatric patients originates from deep-rooted prejudices and conservative interpretations of the psychiatric disorders. The identification of an individual with a ‘mental illness’ is called a labelling reaction which can lead to stigmatizing attitudes and behaviour towards the labelled individuals. Stigmatisation of individuals with a diagnosis of’ ‘BPD’ has a broad range of harmful consequences. These include problems in interpersonal relationships, missed opportunities for education, employment, and housing, and clinicians emotionally distancing themselves from them (Aviram et al., 2006). This negative reaction from clinicians may be particularly upsetting for individuals with a diagnosis of ‘BPD’ as they are extremely sensitive to communications of rejection and abandonment.

Gaines (1992) argues that psychiatric classification is culturally constructed and expresses an underlying ethnopsychology of the ideal self. It communicates what traits a culture deems valuable and what is considered ‘abnormal’. Thus, the ‘personality disorder’ diagnosis is a communication of what society disapproves of and struggles to tolerate. Scanlon and Adlam (2006) explored links between homelessness, considered as a state of mind as well as of body, and personality disorder. They believe ‘homelessness’ could be seen as both a symptom and a communication of unhoused and dis-membered states of mind, the feelings of chronic emptiness that are characteristic of people with ‘personality disorders’ due to their impaired capacity to mentalise (Fonaghy & Bateman, 2007).

Scanlon and Adlam (2006) explain that the ‘unhoused’ and ‘dis-membered’ are feared and repelled because they threaten our idea of what it is to feel that we are in a ‘housed’ state of mind and members of normal social groupings. The ‘homeless’ and individuals with a ‘personality disorder’ diagnosis are also punished by society when it assumes their actions are intentional, meaning that others hold no responsibility to offer support (Scanlon & Adlam, 2006; NIMHE, 2003). Interventions received can often be experienced as more like ‘revenge’ or ‘retaliation’ or, at the very least, prejudice and discrimination (Kelly & May, 1982; Lewis & Appleby, 1988, Norton & Dolan, 1995), such as disproportionate levels of sedative medication; staff who find reasons to discharge from treatment prematurely and stitches applied to cuts without anaesthetic, all of which were reported by participants.

Scanlon and Adlam (2006) note staff working with clients with unhoused and dis-membered states of mind inevitably find themselves caught up in related states of unhoused-ness, experiencing feelings of distance and alienation both within themselves and from colleagues. Empathy is replaced by staff’s constant unconscious attempts to defend themselves against the anxiety which is evoked in response to client distress. To move from displacement to cohesion within the team, Scanlon & Adlam (2006) suggest individual workers need to feel ‘housed’ within their team or supported to reflect on and process their feelings of being ‘unhoused’. This will dissipate anxiety, allowing better containment of client trauma and support to address their issues. This demonstrates the importance of ongoing supervision and attendance of reflective practice groups to support teams to manage the impact of vicarious trauma.

Lights on, but Nobody’s Home

Contrary to stereotype, to survive a society which actively disapproves of expression of emotional vulnerability, individuals learn to cover up their intense fluctuating emotions to function. Over time, a mask forms which hides their emotional pain from a cold and rejecting society. This defence creates the illusion that they feel okay and can function. However, the mask can only be worn for so long before it melts away when the individual becomes consumed in the overwhelming despair that is crisis. Such distress can easily be missed or dismissed by an under-resourced mental health system. Unless risk is clearly visible, it does not exist, and individuals are turned away.

Woollaston and Hixenbaugh (2008) explored nurses’ relationships with ‘BPD’ patients, who perceived them as a ‘destructive whirlwind’. This was described as ‘a powerful, dangerous, unrelenting and unstoppable force which leaves a trail of destruction in its wake’, (p.705). Participants had experienced multiple traumatic events on the ward with these patients, including aggressive and high-risk behaviours. However, the participants in this study present an alternative response to managing the distressing experiences associated with ‘BPD’. This demonstrates the importance of acknowledging the individual and the differences in personal circumstances which lead to varied presentations, making stereotyped assumptions inaccurate and unfair.

Gillard et al. (2015) explored understandings of ‘recovery’ with individuals with a diagnosis of ‘BPD’ who perceived the external world as an unpredictable, and potentially harmful and hostile place. Participants used the same imagery of having to put on a mask, but this time in relation to having to hide themselves to give the impression that they were not ‘mentally ill’ because of the stigma attached to it. Not everyone with a ‘BPD’ diagnosis openly expresses their emotions and therapists and other mental health professionals must be mindful of this, and willing to probe beyond the surface to get a better picture of the individual’s state of mind.

There is something about the distress of this clinical group that professionals cannot see or choose to ignore. Studies have suggested that staff working with individuals with a diagnosis of ‘BPD’ are more socially rejecting of them than patients with other psychiatric diagnoses (Markham, 2003) and some clinicians may emotionally distance themselves from them (Aviram et al., 2006). At times, there appears to be a disconnection between what staff should know about ‘BPD’ and how that translates into the quality of care clients receive. Rogers and Dunne (2013) reported that individuals with a diagnosis of ‘BPD’ feel that there is a lack of understanding among staff of ‘personality disorder’. Despite the abundance of literature describing the fears of rejection/ abandonment and emotional dysregulation that individuals with a diagnosis of ‘BPD’ experience, participants reported that staff appeared to perpetuate these features by making rejecting comments while they were present. Participants in this study described a similar issue where services evoked a sense of abandonment with poor-time keeping and withdrawal of crisis services.

Numerous factors contribute to negative staff attitudes towards individuals with a diagnosis of ‘BPD’ and their response of turning a blind eye to their distress. Negative attitudes from nurses towards patients with ‘BPD’ in comparison to patients with other diagnoses has been linked to the belief that individuals with ‘BPD’ have a higher degree of control over their negative behaviours (Markham & Trower, 2003). Bodner et al. (2011) found that nurses, psychologists, and psychiatrists expressed high frustration feelings towards patients with ‘BPD’, and that these feelings and the difficulties expected in their treatment were thought to be explained by the suicidal tendencies of ‘BPD’ patients. Woollaston and Hixenbaugh (2008) reported another reason nursing staff experienced ‘BPD’ patients negatively was because they felt they were unable to help them.

Therapeutic work with clients with a diagnosis of ‘BPD’ is recognised to be challenging due to strong negative counter-transferential responses that are evoked within therapists (Holmes, 2004). Bourke and Grenyer (2010) found that therapists expressed significantly more negative attitudes and felt less satisfied in their therapeutic role with patients with ‘BPD’ compared with patients with major depressive disorder (MDD), despite a consistent wish to support them. Following this, Bourke and Grenyer (2013) reported that therapists expressed greater emotional distress and an increased need for supportive supervision in their clinical work with patients with ‘BPD’ compared to patients with MDD. These many challenges facing professionals working with individuals with a diagnosis of ‘BPD’ highlight the need for continuous access to professional support including supervision and reflective practice groups to protect the wellbeing of both clients and clinicians.

IMPLICATIONS FOR COUNSELLING PSYCHOLOGY

De-Othering

The clinical implications for this theme resonate with my personal development as a therapist-researcher. I was unaware of the assumptions relating to the values of my discipline which occasionally interfered with my ability to fully immerse myself in participant narratives during the pilot interviews. Once I recognised this and bracketed my beliefs about 'BPD', I was able to fully engage with the research interviews as a collaborative-co-constructed process between myself and the participants. The opening question allowed participants the space to tell their story to which I listened attentively. Several participants informed me that this was the first time they had really felt heard. This process of feeling heard and being given the space to make sense of one's own experiences is important in starting the process of 'de-othering' because it de-pathologises their experiences.

The participants of Nehls's (1999) study all expressed the wish to speak and for clinicians to listen, suggesting that dialogue, by its nature, is therapeutic. An emphasis on hearing the client's narrative rather than intervention being dictated by their diagnosis encourages clinicians to view clients as authors of knowledge from whom others have something to learn, rather than as objects (Caputo, 1993). They are the experts by lived experience with significant insights to share. We need to listen.

Once I heard their narratives, in addressing the interview questions, I found that a collaborative and curious approach of wanting to find the answers together was useful in building the alliance between myself and my participants and gaining access to the rich detail of their experiences. In therapy, Anderson and Goulishian (1992) describe how therapists take an approach of asking their client questions from a position of ‘not knowing’, which creates a space for the facilitation of a dialogical conversation. This communicates an attitude of genuine curiosity in the client and a need to know more, instead of conveying preconceived views and expectations about the client, their issue or what needs to be changed.

In therapy, participants really valued having someone to listen to their life experiences, to validate their feelings in response to what they had been through, and to help them to make sense of these events in relation to their current experiences. This process was only described as formulation by one participant, but most participants reflected on the benefits of being heard and supported to understand how past life events influenced their current experiences. Livesley (2001) highlights the importance of using an in-depth formulation collaboratively with individuals with a diagnosis of ‘BPD’ and the wider care team to inform treatment goals. Feeling heard and having one’s emotions validated was noted to be a new experience for participants which triggered massive shifts in their thinking. Yeandle et al. (2015) stated that one of the main complaints made by service users in their journey through the mental health system is that although they share their story with many professionals, they never feel heard. They argue that working more systemically and collaboratively with a mental health professional can offer a valuable alternative to this experience, where explicit feedback presented to the client in the form of their written formulation provides tangible evidence that the staff member supporting them has heard and understood their experiences. For the participants, development of this self-knowledge not only ‘de-others’ or depathologizes their sense of self but provides a sense of empowerment and greater control over their internal and external world as they now understand what is happening to them. It supports improved tolerance for symptoms of ‘BPD’ which cannot be changed, such as hearing voices and dissociation, and motivates them to apply adaptive coping strategies to those that can be changed.

It was clear that participants’ attitudes towards their diagnosis and their understanding of its impact on their lives was dependent on staff understanding of the diagnosis and their attitudes towards individuals who attracted it. Some participants suffered quite damaging interactions with mental health services where they felt discriminated against because of their diagnosis. They reported that services did not listen to them, judged them to be ‘attention-seeking’, and then rejected them from services following diagnosis because their condition was considered ‘untreatable’. They felt the diagnosis was a stigmatising label which put the blame on them and dismissed their experiences of adversity. However, others reported that the diagnosis had a positive impact on their lives because it provided a sense of relief that they finally had an explanation which captured the depth and complexity of their experiences. Having an accurate diagnosis also ensured that they were prescribed the right medication and referred for appropriate psychological intervention.

These variations in responses to the ‘BPD’ diagnosis are described by Horn et al. (2007) who explored participants experiences of receiving the diagnosis and the perceived consequences of this. Knowledge could be experienced as power when the diagnosis gave them a sense of understanding and control. Information about one's condition through receiving the diagnosis with an explanation of how it applied to the individual was also described by participants in this study as empowering. Larivière et al. (2015) found that receiving explanations about the diagnosis helped participants to understand themselves and this supported self-acceptance and discussion of their feelings. However, participants in both the study by Horn et al. (2007) and this study felt knowledge could be disempowering when information about the diagnosis was not provided or withheld. Counselling Psychologists may need to prioritise providing this information to their clients and supporting them to make sense of it in relation to their experiences when this has not been done by other staff members.

What made the difference to participants in receiving their diagnosis was the attitude of the clinician delivering this information. Participants naturally felt despair when their diagnosis was not explained to them, and they were told it was 'untreatable'. However, when staff took the time to explain what the diagnosis meant and how it applied to their individual experiences, they felt more hopeful about their future. This is supported by Morris et al. (2014) who found that the diagnostic process influenced how service users felt about 'BPD'. When participants were told about their diagnosis in an insensitive manner, with limited information and opportunity for discussion, they felt less positive about their condition, treatment, and recovery, than participants who felt that the diagnostic process had been helpful for them and handled well by staff.

Horn et al. (2007) found the diagnosis could be experienced as a way for services to reject service-users and as a response to their experiences not fitting into clear categories. Participants felt that services needed to categorise them even though they could not help them. This prompts Counselling Psychologists to ask, ‘Who is the diagnosis really for?’ Does it truly benefit the client, or does it reflect a need from professionals to control and have power over a situation? Horn et al. (2007) conclude that it may be helpful to attend to the aspects of the diagnosis that are useful to the individual and to share knowledge through formulation (Johnstone & Dallos, 2013) rather than focusing on diagnosis, to allow a deeper understanding of the multiple psychosocial factors impacting upon one’s experiences in collaboration with the therapist.

Many helpful elements of the ‘de-othering’ process were concerned with balancing the power dynamic between therapist and client so the client could feel like a valued equal. Knowing one’s therapist, including the use of minor self-disclosure (minor to preserve professional boundaries) was considered paramount for trust and the quality of the relationship. The saliency of therapist self-disclosure for individuals with a diagnosis of ‘BPD’ has also been reported by Araminta (2000) in a study exploring clients’ and therapists’ experiences of DBT.

Someone to be There

Individuals with a diagnosis of ‘BPD’ need to develop a healthy attachment to a secure base which must be accessible when needed. These individuals have repeatedly identified healthy relationships as a vital component of recovery (e.g. Ng et al., 2019). However, Gillard et al. (2015) conclude that since relationships can feel threating for this group, practitioners need to provide a safe space in which positive relationships can be modelled and developed.

Though it is important to be mindful of developing a client’s identity beyond that of a service-user and to encourage independence, overall, the option for long-term, open-ended support was considered the most desirable treatment approach. This is supported by Fonagy’s (2015) findings in a review of outcome studies and meta-analyses of effectiveness studies of psychodynamic therapy for the most prevalent mental health issues. The evidence base supports relatively long-term psychodynamic treatment of some ‘personality disorders’, particularly ‘BPD’ (e.g. Doering et al., 2010).

Mentalisation is the capacity to make sense of self and of others in terms of subjective states and mental processes and its development is critically dependent on whether as infants our own mental states were adequately understood by our caregivers (Fonaghy & Bateman, 2007). While individuals with ‘BPD’ can mentalise, it is thought that they are more likely to abandon this capacity under high emotional arousal because mentalisation was not as well established during the early years, partly as a result of early inconsistent experiences.

Luyten et al. (2020) argue that the negative impact of complex trauma in the problems with self and identity in ‘BPD’ patients should be considered within a broad framework, emphasising continuous interactions between environmental factors (attachment figures, peers, and sociocultural context) and biological factors. These interactions disrupt the evolutionarily pre-wired human capacity for social learning and salutogenesis by detrimental effects on the capacity for epistemic trust. This leads to impairments in the capacity for attachment and the associated capacity for social cognition or mentalising, closing the individual off from the social world and thus the possibility of learning and the social recalibration of the mind.

Luyten et al. (2020) explain that these individuals need another caring human mind who will mirror their experience, describe how their mind has been affected by trauma and how problems can be addressed. This experience of being held in mind by someone else, recognising that that person holds an accurate representation of your ‘imagined self’ in their social imagination, is crucial in restoring a sense of agency, control, and sense of selfhood. It nurtures the emergence of mentalisation and epistemic trust, allowing for the capacity for salutogenesis. Counselling Psychologists must begin the process of holding their client in mind as soon as possible. Early mentalisation will improve our understanding of ‘the other’, and as this understanding is shared within the team and used to inform practice, one’s service will become more approachable and containing to clients.

Participants stressed the importance of continuity of care because of the nature of distress suffered. Since mentalisation is understood to deteriorate under distress, this suggests that support to mentalise or being ‘held in mind’ needs to be extended beyond therapy and should centre all interactions between individuals and mental health services. Individuals with a diagnosis of ‘BPD’ would likely benefit from a consistent, continuous approach to their care from their team as a ‘mentalising container’.

An example of a useful parallel type of intervention is found in Reflective Network Therapy (RNT, Kliman & Burian, 2011), where a child’s psychotherapy sessions are witnessed, shared, and reflected on in the real-life space of the classroom by teachers and children in the group, who become a complex network of interactive helpers working as a team. Material from the setting is used in session and all information is openly communicated. There is identification of each child with each other child’s socially discussed mental life and therapeutic process. RNT supports the child to think about themselves and others as a result of receiving multiple sources of reflection from others in the reflective network. Within a mental health service, reflective network principles might be applied through more frequent meetings with the client and their staff team who would share their reflections of the client’s mental life and progress of their work with them. The experience of being ‘held in mind’ by multiple minds at once may support the development of the client’s mentalisation capacity, whilst also reinforcing a consistent and continuous model of care. Group therapy for ‘BPD’ also provides opportunities to develop mentalisation by sharing lived experiences and offering support to fellow group members.

One cost-effective application of group mentalisation principles to working with individuals with a diagnosis of ‘BPD’ might be the development of additional ‘havens’ (Castillo et al., 2013). The Haven Project in Essex has emerged as a unique model where therapeutic community principles have been combined with a crisis unit. It offers a therapy and group programme, 24-hour crisis phone and text lines, a Safe Centre for those presenting in crisis and a crisis unit. The 24-hour availability of the service allows users to internalise a sense of safety even when they are not there (Castillo et al., 2013).

Giving What’s Needed

The main clinical implication of this theme is that counselling psychologists and other mental health professionals working with individuals with a diagnosis of ‘BPD’ need to recognise their client as a unique person, with individual therapeutic and service needs which will depend on their preferences, situation, and stage of their ‘healing journey’. Staff must have the knowledge and flexibility to provide the type of support that is needed in the moment. In welcoming ‘the Other’, Cooper (2009) describes a willingness to attune, and be fully responsive to the client’s unique and changing needs and wants. In the pluralistic framework for counselling and counselling psychology (Cooper & McLeod, 2011), there is a particular emphasis on dialogue around the goals and tasks of therapy. This approach resists a ‘one size fits all’ mentality, where client and therapist collaboratively discuss from the beginning what the client wants from therapy and how they think it might be achieved.

Discovering how to ‘Give What’s Needed’ may begin with making time to actively listen to the client’s story, paying particular attention as to how they have been treated historically by services. The therapist can learn how to build the alliance by learning about what has and has not been helpful for the client in previous therapeutic relationships. When considered appropriate, this information could be shared with the client’s team to inform their practice to ensure it is client centred. Exploring a client’s insight into their condition may help the therapist to better understand their experiences and to recognise the signs that their mood is deteriorating, so this information can be detailed within a care plan or risk assessment to protect the client’s safety. Collaboration to ensure client-centred treatment planning for all aspects of care is vital if the client is to feel heard and for intervention to be successful (Rogers & Dunne, 2013).

The impulsive nature and affective instability of individuals with a diagnosis of ‘BPD’ suggests that services need to be flexible and accessible to meet their needs (Fallon, 2003). Care needs to be continuously accessible with plans in place detailing coping strategies and sources of support to adaptively manage crisis. Participants stressed that professionals working with them needed a better understanding of what it is like to live with intense and rapidly changing emotions, how this influences their care needs and their capacity to engage in treatment. Counselling psychologists have a role in promoting effective participation of clients in service design and delivery (NICE, 2011; Onyett, 2007). They might inform practice and enhance professional understanding of lived experience of ‘BPD’ by contributing to staff training, providing service evaluation feedback, and attending team community meetings.

Participants reflected about the importance of timing in delivering a therapeutic intervention. Therapy was thought challenging, therefore, one had to be ready for change to engage, otherwise time and resources would be wasted. The transtheoretical model (TTM; Prochaska & DiClemente, 1983; Prochaska, et al,1992) is a framework which was developed to describe, explain, and predict the process of intentional change of any behaviour problem. There are five stages known as precontemplation, contemplation, preparation, action, and maintenance. This model has been used as a framework to conceptualise both the phases of treatment and the process of change in psychotherapies for ‘personality disorders’ (Livesley, 2005). Treatment begins with structured approaches to manage risk, and as the client stabilises these are supplemented with less structured interpersonal strategies to explore and change maladaptive interpersonal patterns, cognitions, and traits and to forge a more integrated and adaptive self-structure or identity. Motivation to change is deemed essential if treatment is to succeed, but low motivation, passivity, and feelings of helplessness are characteristic of ‘personality disorders’.

Livesley, (2005) argues motivation cannot be a prerequisite for treatment, and therapists need to make extensive use of motivational interviewing techniques (Miller & Rollnick, 1991) to elicit and reaffirm commitment to change. Hope is built by the therapist’s approach to treatment and by reminding patients of their previous successes, no matter how small. Concerning motivation to change, participants described staff blaming them for their behaviour and wanting them to ‘take responsibility’, rather than being encouraging and supportive. Livesley (2005) recommends therapists should maintain a supportive stance when motivation is low and attempt to build it by exploring the consequences of maladaptive behaviour, rather than being confrontational and coercive which can further rupture the alliance and increase client reactivity.

Corned Beef Sandwiches and Paper Suits

Individuals with a diagnosis of ‘BPD’ endure a lifetime of stigmatisation and rejection by society and mental health services (Markham, 2003; Nehls, 1998). Participants described being made to feel that they were ‘attention-seeking’ and should take responsibility for their selfish behaviour. Counselling Psychologists can address this harmful process both in their relational approach to therapy and with the psychological knowledge and reflective practice they contribute to teams and wider services.

Individuals with a diagnosis of ‘BPD’ deserve support from a caring therapeutic relationship which recognises them as valued human beings, and validates the difficult life experiences they have suffered. To deconstruct the belief that fault lies within the individual, a collaborative approach to formulation brings to their attention the broad range of psychosocial factors which contribute to the onset and maintenance of their experiences. This might involve discussion of the standards and expectations society demands from its citizens (Johnstone & Boyle, 2018) and how these impact on mental health. Sharing the theory and outcome data on the effectiveness of the intervention delivered was thought helpful in avoiding self-blame if an outcome was unsuccessful. Valued therapist qualities included a non-judgemental attitude and willingness to openly engage in self-reflective practice to improve the quality of support provided.

Counselling Psychologists can support a team to gain a better understanding of their clients' experiences through offering formulation, reflective practice groups, supervision, and consultation (Onyett, 2007). However, working with clients with a diagnosis of 'BPD' has presented mental health teams with numerous challenges which can be difficult to address. Wallace (2019) explored the social-psychological processes involved when mental health teams make sense of people who receive a diagnosis of 'BPD'. It was proposed that under conditions including contrasting ideas about 'personality disorder' and 'mental illness', a culture of individual responsibility and mismatch between client need and service design meant that working with clients with a diagnosis of 'BPD' was experienced as posing two core threats to the professional sense of self. These were 'Feeling responsible but not having control' and 'Experiencing the self as unable to help'.

To reduce threat to professional self, participants engaged in either 'distancing' or 'connecting' responses. Where staff engaged in distancing responses, contact with the client and their distress was avoided. The client was perceived as being in control with staff querying the clients need for or right to help, to justify their 'distancing' from them. Where 'connecting' responses were practiced, staff were able to stay with the client and their distress and they perceived the client as also feeling powerless and out of control. They understood the client needed a different kind of help. Wallace (2019) concluded interventions should aim to reduce the experienced threat to the professional self and make connecting responses more possible. This was thought to require a framework for understanding the distress of ‘BPD’ which would acknowledge our shared humanity and validate distress as an understandable response to historical and current experience.

In critique of the medical model of mental health, Johnstone and Boyle (2018) offer an alternative framework for understanding and identifying patterns in emotional distress which could improve professionals understanding of their clients with a diagnosis of ‘BPD’ and their responses to them. It is called the ‘Power Threat Meaning Framework’. Professionals are invited to consider in relation to their client the operation of all types of power, including possible re-traumatisation by mental health services, the kinds of threat that the negative operation of power may pose to the individual, the central role of meaning in shaping the operation, experience and expression of power, threat, and our responses to threat. In response to all of these, professionals must reflect on the learned and evolved threat responses that an individual may need to draw upon to ensure emotional, physical, relational, and social survival. ‘Symptoms’ are now understood as reactions to threat or ‘survival strategies’.

Johnstone and Boyle (2018) replace the position of ‘What is wrong with you?’ with ‘What has happened to you?’ (How is Power operating in your life?), ‘How did it affect you?’ (What kind of Threats does this pose?), ‘What sense did you make of it?’ (What is the meaning of these situations and experiences to you?), ‘What did you have to do to survive?’ (What kinds of threat response are you using?), ‘What are your strengths?’ (What access to power resources do you have?) and ‘What is your story?’. This approach shatters the ‘BPD’ stereotype, replacing the image of the individual as a criminal to that of a brave survivor of adversity, doing the best they could with the limited resources available to them.

Lights on, but Nobody’s Home

Individuals with a diagnosis of ‘BPD’ need to be seen and they need to feel heard. When services re-enact historical experiences of the individual not feeling heard or being invalidated by their caregiver by ignoring them or actively rejecting their cries for help (Johnstone & Dallos, 2013) this reinforces their sense of feeling unworthy of care. This group of individuals may be labelled as ‘attention-seeking’ (Nehls, 1999) however, the statistics challenge the stigmatised image of ‘BPD’ and reflect the validity of their emotional distress with 10% completing suicide (Pompili et al., 2005) which is a rate of suicide 50 times higher than the general population (McKeow et al., 2006).

The lack of resources within the NHS both within mental health services and in Accident Emergency services mean that only individuals who are at high risk to themselves will receive intervention. NIMHE (2003) states that only those who suffer the most significant distress or difficulty will be referred to secondary services, most people with a ‘personality disorder’ who require treatment will be cared for within primary care. Primary care can only offer brief therapeutic intervention making it unsuitable and potentially harmful for attempting to address the complex needs of individuals with a diagnosis of ‘BPD’. Services send individuals the message that they need to be at risk and to have self-harmed to be considered worthy of care, but when they present to services in this way they are rejected and labelled as ‘time wasters’ and ‘attention-seeking’ by services (Nehls, 1999). This perpetuates the cycle of ‘risk leads to recognition’ and participants described having to ‘up their game’ in the self-destructive behaviours they engaged in just so services would acknowledge them, but some staff never did. As Counselling Psychologists, we need to acknowledge that this cycle is being played out for individuals both in our direct communications with them in therapy and to the team in formulation meetings to ensure we are doing all we can to break this cycle, even when we feel overwhelmed by the level of risk that these individuals present (Bodner et al., 2011). Participants reported that their self-harming behaviours reduced once they were seen and heard by a service.

Validating the client’s experiences begins to undo a lifetime of being ignored and rejected, supporting the development of trust and the potential of building a secure attachment base. It is our duty to model this approach to care and to support our colleagues to do the same. Recognising, acknowledging, and accepting the effects of adverse experiences have a settling effect early in treatment and the consistent application of validation assists in countering earlier invalidating experiences, thus promoting self-validation and the nurturing of a more adaptive self-structure (Livesley, 2005).

Counselling Psychologists must also be mindful that these individuals may have trained themselves to wear a ‘mask’ to hide their feelings so that they are able to function in a society which disapproves of emotional dysregulation. They must actively look beyond their client’s surface presentation to accurately assess their mental state and risk assess accordingly, and support colleagues to do the same. Signs of deterioration must be detailed in care plans and risk assessments, so staff know what to look for if the individual is unable to communicate their distress.

All staff working with individuals with a diagnosis of ‘BPD’ must have a good understanding of the associated symptoms and how these impact on client wellbeing. Participants stressed that those working with ‘BPD’ should have a good understanding of what it means to live with anxious preoccupation of real or imagined abandonment (DSM-5, APA, 2013; Rogers & Dunne, 2013). This triggers individuals to perceive communications from others in a negative light shaped by experiences of abandonment. Staff working with these individuals need to be mindful of this and whilst holding boundaries, should try to manage client anxiety with good time-keeping, keeping to appointments, offering continuous access to care and continuity of staff. Where breaks in contact cannot be helped, it is important that staff are transparent in their communication, so the individual does not feel rejected.

Finally, Mosquera and Steele (2017) describe how traumatic experiences are ubiquitous in clients with ‘BPD’ and that there is a significant overlap in symptoms of complex post-traumatic stress disorder and ‘BPD’. Therefore, it is vital that individuals with a diagnosis of ‘BPD’ are supported by trauma informed therapists within a trauma-informed service. The Blue Knot Foundation (ASCA, Kezelman & Stavropoulos, 2012) describes the principles for trauma-informed care for both individual clinicians and the organisation, where recovery-orientated integrated support is based on the five foundational principles of ‘safety’, ‘trustworthiness’, ‘choice’, ‘collaboration’ and ‘empowerment’ (Fallot & Harris, 2009).

LIMITATIONS OF THE RESEARCH

This study's design with the adaptation of the traditional semi-structured interview to incorporate an element of biographical narrative interviewing supported participants to feel heard and to share rich narratives about their psychological needs from mental health services. It allowed the research question to develop from a relatively simple issue regarding therapeutic preferences into an exploration of the much broader emotional needs individuals have from mental health services and society. However, this study was not without limitations which must be acknowledged here.

No males participated in this study, all participants identified as either female or non-binary. NIMHE (2003) states that the sex ratio for specific types of 'personality disorder' is variable, where 'antisocial personality disorder' is commoner in males and 'BPD' in females. The psychosocial factors related to the onset of 'antisocial personality disorder' include being single, young, male, of low socio-economic status and poorly educated (NIMHE, 2003). High prevalence rates of 'personality disorder', most commonly 'antisocial personality disorder' have been found in the prison population. To learn more about the psychosocial factors impacting upon the wellbeing of males with a diagnosis of 'personality disorder' and to ascertain their needs from therapy and mental health services, this study should be repeated with participants from within the prison population.

Despite most participants identifying as female and describing the psychosocial factors which impacted upon their mental health and access to services, discussion of the theory that the 'BPD' diagnosis is a gendered construct influenced by societal expectations of women (Simmons,1992) was not explored when perhaps it should have been. The sample size of ten participants met the minimum requirements for Braun and Clarke's (2013) recommendation for a research project of this nature. Though I was initially hesitant during the recruitment phase about whether this would be sufficient for the production of a deep and detailed analysis, all participants contributed full and rich narratives which resulted in a saturated sample.

Following preliminary data analysis, participants received a summary report of the findings, including an initial thematic map and an explanation of each of the themes. Some of them responded to this and their thoughts were integrated into the final analysis and discussion of the results. Unfortunately, due to time constraints, I have not yet been able to share the final analysis of the data with participants but intend to do so as soon as possible.

FUTURE RESEARCH

Asking individuals with a diagnosis of ‘BPD’ about whether a relational or directive therapeutic approach would be most effective in supporting clients with the same diagnosis opened the door to the uncovering of a vast array of interlinking emotional needs for therapy and mental health services. These needs represent not only the adversity of early developmental experiences but also the repetition of these experiences through a relationship with a society which continually undermines their sense of worthiness and value as human beings.

This research shines a light on the psychosocial factors impacting upon the wellbeing of individuals with a diagnosis of ‘BPD’, opening multiple lines of enquiry for future research. This might begin by repeating the study with men, possibly involving recruitment from within the prison population which may draw our attention to additional psychosocial factors affecting mental health that may have been missed in this study. The relationship between gender identity and societal expectations was not raised as an issue within the current study and should be further investigated. This study did raise the emotive issue of the relationship between mental health and parenting, and the psychosocial factors which can negatively impact on this relationship. It is important to explore this further to better understand the barriers to the support which would help parents with a diagnosis of ‘BPD’ to care for their children, so that a better quality of care can be provided in future to support families to stay together.

These themes as ‘healing’ or ‘harming’ processes for individuals with a diagnosis of ‘BPD’ could be shared with psychologists working in mental health teams with these individuals to enquire about their experiences and reflections of these themes in their therapeutic work with this client group and with supporting their team. Previous research has shown that teams engage in distancing defense strategies to manage uncomfortable feelings evoked when working with individuals with ‘personality disorders’ (Scanlon & Adlam, 2006; Wallace, 2019). This discussion might shed further light on the working conditions which contribute to the facilitation of these defences (e.g. lack of resources, limited reflective practice and poor communication within teams), and what can be done to address them so both clients and staff feel more contained. The exploration could be extended to involving other staff who oversee the care of these individuals including care coordinators and team leaders. It would be helpful to gain the insights of team psychologists about the model of the team as a mentalizing container for clients and whether this would be possible in practice.

CONCLUSIONS

Though the qualitative and quantitative evidence base for psychological treatment for ‘BPD’ has evidenced that effective interventions are available, they are not available to all and do not address all the difficulties in living that individuals with this diagnosis experience. Participants experiences of support for their mental health reflected ‘postcode prescribing’, where availability and quality of care available to individuals is dependent on where you live. It has been concluded that long-term, open-ended support is what this group of individuals need from mental health services. This research began with the intention of learning more about the therapeutic factors that individuals with a diagnosis of ‘BPD’ find helpful. What was shared in participants’ narratives was a much deeper expression of their emotional needs from mental health services which were shaped by both developmental attachment experiences and wider experiences of their engagement with society. These individuals have felt alienated and ‘othered’, unloved, stigmatised, criminalised, ignored, and invisible. These lived experiences and the hope of the opposite experience and how these might be achieved are captured in the themes presented in the findings of this research.

Society and mental health services judge, reject and reinforce the emotional distress of individuals with a diagnosis of ‘personality disorders’, thus re-enacting historical trauma for the individual. Professionals reject when they feel powerless against the distressing emotions that working with this client group can sometimes evoke. As Counselling Psychologists whose practice centres around the therapeutic relationship, we have a duty to hear and see the client, to support them to make sense of their experiences and to support others to do so. We need to hold them in mind and allow them to feel safe. Being aware of these ‘healing’ and ‘harmful’ processes for individuals with a diagnosis of ‘BPD’ in mental health services can assist us in strengthening the therapeutic relationship by informing us of what is beneficial and what is detrimental to the wellbeing of these clients, along with the origin of these experiences. Bringing these processes to the attention of one’s team and wider services enhances understanding of the broader psychosocial factors impacting upon mental health which must be integrated into how the client’s issues are made sense of and how intervention is formulated. The processes call for the need for a secure base and available consistent care that mirrors the individual’s mental state, allowing them to experience a sense of holding and safety that will eventually support them to be independent. Whatever the availability of a service to provide psychological intervention, awareness of these themes can make an immediate positive impact on the quality of care that individuals receive.

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APPENDIX SECTION

APPENDIX A

Emerging Health CIC **www.emerginghealth.co.uk**

To Beth Hartnell,
Health and Social Sciences Department,
University of the West of England,
Coldharbour Lane,
Bristol,
BS16 1QY

From Emerging Health,
Studio 11b,
Greenway Farm,
Bath Road,
Wick,
Bristol.
BS30 5RL
8.8.17.

Dear Beth,

Emerging Health can assist you in the recruitment of participants for your research project "Being with" versus "Doing to" in therapy: What type of approach do individuals with a diagnosis of Borderline Personality Disorder think Counselling Psychologists should adopt in their work with them?"

In the following ways,

By forwarding an email with details of your research project, advertising recruitment.

In the above scenario, we would be making it clear and transparent that we are only passing on information that might be of interest to people connected with Emerging Health and that in no way do we take any responsibility for the research activity as a whole.

We are happy to do the above providing that we receive confirmation of relevant Ethics Committee approval for the study.

Yours sincerely,

Iola Davies.

Emerging Health director.

APPENDIX B

University of the West of England
BRISTOL

There is a debate amongst Counselling Psychologists about whether in supporting clients with a diagnosis of Borderline Personality Disorder, our approach should focus on ‘being with’ our clients, where their emotional experiences are validated within a strong therapeutic relationship, or whether a more directive and manualised therapeutic approach employing strategies to reduce the frequency of problematic behaviours would better address client needs.

What do you think?

If you are over 18 and have a diagnosis of Borderline Personality Disorder/ Emotionally Unstable Personality Disorder, and would like to share your opinion on this debate, please email Beth Hartnell, trainee Counselling Psychologist at Bristol West of England University: Bethan2.Hartnell@live.uwe.ac.uk.

Supervised by Nigel Williams, Senior Lecturer in Counselling Psychology at the University of the West of England. Email: Nigel3.Williams@uwe.ac.uk

Participants will receive refreshments and a £10 “Love to Shop” voucher as a gesture of appreciation for their time.

APPENDIX C

PARTICIPANT INFORMATION SHEET

You are being invited to take part in a research study. Before deciding on whether or not you wish to take part, it is important that you understand the purpose of this research and what it will involve. Please take the time to read the following information carefully, and feel free to ask me any questions if there is something that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

My name is Beth Hartnell and I am a trainee Counselling Psychologist at the University of the West of England. Following the completion of a Primary Mental Health Care placement which provides brief psychological therapy for clients who often have complex mental health issues including Borderline Personality Disorder (BPD), I have become more concerned with client expectations of therapy and whether their needs of therapy have been fulfilled. Within mental health services, there is a continuing pressure to provide brief effective therapy for BPD in order to reduce costs and time spent by clients on the waiting list. These restrictions should not be at the cost of the development of a supportive therapeutic relationship where clients can be heard and understood.

Within the discipline of Counselling Psychology, there has been a debate about whether in supporting clients with a diagnosis of BPD, our approach should focus on ‘being with’ our clients, where their emotional experiences are validated within a strong therapeutic relationship, or whether a more directive and manualised therapeutic approach employing strategies to reduce the frequency of problematic behaviours would better address client needs. The aim of this study is to give a voice to those directly affected by this debate, by interviewing individuals with a diagnosis of BPD about what type of therapeutic approach they think Counselling Psychologists should adopt when providing therapy for clients of the same diagnosis.

By participating in this study, you will be making an important contribution to the ongoing evaluation of psychological therapy for BPD by representing the needs of those who wish to access it, in sharing your experiences of therapy and your beliefs about how clients with a diagnosis of BPD should be supported by Counselling Psychologists in therapy. You will also be providing important information to both trainee and qualified Counselling Psychologists about what is required of them in the building of a strong therapeutic relationship with clients who have received a diagnosis of BPD. This might have an important impact on the outcome of future therapeutic interventions for BPD.

Participation in this study is being offered to individuals who use the services of the personality disorder organization, Emerging Health and are over 18 with a clinical diagnosis of BPD (or Emotionally Unstable Personality Disorder, EUPD). The research aims to study the experiences of approximately 10-12 individuals with a diagnosis of BPD. Participation will involve answering a series of questions about how you experience BPD, any experience of psychological therapy you have received for BPD and your thoughts of how therapy for BPD should be delivered. Individual interviews may be either face-to-face or over Skype or FaceTime and will be conducted by myself. Interviews should last between one and two hours, and would take place at a time and location convenient for you.

As this will be in an in-depth discussion of a highly emotive topic, there is a possibility that participation in this research may evoke feelings. I hope that you will find the subject matter interesting and will enjoy sharing your experiences. However, if you do feel after participating that you need further support I will guide you to this:

SupportLine: 01708 765 200

Sane Line: 0300 304 7000

Samaritans: 116 123

The interview will be audio-recorded and transcribed by myself, with your consent. All the data will be stored confidentially in password-protected computer files which only my supervisor and I will be able to access. Participation in this research is entirely voluntary. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form, which you will receive a copy of. You would be able to withdraw from the research prior to and during the interview, without having to give a reason. You would also have the opportunity to withdraw part or all of your interview material from the study for up to one month after the interview has taken place.

All information provided in individual interviews is confidential. However, as a clinical researcher, I have a duty of care to break confidentiality if information comes to light which suggests that there may be risk of harm to a participant or to another person, or if I am under legal obligation to disclose information. In all written and oral research presentations, all identifying information will be altered, and a pseudonym will be given to any of your data that is used. All participants will be offered a copy of the report before submission for assessment and publication to acquire feedback. If requested, participant data can be edited or removed to reflect what is felt to be appropriate before submission.

If you are unhappy about any part of this research study and wish to make a complaint, my supervisor, Nigel Williams, Senior Lecturer in Counselling Psychology at the University of the West of England, who can be contacted via email, will address your concerns:

Nigel3.Williams@uwe.ac.uk.

Thank you for your time and for showing an interest in my research. If you would like to be interviewed, have any queries or would like more information, please email me at:

Bethan2.Hartnell@live.uwe.ac.uk

APPENDIX D

University of the
West of England
BRISTOL

CONSENT TO PARTICIPATE IN RESEARCH

Researcher: Beth Hartnell

Supervisor: Nigel Williams

I ………………………… (insert name) am over 18 years of age and agree to participate in this research. I have been given and have understood an explanation of this research project and what my participation entails.

I have had the opportunity to ask questions about this project and have them answered. I understand that my participation is entirely voluntary. I have been informed of my right to withdraw any or all of the information I provide from the research at any time (within a month of participation as specified in the information sheet), without giving a reason. I understand that I am under no obligation to answer any particular questions. I understand that any information I provide will be kept confidentially.

Please tick the following boxes:

☐ I agree to participate in an individual interview about whether Counselling Psychologists should adopt an approach of ‘being with’ their clients with a diagnosis of BPD, where their emotional experiences are validated within a strong therapeutic relationship, or whether they should adopt a more directive and manualised therapeutic approach employing strategies to reduce the frequency of problematic behaviours.

☐ I consent for the interview material to be used to write the thesis report, a journal article, a poster presentation and to be discussed in oral presentations about the research.

☐ I agree to the collection of demographic data that will be complied into a table to be presented in the thesis report and a journal article.

☐ I agree to the interview being audio-recorded and transcribed for the purposes of research conducted by Beth Hartnell. I understand that anonymised extracts from the interview may be quoted in both written reports, oral presentations and a poster presentation.

☐ I agree that Beth Hartnell will keep the interview material in order to write the reports, the poster and to prepare for oral presentations of the research. I understand that the research material will be destroyed once all forms of assessment relating to the research have been completed.

Signed: ....

Name: ………………………… (please print clearly)

Date: …………………………

APPENDIX E

University of the West of England BRISTOL

CONSENT TO PARTICIPATE IN RESEARCH

Researcher: Beth Hartnell

Supervisor: Nigel Williams

I ………………………… (insert name) am over 18 years of age and agree to participate in this research. I have been given and have understood an explanation of this research project and what my participation entails.

I have had the opportunity to ask questions about this project and have them answered. I understand that my participation is entirely voluntary. I have been informed of my right to withdraw any or all of the information I provide from the research at any time (within a month of participation as specified in the information sheet), without giving a reason. I understand that if I decide that I would like to withdraw part or all of my interview material then I need to inform the researcher by emailing her at: Bethan2.Hartnell@live.uwe.ac.uk and she will ensure that the specified interview material will be removed from all reports and presentations relating to the research. I understand that I am under no obligation to answer any particular questions. I understand that any information I provide will be kept confidentially.

Please tick the following boxes:

☐ I agree to participate in an individual interview about whether Counselling Psychologists should adopt an approach of ‘being with’ their clients with a diagnosis of BPD, where their emotional experiences are validated within a strong therapeutic relationship, or whether they should adopt a more directive and manualised therapeutic approach employing strategies to reduce the frequency of problematic behaviours.

☐ I consent for the interview material to be used to write the thesis report, a journal article, a poster presentation and to be discussed in oral presentations about the research. I understand that the interview material will be anonymised before being used in any written report or oral presentation relating to the research.

☐ I agree to the collection of demographic data that will be complied into a table to be presented in the thesis report and a journal article.

☐ I agree to the interview being audio-recorded and transcribed for the purposes of research conducted by Beth Hartnell. I understand that anonymised extracts from the interview may be quoted in both written reports, oral presentations and a poster presentation.

☐ I agree that Beth Hartnell will keep the interview material in order to write the reports, the poster and to prepare for oral presentations of the research. I understand that the research material will be destroyed once all forms of assessment relating to the research have been completed.

☐ I consent for the interview material that I provided in Beth Hartnell's previous research project on the lived experiences of individuals who have received a diagnosis of Borderline Personality Disorder before and after therapeutic intervention to be used in this research project.

Signed: ....

Name: ………………………… (please print clearly)

Date: …………………………

<u>APPENDIX F</u>

Demographics Questionnaire

Please answer the following questions in order for me to have a better understanding about the range of people I am interviewing. All data collected is anonymous. Please circle the answer most appropriate to you, or write your answer in the space provided.

How old are you?	
I am:	Male Female Other: ________
I am:	Full-time employed Part-time employed Full-time student Part-time student Other: ________
If you work, what is your occupation?	
How would you describe your sexuality?	Heterosexual Bisexual Lesbian Gay Other: ________ Rather not say

How would you describe your social class? (e.g. middle class; working class; no class category)	
How would you describe your racial/ ethnic background? (e.g. White; Black; White Jewish; Asian Muslim)	
Do you consider yourself to be disabled?	
Have you received a diagnosis of Borderline Personality Disorder? If so, who provided this diagnosis?	
Have you received a diagnosis of any other mental health issue and if so what diagnosis did you receive?	
Have you received therapeutic intervention for a diagnosis of Borderline Personality Disorder? If so, what kind of therapy did you receive?	
If you have received therapeutic intervention, what was the duration of this treatment and how long ago did this finish?	
Please provide an email address that can be used to contact you throughout the study (it will only be used for the purposes of this research).	

Thank you.

APPENDIX G

Interview Schedule

1. Can you tell me a bit about your life story in relation to Borderline Personality Disorder - the factors you believe may have contributed to your diagnosis, how you experience it's symptoms and any intervention you may have received for it.

2. Have you had any experience of psychological therapy? If you have, was it for BPD? If you have not, would you like to receive it?

3. If you have had therapy, did you find it beneficial? If so, in what way? If not, in what way? How could it have been improved?

4. There is a debate amongst Counselling Psychologists about whether in supporting clients with a diagnosis of Borderline Personality Disorder, our approach should focus on 'being with' our clients, where their emotional experiences are validated within a strong therapeutic relationship, or whether a more directive and manualised therapeutic approach employing strategies to reduce the frequency of problematic behaviours would better address client needs. What do you think? What do you think the role of a Counselling Psychologist should be in supporting someone with a diagnosis of BPD?

5. What are the strengths and weaknesses of a "being with" approach – is it sufficient? (Please give examples where possible).

6. What are the strengths and weaknesses of a more directive and manualised therapeutic approach? (Please give examples where possible).

7. How might a “being with” approach or a more directive and manualised therapeutic approach affect an individual’s feelings towards their therapist and the therapeutic relationship?

8. How do you feel about the therapist(s) you have worked with? Do you still think about them?

9. Could you tell me about your experiences of being in crisis? What did you need when you were in crisis? Did you get what you needed? What might have made a difference to you? Is a different therapeutic approach required when someone is in crisis?

10. Has what you have wanted from a therapist changed over time?

11. Are there any other factors that might influence the approach that a therapist should take when supporting an individual with a diagnosis of BPD?

12. For trainee Counselling Psychologists who hope to support individuals with a diagnosis of BPD in the future, is there anything else you would like them to know?

13. Do you have any questions or any other views or thoughts you’d like to share?

APPENDIX H

Debrief Form

Thank you for participating in my research!

The purpose of this research is to invite individuals with a diagnosis of Borderline Personality Disorder to share their views on what sort of therapeutic approach they think Counselling Psychologists should adopt in therapy with clients of the same diagnosis. As a trainee Counselling Psychologist adapting to practice within the limited resources of the NHS, I would like to enhance my understanding of how individuals with a diagnosis of BPD prefer to be supported in therapy, so that Counselling Psychologists have a clear understanding of how they need to be and what they need to do in order to provide the best therapeutic environment for a client's needs to be fulfilled. The information obtained from this study might have an important role to play in enhancing the understanding of both trainee and qualified Counselling Psychologists about what it means to live with BPD, and what is important to provide from the therapeutic approach from which one practices.

I am very grateful for your participation in this research. If you have any questions, please email me at: Bethan2.Hartnell@live.uwe.ac.uk.

THANK YOU

APPENDIX I

DSM-5 (2013) Criteria for “Borderline Personality Disorder”:

“The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose borderline personality disorder, the following criteria must be met:

*A. Significant impairments in **personality functioning** manifest by:*
   *1. Impairments in **self functioning** (a or b):*
      *a. **Identity**: Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.*

      *b. **Self-direction**: Instability in goals, aspirations, values, or career plans.*

AND

   *2. Impairments in **interpersonal functioning** (a or b):*
      *a. **Empathy**: Compromised ability to recognise the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.*

      *b. **Intimacy**: Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between over involvement and withdrawal.*

*B. Pathological **personality traits** in the following domains:*
   *1. **Negative Affectivity**, characterised by:*
      *a. **Emotional liability**: Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/ or out of proportion to events and circumstances.*

      *b. **Anxiousness**: Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.*

      *c. **Separation insecurity**: Fears of rejection by – and/or separation from*

– significant others, associated with fears of excessive dependency and complete loss of autonomy.

   - d. ***Depressivity**: Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feeling of inferior self-worth; thoughts of suicide and suicidal behaviour.*

2. ***Disinhibition**, characterised by:*
   - a. ***Impulsivity**: Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behaviour under emotional distress.*

   - b. ***Risk taking**: Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger.*

3. ***Antagonism**, characterised by:*
   - a. ***Hostility**: Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.*

C. *The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.*

D. *The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment.*

E. *The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).*

APPENDIX J

Summary of Participant Information

Pseudonym	Demographic Information	Mental Health History
Debbie	Age not given Female Part-time employed Lesbian Class not given White Disabled	Diagnosis of 'BPD' received by psychiatrist Comorbid clinical depression and bipolar "Intense talking therapy" (Therapeutic Community) received to address 'BPD' 3 years of treatment ending in 2015
Stephanie	54 years Female ESA – off sick long-term Heterosexual Lower Middle Class White Disabled	Diagnosis of 'BPD' provided by psychiatrist in 2016 Comorbid Anxious-Avoidant Attachment Disorder. Diagnosed with depression and anxiety before 'BPD' diagnosis. No therapy received to address 'BPD'. Therapy received for depression.
Charlotte	38 years Female Unemployed Heterosexual Middle Class White Considers herself disabled with 'BPD'	Diagnosis of 'BPD' received by psychiatrist, although this is always re-discussed Comorbid bipolar, manic depression, anxiety, and PTSD Ongoing counselling for 'BPD'
Deanna	28 years Female Not working Chose not to disclose sexuality	Diagnosis of 'BPD' provided by General Practitioner Comorbid Unipolar Anxiety and Depression

	Social class not given White Considers oneself disabled: 'hearing and learning problems'	Offered CBT and DBT to address 'BPD', "but not the right time to commit to the programme".
Louis	27 years Non-binary Part-time student Bisexual No social class White Disabled	Diagnosis of 'BPD' provided by psychiatrist and clinical psychologist Comorbid depression, anorexia, gender dysphoria and body dysmorphia Therapies to address 'BPD' including DBT, CAT, Radical Openness, Therapeutic Community and EMDR 18 months of DBT ended in 2013, 2 years of CAT ended in 2016, 6 months of Radical Openness ended in 2015, 18 months of a Therapeutic Community ended in 2016 and 6 months of EMDR ended in 2016
Cathy	48 years Female Retired Bisexual Middle Class White Other Disabled	Diagnosis of 'BPD' provided by psychiatrist Comorbid depression and anxiety Support from CPN and psychiatrist to address 'BPD' Support ended in 2000
Sarah	Age not given Female Unemployed/ on sick leave Bisexual White Middle Class Not disabled	Diagnosis of 'BPD' provided by psychiatrist and community psychiatric nurse (CPN) Comorbid depression and anxiety Therapies to address 'BPD' including DBT, psychotherapy, art therapy, counselling and CPN support Duration of therapy ranging from 9 months to 2 years. "Formal

		support" ended in 2015. Still receiving private counselling.
Alex	23 years Non-Binary Student on medical interruption Lesbian Working Class White British Disabled	Diagnosis of 'BPD' provided in 2011 aged 17 by Child and Adolescent Mental Health Services (CAMHS) Comorbid bulimia Under the age of 18, received DBT from CAMHS, guided self-help post DBT, Art, Drama and Play Therapy. DBT from the Eating Disorders service. Person Centred Counselling (private), Managing Emotions group (DBT based), online CBT and Family Therapy. Family Therapy ongoing from summer 2016 onwards. DBT ended in 2016.
Rachel	Age not given Female Full-time employed Lesbian Working class background White British Not disabled	Diagnosis of 'BPD' received by psychiatrist Comorbid depression, anxiety and eating disorder (EDNOS) Therapies to address 'BPD' including counselling and DBT Brief intervention of 6 sessions of counselling, counselling for 2 years finishing in 2017 and ongoing DBT for 6 months.
Lexi	27 years Female Full-time employed Lesbian Middle Class White Northern Irish Not disabled	Diagnosis of 'BPD' received by Clinical Psychologist Comorbid depression and Atypical Anorexia Nervosa "Some bits of DBT" used to address 'BPD' DBT for about 6 months ending in 2016.

APPENDIX K

Participant Vignettes

“Louis”

Louis transitioned from female to male in early adulthood, but now in their late twenties identifies as non-binary. They have experienced mental health issues since childhood and first presented to services at 12 years old. They attribute many of their ‘BPD’ symptoms to emotional invalidation by their caregivers and to multiple experiences of sexual abuse. They received the diagnosis in their early twenties, and then engaged in a variety of therapeutic interventions. They consider themselves “recovered in a lot of ways”.

“Rachel”

Rachel is a woman in her late twenties who received the diagnosis a year before her interview. She is in a relationship with fellow participant, Lexi. At 12 years old, she started to notice that “things didn’t feel quite right” and used self-harm as it was her only known means of coping. Being bullied at school over her sexuality is thought to be a significant contributing factor to the onset of her emotional distress. Therapeutic interventions include brief therapy, long term-relational work and she was receiving DBT at the time of interview, but only individual sessions.

“Lexi”

Lexi is a woman in her late twenties who describes her ‘BPD’ symptoms as her “wonkiness” or “crankiness”. She feels she has always struggled socially and does not identify anything in her upbringing that might have contributed to this. She was diagnosed by a personality disorder service in her early twenties, spending many years on waiting lists before receiving DBT. Whilst waiting for therapy, she sought help from her GP and staff at A & E, at a time when she felt particularly unsafe. She was dismissed from services, and this rejection motivated her to “fix” herself by relinquishing her use of self-harm as a coping mechanism.

“Deanna”

Deanna described herself as a “difficult child” who was subject to bullying and family problems. She is a woman in her late twenties with moderate learning difficulties, who was diagnosed by her GP three years prior to interview. She recalls beginning to self-harm not long after being diagnosed as diabetic, reflecting that she always felt different from other children. Although she has experience of being discharged from counselling services for being “too complex”, she has been supported by her GP and has received counselling from a young person’s charity. She is under secondary care services and has been encouraged to engage with DBT but does not feel ready for this.

“Sarah”

Sarah grew up in a chaotic environment, with a constant struggle for attention and a lack of consistent boundaries. She was bullied throughout school and suffered with depression. It was a battle to be recognised by mental health services. Once accepted she received long-term support from various professionals within the community mental health team. This included psychotherapy and DBT skills. However, there were instances of being left without support, abrupt unwanted therapeutic endings and not feeling heard which she felt were detrimental to her mental health. Sarah has contributed to the improvement of her local mental health services and has delivered training in “personality disorders”.

“Cathy”

Cathy is Sarah’s partner and Alex’s mother. She is in her late forties and has endured abusive relationships for most of her life. Lack of support with mentalisation has meant she has always struggled to read other people, leaving her vulnerable in relationships. She received the diagnosis following a period of being under section. She feels that having the diagnosis has meant professionals have never wanted to listen to her and that she was seen as “attention-seeking”. However, she has received long-term support from a psychologist, CPN and a ‘BPD’ support group. She continues to receive therapy.

“Debbie”

As a result of a traumatic life event in childhood, Debbie did not receive adequate emotional support from her caregivers. She endured multiple abusive experiences in her teenage years, for which she received no support. Her “rebellious” behaviour helped her to cope. Initially, in response to her crises, professionals offered medication and ECT. She was eventually diagnosed with ‘BPD’ and received DBT which was unsuccessful. She moved to a new area and was able to self-refer into a therapeutic community. Following this successful intervention, she now works for an organisation which facilitates the teaching of personality disorders to professionals.

“Stephanie”

Stephanie is a woman in her mid-fifties who has endured a repeating pattern of traumatic loss across her lifetime, with little support to process it. She was raised in an environment which discouraged emotional expression and lacked consistent boundaries. One caregiver suffered from mental health issues and was therefore unable to meet her emotional needs. She has never felt heard in personal relationships or with mental health services and battled for the correct diagnosis. She has had some counselling and has attended a psychoeducational support group, but neither met her needs. When services failed to provide support, she set up a ‘BPD’ support group herself.

“Charlotte”

Charlotte is a woman in her late thirties, who was diagnosed a year before interview. She recalls feeling different and struggling with her emotions since childhood. She was told to ignore her feelings as mental health was thought to restrict one’s life choices. Following several episodes of crisis, she was finally recognised by mental health services, though her diagnosis remained fluid. She conducted her own research and found the ‘BPD’ diagnosis, which her psychiatrist confirmed. She has attended a service-user led ‘BPD’ support group, has had several courses of counselling and continues to receive support from a trauma service.

“Alex”

Alex had a chaotic upbringing and has received therapeutic input from infancy. She left home in her late teens, and after a period of homelessness, received the diagnosis following an adolescent inpatient admission. Difficulty in accessing a safe living space impacted negatively on her mental health, increasing her need for services who could be dismissive. Eventually, long-term support from a charity helped her to rebuild her life. She has received several courses of DBT, counselling and participated in a psychoeducational group. She moved for university and now receives a comprehensive care package from an adult mental health team.

APPENDIX L

Development of the Thematic Map

Figure 1. Initial Thematic Map

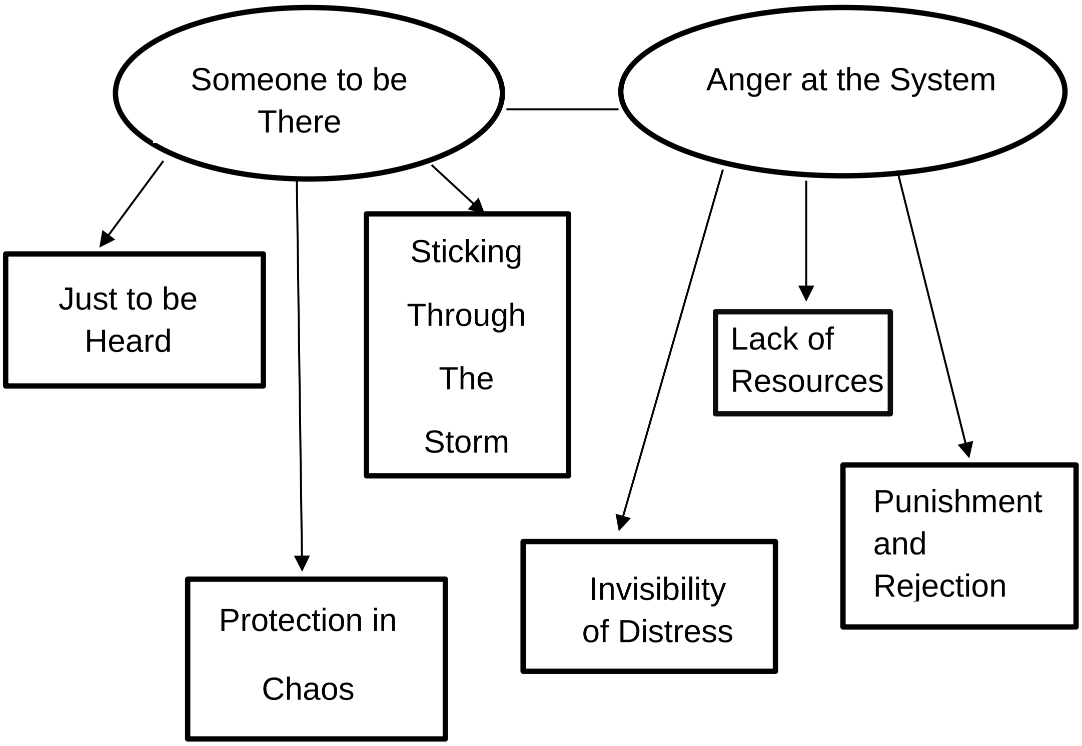


Figure 2. Developed Thematic Map

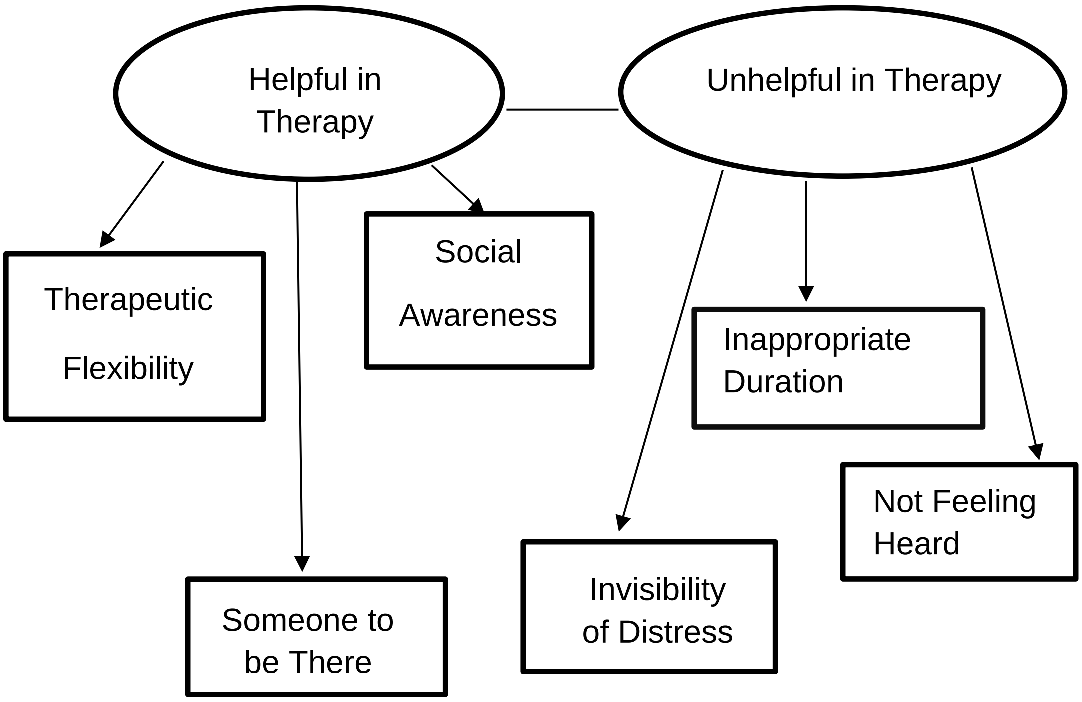


Figure 3. Developed Thematic Map

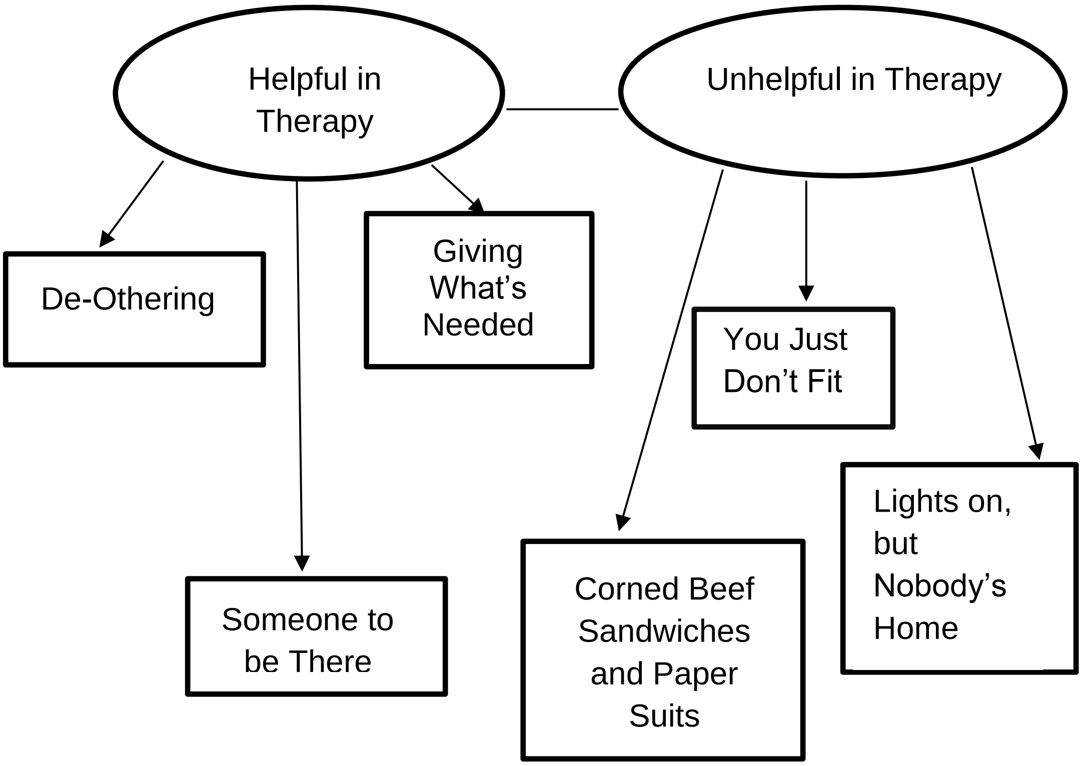


Figure 4. Developed Thematic Map

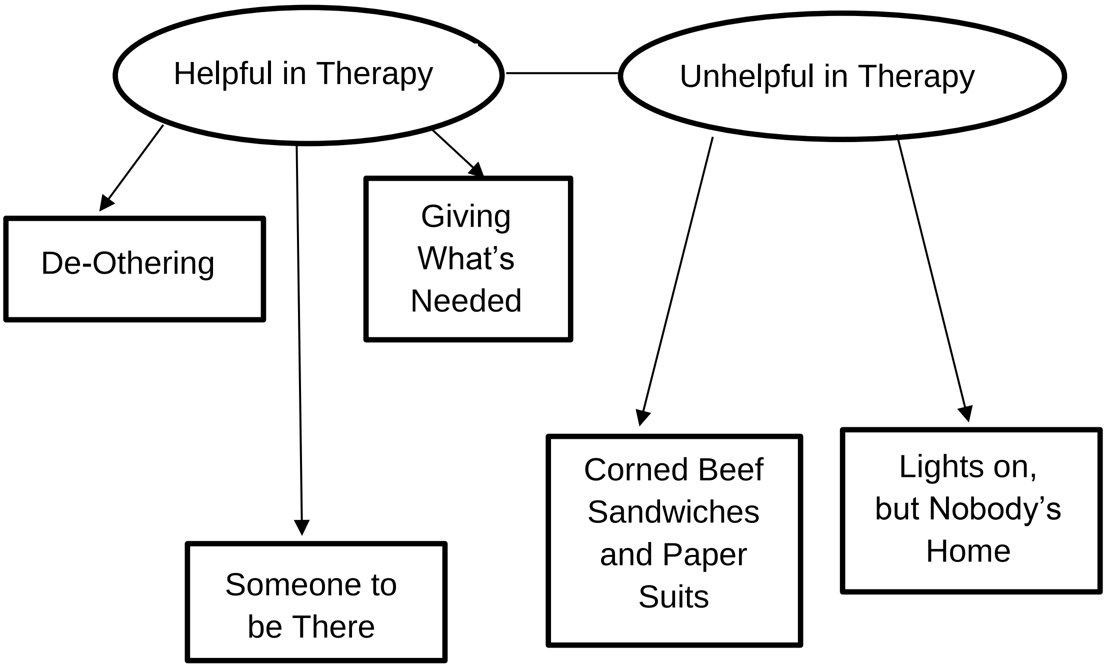
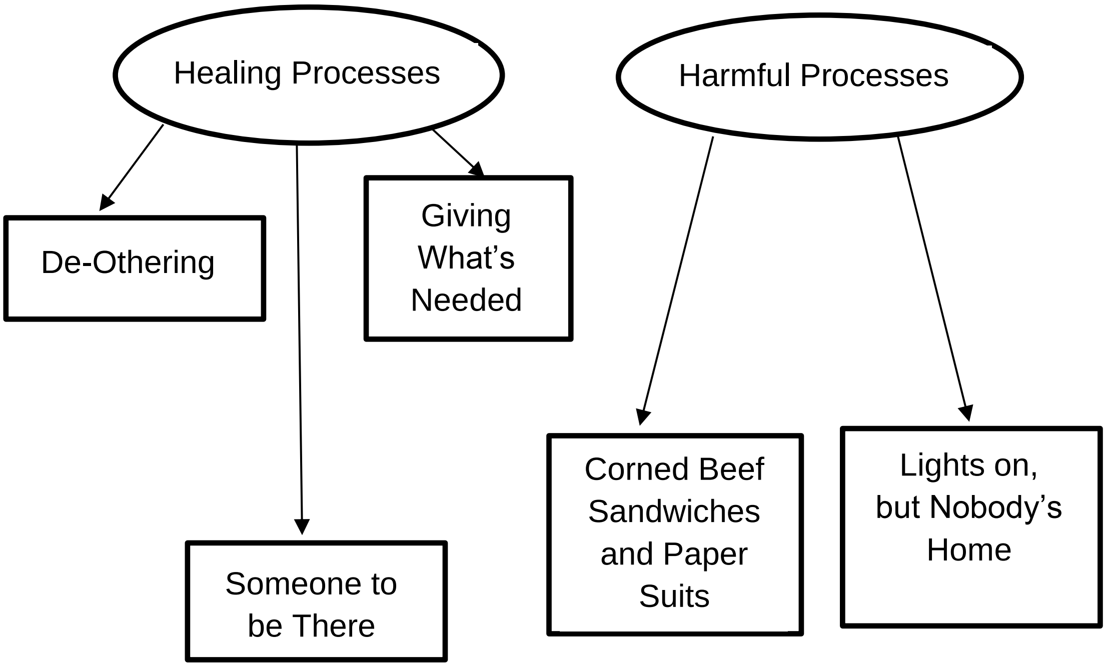


Figure 5. Final Thematic Map



APPENDIX M

Thematic Flow Diagrams

Figure 1. Flow Diagram for De-Othering

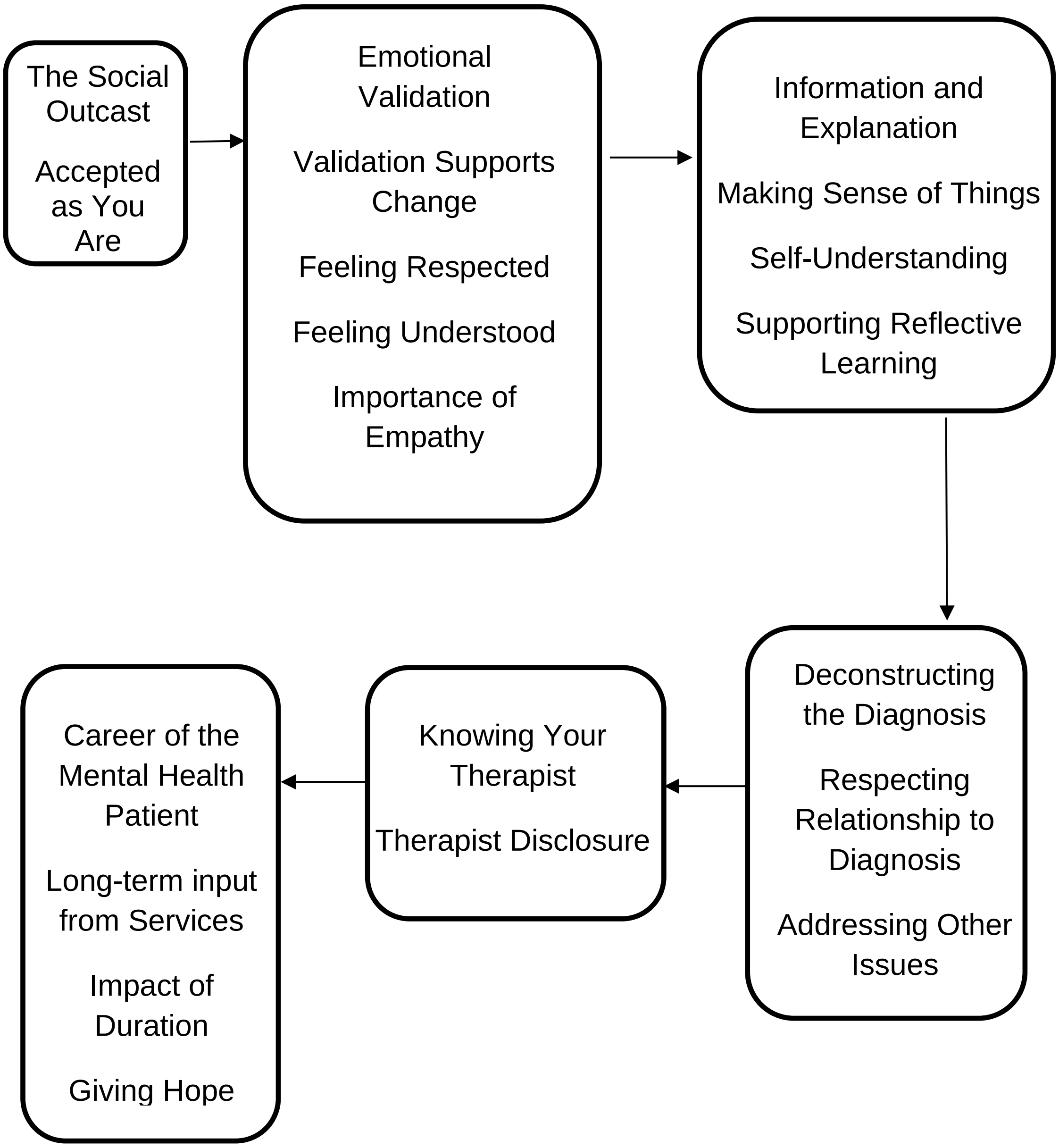


Figure 2. Flow Diagram for Someone to be There

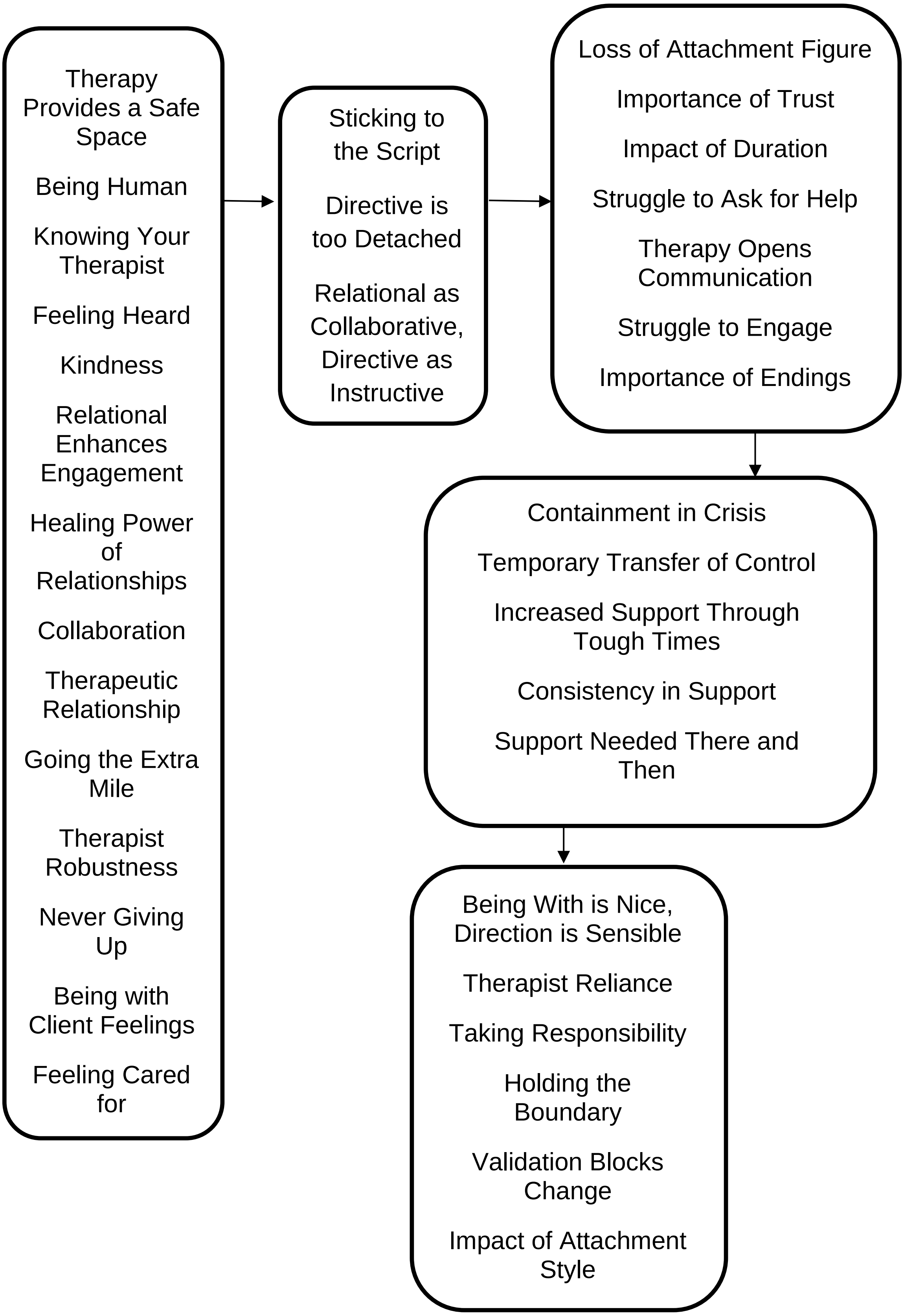


Figure 3. Flow Diagram for Giving What's Needed

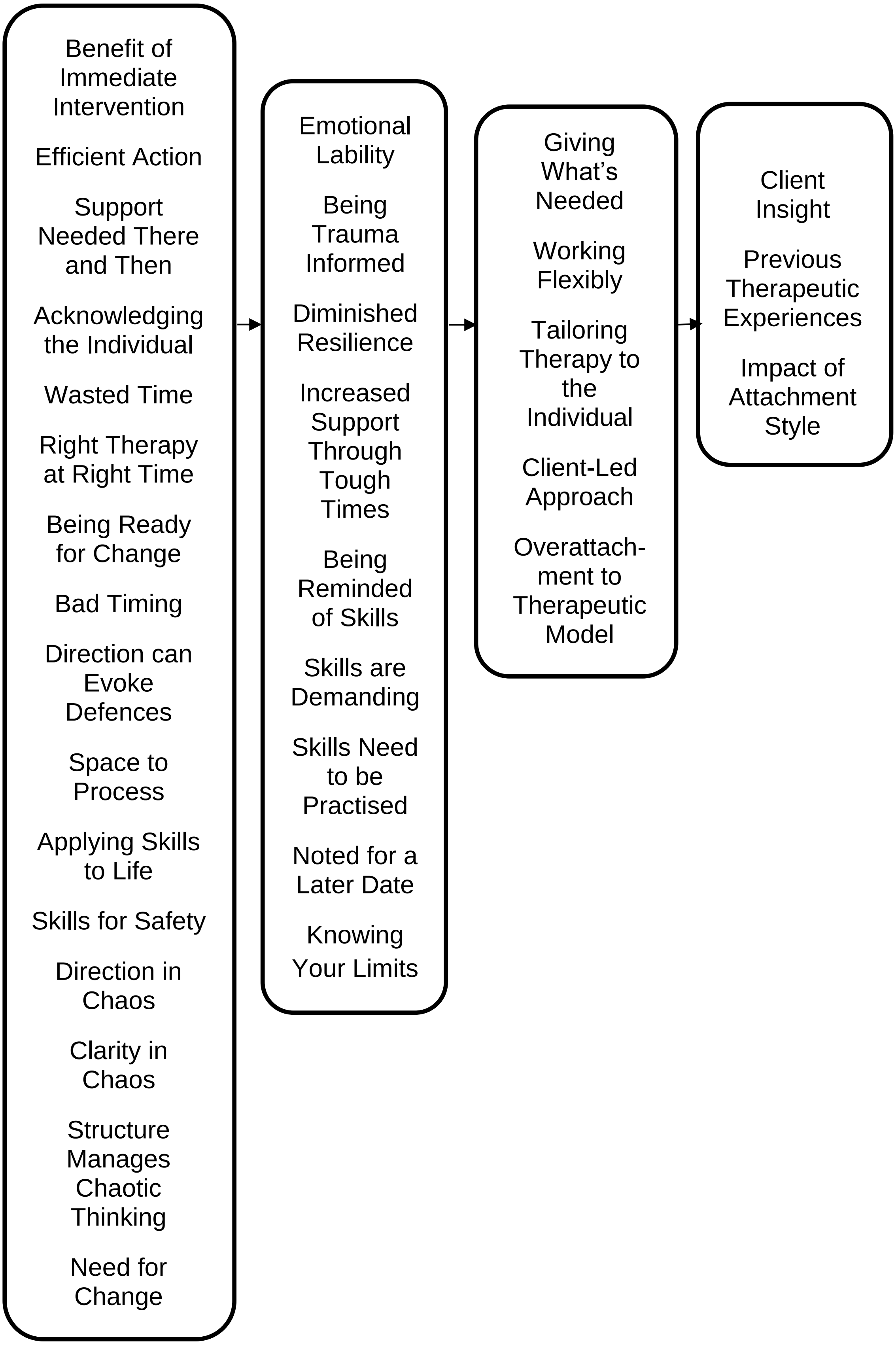


Figure 4. Flow Diagram for Corned Beef Sandwiches and Paper Suits

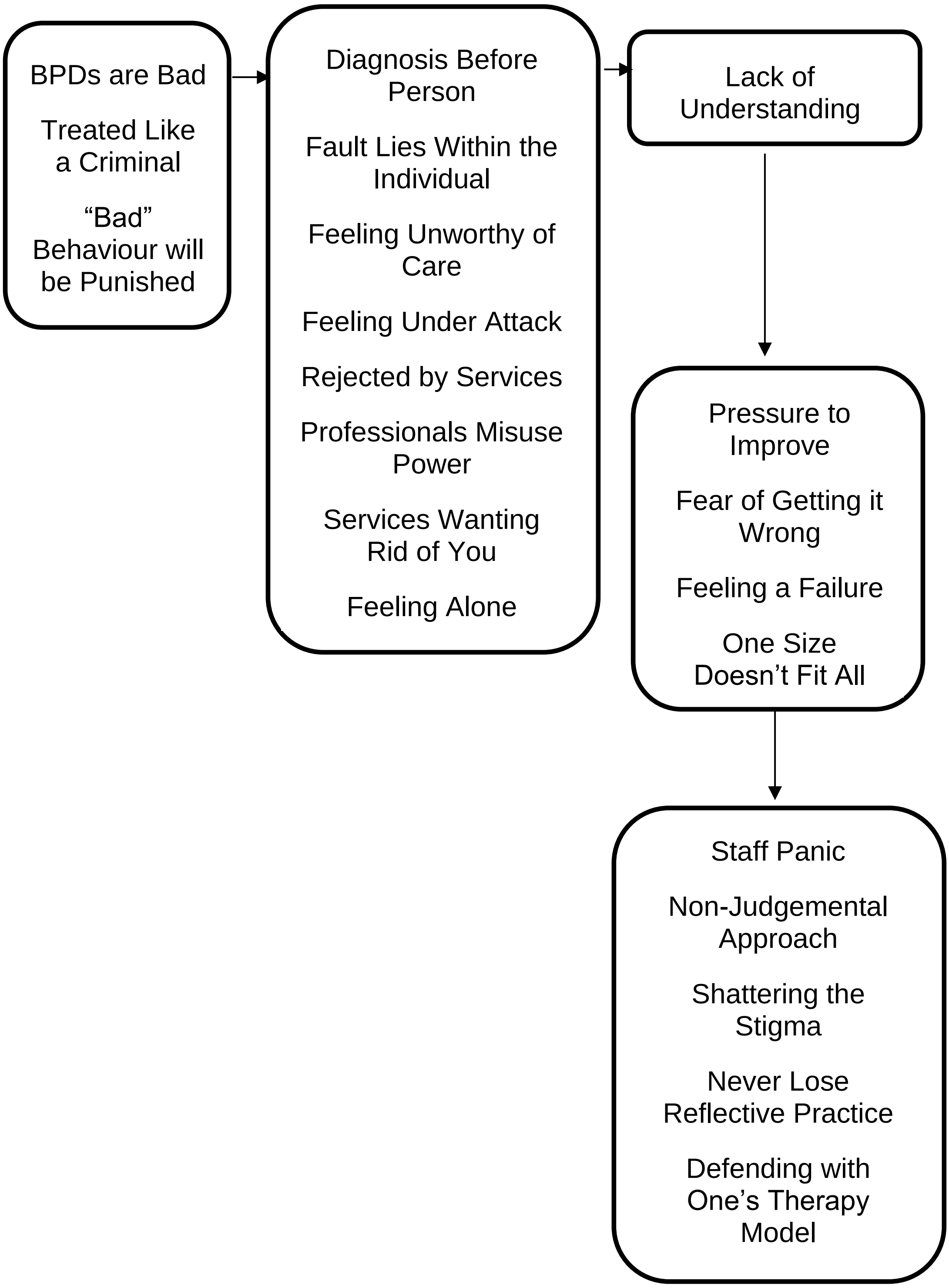
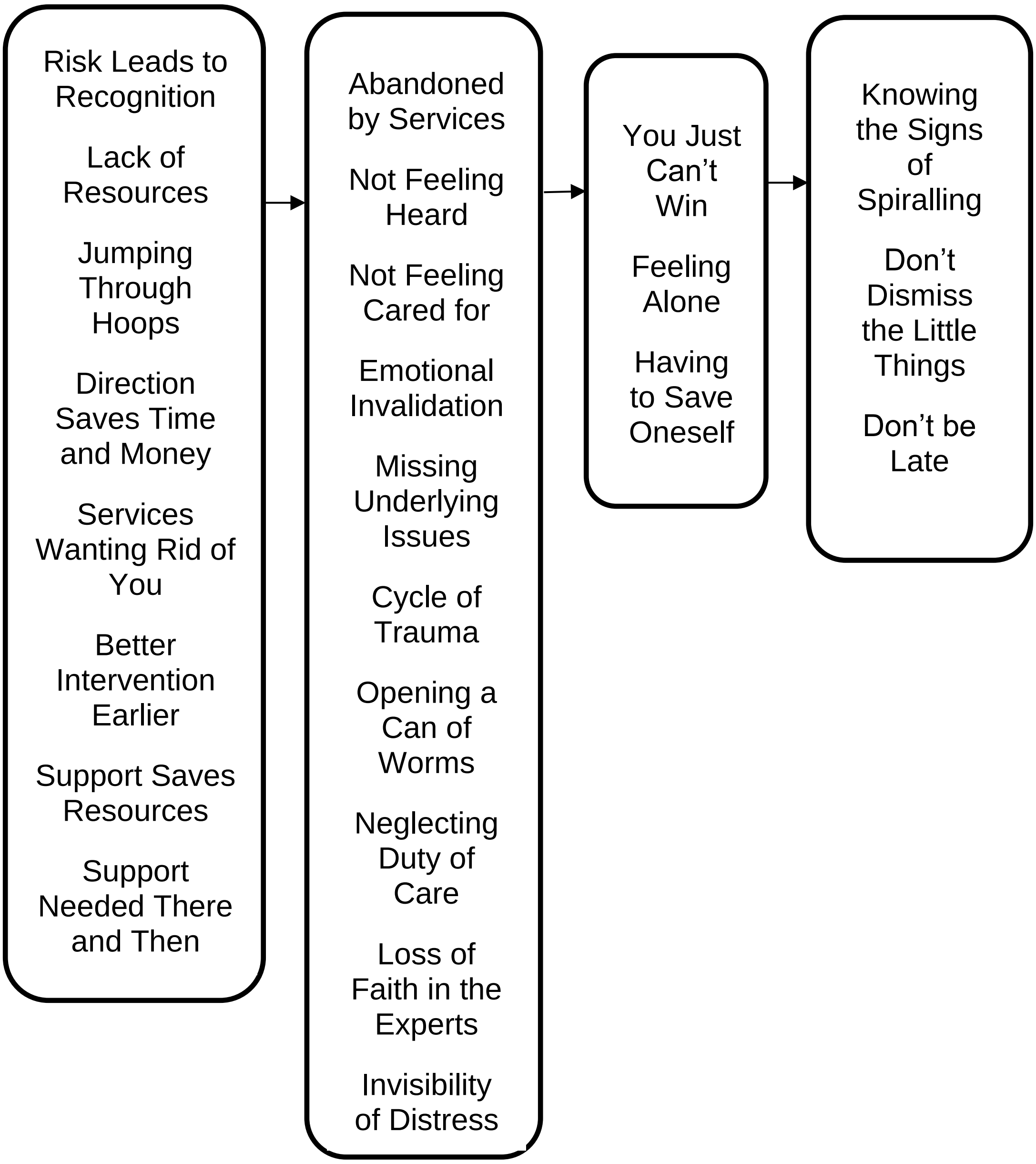


Figure 5. Lights on, but Nobody's Home



APPENDIX N

Example of Coded Data Extract

“Charlotte”	Open Codes	Focus Codes
P:… it’s really important that, you know, and this is where it’s different to any other therapy, for somebody, for a patient like me, you need to be able to contact your therapist and know that they will respond to you as well, where, you, you, it… like an example today, I was driving today to go and meet a… to go and collect a book from a different village and um, the number of times that I was thinking “God, if I just swerved a bit, and went off this road and hit that tree”, and that… did you get that? *R: Yes, I did get that, thank you, yeah.* *P: So yeah, so like the times that things like that happen, and then you don’t always know why you’re thinking it, but you should be able to say to somebody, “Do you know what? I did just say that to myself” and “I did just feel like that”, and you should, and it, like I think this is the biggest thing, the more that you start to unravel a condition like this, the more crap and muck is gunna turn up that you are gunna start feeling more unraveled before you’re gunna start feeling any better.*	Support needs to be consistency available to individuals whenever needed. Multiple risk factors mean extra support is needed to keep them safe in times of crisis. Need to know you can ask for support and someone will be there. Support can be tailored around what is needed. Specific to BPD, need for someone to be there for more intensive support for at risk states of mind. Power of impulses leading to the individual putting themselves at serious risk. Importance of collaboration with the mental health team. Need to have someone with whom you can share important reflections and feelings with when going through emotional turmoil. Support needs to be around the clock for when painful feelings resurface. Processing underlying trauma will evoke distress which needs to be contained whenever it arises to prevent use of harmful coping strategies.	Consistency in Support Someone to be There Giving What’s Needed Working Flexibly Increased Support Through Tough Times Impulsivity Containment in Crisis Collaboration Space to Process Support Needed There and Then Benefit of Immediate Intervention Trauma Cycle of BPD Being Trauma Informed Diminished Resilience

RESEARCH SUMMARY

Individuals with a diagnosis of ‘Borderline Personality Disorder’ (‘BPD’) experience significant impairments in personality functioning and interpersonal functioning including impairments to their sense of identity, lack of self-direction, impaired ability to empathise with others and chaotic interpersonal relationships. They experience strong negative emotions which fluctuate rapidly, have a tendency to behave impulsively and engage in risk taking behaviours (DSM-5, APA, 2013). Approximately 69-80% will self-mutilate or attempt suicide while in a distressed or crisis state of mind, and 10% will complete suicide (Pompili, Girardi, Ruberto, & Tatarelli, 2005). The emotional volatility of ‘BPD’ often results in those with the condition being emotionally rejected and stigmatized by others, including the clinicians whose insight and support is desperately desired (Aviram et al., 2006). Once a diagnosis of ‘BPD’ is received, for some individuals, this result represents a sense of hope, control and an explanation for their past and present feelings and behaviour (Horn et al., 2007; Crawford et al., 2007). However, others interpret this outcome as confirmation that they are a “bad” person or a “failure” (Ramon et al., 2001).

Multiple theories have been developed to explain the onset of ‘BPD’ and have been accompanied by therapeutic interventions. These include object relations theory and transference-focused therapy (Kernberg, 1967, 1975), attachment theory and mentalisation-based therapy (Fonaghy et al., 2004, Fonaghy & Bateman, 2007) and biosocial theory and dialectical behavioural therapy (Linehan ,1993). Factors associated with the onset of ‘BPD’ include experience of trauma (Westen et al., 1990), neurobiological factors (Rusch et al.,2003) and the social construction of gender (Simmons, 1992).

NICE guidelines for the recognition and management of ‘BPD’ (2009) state that the extent of the emotional and behavioural problems experienced by people with ‘BPD’ varies considerably. Some individuals can maintain relationships and employment, but others experience repeated crises and are frequent users of psychiatric and acute hospital emergency services. Individuals with ‘BPD’ have sometimes been excluded from health or social care services because of their diagnosis, possibly due to lack of staff confidence and skill in this area (NICE, 2009). People with a primary diagnosis of ‘personality disorder’ are frequently unable to access the care they need from secondary mental health services, and specialised ‘personality disorder’ services are rare (NIMHE, 2003). Within mental health services, there is a continuing pressure to offer effective therapeutic intervention to reduce psychological distress within a limited time frame in order to minimise the time a client spends on the waiting list and the financial cost to the organisation for providing this service. Chalkley (2015) describes how the significant pressure on practitioners to keep their therapeutic work short and highly structured has prevented them from being able to immerse themselves in the content of their clients concerns, because of the need to achieve particular goals within a limited time frame. However, despite these ongoing restrictions, Counselling Psychologists have an obligation to stay true to the needs of their clients and to provide a platform from which their voices can be heard. The demands on mental health services should not be at the expense of the provision of a supportive therapeutic relationship (Ashley, 2010). This therapeutic approach focused towards the content of client experiences can be described as the humanistic or 'being with' approach, which highly values attention to client subjective experience, personal meaning and self-worth in the context of an accepting and supportive therapeutic relationship (du Plock, 2010). Du Plock (2010) contrasts this with ways of working more influenced by medical models, which involve the use of 'expert' knowledge to treat clients and use strategies to promote change, or even 'cure'. This is described as an approach of 'doing to' the client in therapy. Strengths and weaknesses of both approaches in supporting clients with a diagnosis of 'BPD' have been discussed within the discipline of counselling psychology (Steffen, 2013).

Many qualitative studies have been conducted to learn more about the lived experiences of 'BPD', but research into the therapeutic factors they find helpful has been considered limited due to themes being described only at a superficial level with few connections being made between them (Katasakou & Pistrang, 2017). Many generic therapeutic factors were listed as helpful, but it was unclear why they were especially relevant in supporting individuals with a diagnosis of 'BPD'. This study aimed to learn more about the facilitative processes of positive therapeutic change for individuals with a diagnosis of 'BPD', by asking individuals with this diagnosis to share their views on whether they considered a 'being with' relational approach or a 'doing to' directive approach as more effective in supporting clients with the same diagnosis.

The study used a qualitative approach with reflective thematic analysis (Braun & Clarke, 2006, 2019). RTA was chosen because its' theoretical flexibility meant compatibility for use within a constructionist paradigm which was appropriate for the researcher's understanding of 'BPD' as a socially constructed diagnosis (Bjorklund, 2006). Ethical approval was obtained from the University of the West of England Faculty Research Ethics Committee. Ten individuals with a diagnosis of 'BPD' were recruited from a service-user led organisation and participated in individual semi-structured interviews. Before participating, they were given an information sheet and time to ask questions to ensure informed consent to participate. Measures were put in place to manage risk if any of the participants experienced distress as a result of participating in the study. They were made aware that all of their information was confidential and that they could withdraw at any time. Interviews began with a broad opening question designed to elicit narrative to support participants to feel heard and to tell their story. Following this they were asked about their experiences of therapy and how they felt it could have been improved, which of the two approaches they thought was best in supporting individuals with a diagnosis of 'BPD', and the strengths and weaknesses of these approaches. The interview also explored how these approaches would affect the development of the therapeutic relationship and their experiences of crisis.

Braun and Clarke's (2006) six-phase approach to RTA was used to systematically identify, organise, and offer insight into patterns of meaning across the data set (Braun & Clarke, 2012). The initial phase began with transcription of the interview recordings. This supported the process of immersion in the data to allow me to become familiar with the depth and breadth of the content. Following transcription and checking transcripts against the recordings for accuracy, I read and re-read each actively, by searching for meanings and patterns within and across the interviews, noting my initial thoughts in a column adjacent to the transcript entitled ‘Open Codes’ (Charmaz, 2006). I then read through each data item and created a list of codes to identify and provide a label for each feature of the data that was potentially relevant to the research question (Braun & Clarke, 2012). Codes were recorded in a third column entitled ‘Focus Codes’. My first attempt at coding produced descriptive/ semantic codes, only reflecting a summary of participant meaning (e.g. “Not Feeling Heard”). However, over time, with greater engagement with the data and literature, I became able to recognise deeper patterns of meaning across the data set and was able to connect these with relevant theory. In the third phase, codes were sorted into themes. Once codes were sorted into theme-piles, an initial thematic map was drawn which depicted relationships between overarching themes and subthemes within them. Over time, the thematic map underwent several revisions as my engagement with the data set gradually shifted from surface-level awareness to a deeper level of understanding. Themes were refined until it was clear that the codes fitted well within them, that they were distinctive and told a story about the data in relation to the research question. After several revisions of the themes, it became clear that there was a mismatch between the themes and the research question regarding whether individuals with a diagnosis of ‘BPD’ preferred a relational or directive approach to therapy. The narratives spoke of the deep psychosocial issues affecting participants’ mental wellbeing, and the adversity that they had been through in their lives, including repeated experiences of rejection and neglect across their lifetime. These experiences occurred not only as part of early emotional deprivation within an attachment environment, but throughout their development with peers, interpersonal relationships, mental health services and wider society. It became clear that the question the research was asking of its data was ‘What do individuals with a diagnosis of “BPD” really need from Counselling Psychologists?’

Participants spoke of experiences as processes that were “healing” and “harmful”. These were the two overarching themes which had multiple subthemes. Subthemes for “Healing Processes” were “Deothering”, “Someone to be There” and “Giving What’s Needed”. Exploration of participant’s evaluations of the two therapeutic approaches unlocked deeper issues concerning the need for counselling psychologists to reverse the effects of repeated experiences of rejection by caregivers, society, and mental health services towards individuals with a diagnosis of ‘BPD’. It is evident from the data that counselling psychologists have the skills and a responsibility to make a significant contribution to these healing processes. They can achieve this in their therapeutic relationships with clients and by providing information about client needs to their multi-disciplinary team; supporting them to practice a consistent, client-centred, and holistic approach to care. The first process of healing was called “De-othering”. All participants described experiences of feeling like an outcast. These may have been evoked from emotional neglect by caregivers, being bullied, abusive relationships, being dismissed by services or a feeling of rejection by society for failing to meet its standards. Participants described several therapeutic skills used by professionals involved in their care which they found beneficial. Each contributed to dismantling the individual’s feelings of “otherness” and promoted a sense of feeling “normal”, accepted and valued. Participants felt de-othered when they were accepted as they were, when their emotions were validated, and they received information and support to make sense of their diagnosis. “Someone to be There” reflected the need for a supportive secure base that would provide consistent support until the individual was able to manage their emotions independently. Therapists need to allow individuals to feel heard and cared for. They must also be robust enough to be able to sit with the client’s intense emotions. “Giving What’s Needed” reflects the fact that individuals with a diagnosis of ‘BPD’ are all unique and should be treated as such. Participants felt that both relational and directive approaches had useful qualities. The relational approach was important because individuals need to feel heard because they have had a lifetime of having their emotions invalidated. However, the directive approach was important because individuals with a diagnosis of ‘BPD’ experience chaotic thinking which can spiral into a crisis and the structure helps them to focus, build skills for emotional regulation and thus avoid crisis. Which approach is needed and when is dependent on the individual and their personal circumstances, along with the stage of their healing journey. They need therapists and other professionals to understand that they are affected by emotional lability which changes their emotional needs and their ability to engage in therapy. Mental health professionals need to be flexible and to adapt their approach to what is needed at the time.

The “harmful processes” that participants have experienced within their interactions with mental health services and society were “Corned Beef Sandwiches and Paper Suits” and “Lights on, but Nobody’s Home”. “Corned Beef Sandwiches and Paper Suits” reflects an image of criminality and punishment by society for being “bad”. Participants described multiple experiences of being made to feel like “bad” people by mental health services and society. They described services making them feel that they were at fault and that they should take responsibility and change their behaviour. Services judged and rejected them, evoking memories of previous rejections and trauma. Even in therapy they felt that they were in the wrong and that services couldn’t cope with their intense emotional expressions, so services would distance themselves from them. It was felt that therapy could be improved if therapists could be self-reflective and could share the theory and success rates of the therapy being delivered, so that they didn’t feel that there was something wrong with them if they did not achieve success. “Lights on, but Nobody’s Home” concerns the fact that despite the ‘BPD’ stereotype reflecting a person who openly expresses their distress and demands help, individuals with ‘BPD’ must often hide their emotions in order to function so their distress often goes unseen. Services also miss their distress when they are under resourced and only able to support patients who are at immediate risk. This sets up a cycle of “Risk Leads to Recognition”, where the individual feels that they have to self-harm to be considered worthy of care, but services interpret this as attention-seeking, so their cries for help are ignored and the individual is left feeling that they must engage in further self-harm to be considered worthy of care. Therapists often missed or ignored their emotional distress by invalidating their feelings or ignoring their cries for help. It was felt professionals needed to be trauma informed to recognise the risk they posed to individuals by probing about difficult issues and not offering follow up support. If only participants felt seen, heard, and validated by those supporting them, then it was thought that they would suffer significantly less distress.

The findings of this study point to the broad range of psychosocial factors impacting on individuals with a diagnosis of ‘BPD’. This suggests that the issue does not lie within the individual, but that their distress is maintained through their treatment by society and particularly by mental health services who are supposed to represent a source of care and support.

These results have implications not just for therapy, but for how mental health services can improve the quality of care delivered to this client group. To support individuals to feel less ‘othered’, they need to have information and an understanding of their diagnosis that feels comfortable for them. This might involve co-collaboration in the development of their formulation. Engagement in the research process demonstrated that participants appreciated having the opportunity to tell their story and to make sense of their lived experiences. The therapist should adopt a not-knowing curious stance that prevents them from making assumptions about the individuals’ experiences. The clinical implications of “Someone to be There” suggest individuals need consistent accessible support when they start treatment to support them to contain their distress without resorting to previous harmful coping strategies. They might benefit from experiencing their team as a ‘mentalising container’, where the team work together to hold the individuals’ mental state in their mind and reflect it back to them so they start to gain a better understanding of their experiences. The theme “Giving What’s Needed” suggests that all therapeutic intervention needs to be tailored to the individual, depending on what is needed at the time, so therapists need to be flexible. Therapists should consider what has been previously helpful in the client’s earlier engagements with services so that such qualities can be introduced in the present relationship. Factors influencing client wellbeing such as the impact of trauma and emotional lability should be considered when providing an intervention.

To address the judgement and rejection that is represented by the theme “Corned Beef Sandwiches and Paper Suits”, counselling psychologists may support their team to address the defence strategies they may use against these individuals, such as labelling them and engaging in emotional distancing. This may be supported with the use of supervision and team formulation, integrating all psychosocial factors affecting the client’s presentation in order to put their behaviours into context. The Power Threat Meaning Framework (Johnstone & Boyle, 2018) may help to build the relationship between clients and staff, as it makes sense of their behaviour as a self-survival strategy when faced with threat and the misuse of power. It promotes kindness and understanding towards the individual by replacing the question of “What is wrong with you?” with “What has happened to you?” Concerning “Lights on, but Nobody’s Home”, counselling psychologists must ensure that individuals with a diagnosis of ‘BPD’ are seen and heard. Staff working with them must have the clinical skills to look beyond the mask to recognise their true feelings and act where necessary to keep them safe. Validation is also central in supporting this client group, so they no longer feel that it is necessary to engage in harmful behaviours to achieve service recognition and a response to their needs. Staff need to practice trauma informed care and appreciate the lived experience of ‘BPD’, including being mindful of triggers to the client feeling rejected and abandoned. This means holding boundaries but also being a reliable source of support for them when needed.

Participants’ narratives expressed their deep emotional needs from mental health services which were shaped by both developmental attachment experiences and wider experiences of their engagement with society. The themes of this research capture their experiences of having felt alienated, “othered”, unloved, stigmatised, criminalised and ignored. As Counselling Psychologists whose practice centres around the therapeutic relationship, we have a duty to hear and see the client, to support them to make sense of their experiences and to support others to do so. Being aware of these “healing” and “harmful” processes can assist us in strengthening the therapeutic relationship by informing us of what it beneficial and detrimental to the wellbeing of these clients, along with the origin of these experiences. Bringing these processes to the attention of one’s team and wider services enhances understanding of the broader psychosocial factors impacting upon mental health, which must be integrated into how the client’s issues are understood and how intervention is formulated. Whatever the availability of a service to provide psychological intervention, awareness of these themes can make an immediate positive impact on the quality of care that individuals receive.