

'An Emptiness of Connections':

**The Experience of Loneliness in people with Borderline Personality Disorder, both Before and
During the Coronavirus Pandemic**

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

This thesis explored the experience of loneliness and associated factors in people with a self-reported diagnosis of borderline personality disorder (BPD).

Part one is a conceptual review of the current literature and theories surrounding interpersonal difficulties and the experience of loneliness and associated factors in people with BPD. From this, the conceptual review proposes a model of social dissatisfaction in people with BPD.

Part two is an empirical paper that aims to understand the experience of loneliness in people with BPD, both before and during the coronavirus pandemic. This is a qualitative study that uses semi-structured interviews from 20 participants with a self-reported diagnosis of BPD to understand their experience of loneliness, providing a framework of eight main themes.

Part three offers a critical appraisal of the research process. It focuses on the personal beliefs and experiences of the researcher and their attempt to 'bracket' these, whilst also considering how these might have impacted the research study. The critical appraisal concludes by considering the impact of the study on the researcher's clinical practice.

Impact Statement

To the best of my knowledge, this is the largest qualitative study exploring the experience of loneliness in people with borderline personality disorder (BPD) and the only study to explore loneliness in this population during the coronavirus (COVID-19) pandemic.

The research seems timely, as although there is some understanding of the interpersonal difficulties associated with BPD, there is limited knowledge on how this clinical population experiences loneliness and what helps them to feel more connected to others. In addition, we have yet to understand how changes due to a pandemic might impact upon these experiences.

A review of the literature suggests people with BPD are chronically dissatisfied with their relationships and this may lead them to experience urges to self-harm. With suicide being a very real concern for this population, and a thwarted sense of belonging a known risk factor for dying by suicide, it is important for professionals to further understand this experience and how to support people with BPD to feel less lonely and more connected to others.

Past research on interpersonal difficulties in BPD has largely focused on the concept of 'rejection sensitivity', suggesting that this is often a perception rather than a reality. This thesis considers this alongside the other side of the story, namely the impact of stigma, the history of exclusion from services and the controversy surrounding the personality disorder diagnosis.

It is possible there will be future pandemics that lead governments to advise or order the population to limit their physical contact with others. This thesis provides an insight into how people with BPD might experience loneliness and their connections with others during these times, in order to make steps towards reducing crises and begin to think about how they can be best supported. Although the researcher is keen to ensure loneliness is not pathologized, it is essential to ensure that loneliness is also not disregarded, as this experience has serious consequences for physical and mental health and wellbeing.

This conceptual review, empirical paper and critical appraisal aim to provide a step in the right direction towards considering the experience of loneliness in people with BPD, both before and during the COVID-19 pandemic. The researcher will seek to disseminate the findings more widely by publishing in research journals, presenting at conferences and sharing with professional networks and other interested parties. In addition, the researcher has plans to disseminate findings to the study website to ensure it is available to participants, and also on the webpage of 'Borderline Arts' – currently the only charity in the UK for people with BPD.

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Part 1: Conceptual Review:

**Understanding Loneliness and Associated Factors in Borderline Personality Disorder: A Conceptual
Review**

Abstract

People with a diagnosis of borderline personality disorder (BPD) experience chronic feelings of loneliness at a higher proportion than the general population (Liebke, et al., 2017). Interpersonal difficulties are well researched in BPD; however, little is understood about the experience of loneliness. This conceptual review introduces the key topics of BPD and loneliness and highlights the impact of the current global pandemic on the experience of loneliness. It summarises what is currently known about loneliness in BPD and then reviews the key theories in understanding interpersonal difficulties in BPD, as these are important to consider in understanding loneliness. The review goes on to consider relevant research on the factors that may influence loneliness in BPD and proposes a model of social dissatisfaction in BPD, with suggestions on why this experience continues to be maintained. Finally, current gaps in the literature are discussed and research questions are proposed.

Introduction

This project is intended to increase understanding of the experience of loneliness in BPD, both before and during the COVID-19 pandemic. It is widely known that people with BPD experience persistent dissatisfaction in their relationships (Gunderson, 2007; Lieb et al., 2004; Zanarini et al., 2010) and that this contributes towards acts of self-harm and suicide (Yen et al., 2020). More recently, research has suggested that people with BPD report stronger feelings of loneliness than the general population (Liebke et al., 2017), highlighting the need to understand more about how this is experienced. In addition, COVID-19 has caused a considerable amount of disruption to the usual ways in which people experience their social relationships (Haleem et al., 2020), yet currently there is a lack of understanding on how this has impacted the experience of loneliness in people with BPD. This project uses a framework analysis (Ritchie & Spencer, 1994) with the aim to understand the

experience of loneliness in people with BPD, both before and during COVID-19. This is of particular importance as loneliness has serious consequences on both physical and mental health (Cacioppo & Patrick, 2008) and is linked to a thwarted sense of belonging, which is a known risk factor for suicide (Joiner, 2005). Clinicians working with this population would benefit from further understanding of how people with BPD experience loneliness and what might support them to foster connections with others. In addition, understanding the impact of the COVID-19 pandemic on loneliness in this population would lay the ground for how to support people with BPD to manage loneliness during potential future pandemics or social distancing restrictions. This conceptual review defines the key concepts of the study, considers the knowledge thus far on loneliness in BPD and considers the evidence-base on interpersonal difficulties and social dissatisfaction in this population. The review concludes by highlighting the gaps in the literature which motivated this study and provides a summary of the aims of the research.

Borderline Personality Disorder

Defining Borderline Personality Disorder

Borderline personality disorder (BPD) is a serious and complex mental health diagnosis that is characterised by emotional dysregulation and chronic unstable interpersonal relationships (Choi-Kain et al., 2010; Skodol et al., 2002; Zanarini et al., 2010). The most recent Diagnostic and Statistical Manual of Mental Health Disorders ([DSM] 5th ed.; American Psychiatric Association [APA], 2013, pp.663) states BPD is:

A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts as indicated by five or more of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)

- 2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.*
- 3. Identity disturbance: markedly and persistently unstable self-image or sense of self.*
- 4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)*
- 5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.*
- 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).*
- 7. Chronic feelings of emptiness.*
- 8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).*
- 9. Transient, stress-related paranoid ideation or severe dissociative symptoms.*

It is estimated that approximately 1% and 1.4% of the United Kingdom (UK) and United States (US) population respectively have BPD (National Alliance on Mental Health, 2017; National Institute for Health and Care Excellence [NICE], 2009). BPD is highly comorbid with other mental health diagnoses, with 84.5% of adults with BPD in the US also having another mental health disorder (Lenzenweger et al., 2007). People who meet the criteria for a personality disorder make up almost a quarter (24%) of patients seen in UK primary mental health services and approximately half of the patients seen in secondary mental health services (De Girolama & Reich, 1993; Moran et al., 2000). Research also suggests that up to 10% of people with BPD die by suicide (Paris, 2019) and that the suicide risk for people with BPD is approximately 45 times that of the general population (Chesney et al., 2014).

Interpersonal Difficulties in Borderline Personality Disorder

As seen above, difficulties with interpersonal relationships feature throughout the DSM diagnostic criteria of BPD (APA, 2013). BPD is characterised by instability of affect and identity, impulsivity, frequent displays of anger, fear of abandonment and intense relationship patterns (APA, 2013). This can manifest in being highly dependent on, or rejecting of others, angry outbursts in response to perceived rejection, conflict within relationships and self-destructive behaviours (Stanley & Siever, 2010). In addition, deliberate acts of self-harm and suicide attempts often occur in an interpersonal context (Brodsky et al., 2006) and in response to transitions and change (NICE, 2015). It has been suggested that people with BPD might rely heavily on others to manage their experiences of instability of self and heightened affect (Stanley & Siever, 2010), however this may lead to further interpersonal difficulties such as intense relationships and fear of abandonment. Longitudinal research into the psychosocial functioning of people with BPD suggests interpersonal stability is very difficult for people with BPD to maintain (Zanarini et al., 2010).

Loneliness

Defining Loneliness

Loneliness is defined by Hawkley and Cacioppo as “a distressing feeling that accompanies the perception that one’s social needs are not being met by the quantity, or especially the quality, of one’s social relationships” (2010, p.218). Liebke et al. (2017) expand on this by suggesting that being alone refers to social isolation, whilst being lonely refers to the perception of social isolation.

It has been proposed that three forms of connection - intimate, relational, and collective - need to be fulfilled in order to not feel lonely (Hawkley et al., 2005). These refer to the intimate space i.e., closest family and friends, the social space i.e., friendships and acquaintances, and the public space i.e., belonging to wider social groups and collectives (Cacioppo et al., 2015). Cacioppo and Patrick (2008) suggest that the effects of loneliness stem from the interplay of the following three factors: the individual’s level of vulnerability to social disconnection, their ability to self-

regulate the emotions associated with feeling isolated, and the way loneliness affects their mental representations and expectations of others. The experience of loneliness has also been found to alter social cognition, for example when a lonely individual receives a nurturing response from a friend, they are more likely to perceive this interaction as less fulfilling than they hoped it would be (Cacioppo & Patrick, 2008). In addition, experiencing loneliness can cause an individual to be highly sensitive to any indication of rejection, causing them to tune into non-verbal cues (Gardner et al., 2005) and perceive neutral facial expressions more negatively when compared to less lonely individuals (Pickett & Gardner, 2005). In turn, lonely individuals report being less fulfilled by their relationships and more mistrustful of others (Hawkley et al., 2007a; Rotenberg et al., 2004). Specifically, loneliness appears to be affected by maladaptive social cognitions that impair an individual's ability to develop intimate relationships (Masi et al., 2011).

Impact of Loneliness

Research has shown that loneliness can have serious consequences on health and mortality (Gerst-Emerson & Jayawardhana, 2015; Hawkley & Cacioppo, 2010). Loneliness has been linked to cardiovascular health risks (Caspi et al., 2006); increased risk of Alzheimer's disease (Wilson et al., 2007); lower physical activity levels (Hawkley et al., 2009); and poorer outcomes in depression (Erzen & Çikrikci, 2018) and psychological wellbeing (Rohde et al., 2015).

Loneliness has also been linked to the unmet need for belonging (Mellor et al., 2008). This is of particular significance as a thwarted sense of belonging has been suggested to be a key factor in why people die by suicide (Joiner, 2005).

UK Government Response

In recent years, the UK government have taken steps towards tackling the issue of loneliness in the country, following the report 'A Call to Action' (Jo Cox Commission on Loneliness, 2017). Following this, in October 2018 the UK government appointed the first Minister for Loneliness and published a

loneliness strategy (HM Government, 2018a). This strategy aspired to “bring together government, local government, public services, the voluntary and community sector to identify opportunities to tackle loneliness and build more integrated and resilient communities” (HM Government, 2018b). The strategy included three aims: to improve the evidence-base on loneliness, to ensure loneliness is considered in government policies, and to raise awareness and tackle the stigma of loneliness (HM Government, 2018a). In June 2019 the campaign ‘#LetsTalkLoneliness’ was launched in support of the latter aim of reducing the stigma of loneliness and promoting the importance of social connections (HM Government, 2019).

Who is Vulnerable to Loneliness?

The Office for National Statistics (ONS) completed the Community Life Survey which analysed the characteristics and circumstances of loneliness in England (Pyle & Evans, 2018). Their findings included the following:

- *In 2016 to 2017, 5% of adults in England reported feeling lonely “often” or “always”.*
- *Younger adults aged 16 to 24 years reported feeling lonely more often than those in older age groups.*
- *Women reported feeling lonely more often than men.*
- *Those single or widowed were at particular risk of experiencing loneliness more often.*
- *People in poor health or who have conditions they describe as “limiting” were also at particular risk of feeling lonely more often.*
- *Renters reported feeling lonely more often than homeowners.*
- *People who feel that they belong less strongly to their neighbourhood reported feeling lonely more often.*
- *People who have little trust of others in their local area reported feeling lonely more often (Pyle & Evans, 2018).*

It is important to note that this survey asked respondents “how often do you feel lonely” and so the findings are focused on the frequency of loneliness rather than the degree/intensity of loneliness (Pyle & Evans, 2018).

Along with these findings from the ONS, research suggests no one is immune to experiencing loneliness, however, it is more likely in populations vulnerable to social alienation and isolation (Cacioppo et al., 2015). These groups include older individuals living alone, people with mental health difficulties, those with long-term health conditions and stigmatised groups such as those with minority experiences (Andersson, 1998; Cacioppo et al., 2015; Eres et al., 2020).

Current Context: Loneliness and COVID-19

Whilst discussing loneliness it would be remiss to disregard the current global context. In December 2019 there was an outbreak of a new virus in Wuhan, China. This has been named the coronavirus disease 2019 (COVID-19) and is caused by severe acute respiratory syndrome coronavirus 2 ([SARS-CoV-2] Gorbalenya et al., 2020). By June 2021, the number of confirmed cases of people who had been diagnosed with COVID-19 in the UK was over 4.5 million, with over 127,000 people losing their lives to the disease, (*COVID-19 in the UK*, 2021).

Along with the consequences of loss and grief, the COVID-19 pandemic has also had a significant impact on the way people live their lives. At the start of April 2020 approximately 50% of the world’s population was under ‘lockdown’, with 3.9 billion people being asked or ordered to stay at home by their governments to minimise the spread of the virus (Sandford, 2020). Since then, the UK has seen a further two lockdowns. On 31 October 2020 the British Prime Minister announced the second lockdown for the UK, with the population again being asked to stay home as much as possible and households being banned from mixing with other households indoors, with few exceptions (Blackall, 2020). The third UK lockdown was announced on 4 January 2021 with restrictions remaining in place for several months (HM Government, 2021).

With many people staying at home, work, education, and social events transitioned to being online. In April 2020, the video conferencing service *Zoom* reported more than 300 million daily users in virtual meetings and their number of fee-paying accounts tripled (Sherman, 2020). Many health appointments were also moved to remote delivery, with the National Health Service (NHS) publishing guidance for physical and mental health professionals on providing remote telephone or video consultations to patients (2020a; 2020b).

It seems we are yet to understand the full social impact of COVID-19 and indeed the impact on people with BPD (Saltzman et al., 2020). New research concerning loneliness during COVID-19 suggests younger people and those with a history of mental health difficulties expressed the highest levels of loneliness during the first few months of the pandemic (Varga et al., 2021) and this increased depressive symptoms (Lee et al., 2020). Between April and May 2020, the ONS completed a survey to analyse loneliness in Great Britain during the coronavirus pandemic (Rees & Large, 2020). They reported “5.0% of people in Great Britain (2.6 million adults) reported that they felt lonely ‘often’ or ‘always’ between 3 April and 3 May 2020, about the same proportion as pre-lockdown” (Rees & Large, 2020). These findings seem to suggest that the first UK lockdown did not increase loneliness, as the same proportion of the population reported feeling lonely “often” or “always” (Pyle & Evans, 2020; Rees & Large, 2020). It is possible that this highlights the difference between loneliness and being alone, with many more people experiencing social isolation during the first UK lockdown, but the same proportion experiencing loneliness. Although, as mentioned above, it is still unclear whether the intensity of loneliness increased during this lockdown, or indeed subsequent lockdowns, as the survey measured the frequency of loneliness only (Pyle & Evans, 2018; Rees & Large, 2020).

To date, to the author’s knowledge, there has only been two published papers on the impact of COVID-19 on BPD. The first detailed a case study of a woman receiving therapy in Malaysia for BPD, with the author noting that the pandemic triggered a sense of isolation and escalated fears of abandonment (Chong, 2020). As this was based on one individual living in a different country and

culture, caution must be taken to generalise the findings to others with BPD. The other paper proposed clinical hypotheses based on the current literature and suggested those with cluster B personality disorders, which includes BPD, were at increased risk during the pandemic due to their need for physical and emotional proximity to others to protect from abandonment fears and support to regulate their emotions (Preti et al., 2020).

Borderline Personality Disorder and Loneliness

There is very limited understanding of the relationship between loneliness and BPD, however in recent years some steps have been taken to address this. The below summarises what the research tells us thus far about loneliness in BPD.

Loneliness as a factor of BPD

The Borderline Symptom List ([BSL], Bohus et al., 2001) was developed as a self-report instrument to measure the degree of symptomology in people with BPD. A factor analysis revealed seven factors of BPD, including 'social isolation' (Bohus et al., 2001). Later the authors amended the name of this factor to 'loneliness' to reflect that it was subjective in nature. After three months of dialectical behaviour therapy ([DBT] Linehan, 1993), an evidence-based treatment for BPD, significant reductions were found on five of the seven subscales, with loneliness and hostility being the two factors that did not respond to treatment (Bohus et al., 2001). This suggests that despite some focus on interpersonal effectiveness within the therapy, DBT was still not successful in reducing loneliness in people with BPD. It is worth considering however, that the recommended duration of DBT is 12 months (Linehan et al., 1991), which may explain the lack of effectiveness found in this study.

Loneliness Perceived as an Inherent Trait

Sagan (2017) interviewed seven individuals with BPD on their experience of loneliness and used a narrative phenomenological approach to examine them. Amongst the group of participants, loneliness had been experienced since childhood and was perceived as an inherent trait, rather than a state, and as such it could only temporarily be alleviated (Sagan, 2017). Several participants spoke about their use of harmful coping strategies, such as self-harm or substance use, to manage feelings of loneliness (Sagan, 2017). It is worth noting the small sample size in this study and as such any generalisations should be made with caution.

Genetic and Environmental Causes

In a recent twin study, using data from over 11,000 pairs of twins from Australia and the Netherlands, researchers found positive correlations between BPD dimensions and loneliness (Schermer et al., 2020). The authors concluded that their results suggest substantial genetic and unique environmental correlations between loneliness and BPD. The study did not suggest which environmental factors might contribute towards loneliness, nor was it able to attest to whether BPD characteristics have a causal relationship on loneliness or loneliness has a causal relationship with BPD characteristics. Nevertheless, the authors felt this research was hopeful as it demonstrated that a proportion of the correlation between BPD and loneliness was due to environmental factors, suggesting these could be modified (Schermer et al., 2020).

Distinct Concept from Emptiness

In a recent systematic review examining the construct of emptiness in BPD, researchers found that emptiness could be thought of as a sense of disconnection from both the self and others (Miller et al., 2020). The researchers suggest that emptiness is a construct that is distinct from 'loneliness', 'the intolerance of being alone' and 'hopelessness'; however, they suggest more research is required to understand these experiences and how they are related (Miller et al., 2020).

Loneliness Related to Poor Social and Relational Functioning

Liebke et al. (2017) investigated the relationship between loneliness and BPD, particularly looking at the relevance of social functioning and social isolation to the experience of loneliness. Social functioning was assessed on various domains including social engagement, interpersonal communication, prosocial behaviour, recreational activities, independence, and occupation (Liebke et al., 2017). Their findings suggest that higher levels of loneliness were reported by people with BPD than a group of healthy controls. The authors concluded that smaller social networks and reduced social functioning, particularly in the domain of interpersonal communication, were associated with higher levels of loneliness in BPD. Interestingly, although people with BPD reported higher levels of unemployment and of living alone, neither of these were associated with loneliness in this population. The authors concluded that although social isolation and difficulties with social functioning explain some of the picture, they are not enough to account for the enduring sense of loneliness this population experiences (Liebke et al., 2017).

Relationship between Hallucinations and Loneliness

Researchers have sought to understand hallucinations in people with BPD and how these might relate to the experience of depression, anxiety, schizotypy and loneliness (Slotema et al., 2019). The research employed a cross-sectional design and included 60 women with a diagnosis of BPD. The findings suggest that there is a relationship between loneliness and hallucinations in BPD, with 81% of those experiencing hallucinations also indicating strong feelings of loneliness. In addition, the severity of hallucinations was positively correlated with the severity of loneliness, i.e., as the severity of loneliness increased the severity of hallucinations also increased. Due to the cross-sectional design of this study, no assumptions can be made regarding the causality of loneliness and hallucinations.

Loneliness is not associated with Behavioural Mimicry

One study has examined the relationship between behavioural mimicry (imitating or mirroring the behaviour of others) and loneliness in BPD (Hauschild et al., 2018). The researchers were particularly interested in behavioural mimicry due to the findings that this behaviour helps to form social affiliation and feelings of belonging (Chartrand & Lakin, 2013; Lakin et al., 2003). They found behavioural mimicry to be increased in people with BPD however they could not conclude that loneliness and behavioural mimicry were associated in this population (Hauschild et al., 2018). The authors suggest more research is required to understand the link between behavioural mimicry and interpersonal dysfunction to understand this relationship.

Psychological Theories on Interpersonal Difficulties in BPD

Several psychological theories aim to make sense of the interpersonal difficulties experienced by people with BPD and the prevalence of social dissatisfaction in this population, however none of these speak to loneliness specifically. Attachment theory, mentalization, epistemic trust and biosocial theory are discussed below.

Attachment Theory

Perhaps one of the most influential models for understanding how individuals relate to one another is attachment theory (Bowlby, 1980). This suggests infants are biologically predisposed to form attachments to others from which they can seek security and comfort, and that they do this through proximity-seeking behaviours (Bowlby, 1980). The way in which the caregiver responds to these behaviours over time can have an influence on the infant's attachment style (Bowlby, 1988). This attachment style informs the infant's beliefs about themselves, such as the extent to which they are lovable, and their expectations about the behaviour of others, for example, how available others are to them (Weinfield et al., 2008). This internal working model is said to affect the way in which the infant behaves and feels in future relationships (Thompson, 2008). Bowlby proposed that

attachment style “is a principal feature of personality functioning and mental health” (Bowlby, 1988, pp121), suggesting maladaptive mental representations of the self and others can be understood through this theory.

Three main attachment styles have been identified including secure, insecure-avoidant and insecure-resistant (Weinfield et al., 2008). An infant with a secure attachment can use their caregiver as a ‘secure base’ from which to explore the world and as a source of comfort and protection when in distress (Bowlby, 1988). In contrast, infants with an insecure attachment style may show signs of ambivalence towards their caregiver e.g., at times clingy and at other times rejecting; or they might withdraw from their caregiver when distressed (Bowlby, 1988).

In a review of 13 attachment studies involving people with BPD, all studies found a strong association between BPD and insecure attachment, noting people with this attachment style are more likely to be longing for intimacy from others whilst also fearful of dependency and rejection (Agrawal et al., 2004). There is considerable evidence that children with a history of maltreatment are more likely to have an insecure attachment style (Lyons-Ruth et al., 1987). Insecure attachment style has also been associated with several psychological difficulties including hostility, impulsivity, and helplessness (Sroufe, 1988). This is particularly relevant to BPD as research has shown that 83% of people with BPD report a history of an interpersonally traumatic event such as physical and/or sexual abuse (Westphal et al., 2013). Historical child sexual abuse has also been linked to an increased risk of depression, an increased likelihood of using destructive behaviours in conflict situations (Styron & Janoff-Bulman, 1997) and the formation of maladaptive cognitions about others (Ehlers & Clark, 2000). However, maltreatment alone cannot account for the development of an insecure attachment style as not everyone with a diagnosis of BPD reports interpersonal trauma.

Mentalization

Bateman and Fonagy (2004) argue that the importance of attachment lies in its ability to facilitate the development of mentalization skills in the child. Mentalization is defined as “the mental process

by which an individual implicitly and explicitly interprets the actions of himself and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs and reasons” (Bateman & Fonagy, 2004, pp.xxi). This ability has a direct impact on the individual’s social relationships. The authors suggest that a potential consequence of an insecure caregiving base is that the child does not learn to mentalize, which leaves them vulnerable to avoiding thinking about the mental states of themselves and others, and in turn causes difficulties in affect recognition and regulation and in their interpersonal relationships (Bateman & Fonagy, 2004). Although the authors do not attribute a central role to trauma in people with BPD; they suggest that a reduced capacity to mentalize leaves an individual vulnerable to developing BPD, and experiences of psychological abuse, neglect or maltreatment may be a causal factor in shaping the individual’s BPD pathology (Bateman & Fonagy, 2004). Bateman and Fonagy (2004) went on to develop mentalization-based treatment (MBT) as a therapeutic intervention for BPD to specifically promote mentalization skills and improve interpersonal relating (Bateman & Fonagy, 2004).

Impairment in Epistemic Trust

In recent years the theory behind MBT has been extended to include the concept of ‘epistemic trust’ (Fonagy et al., 2015). Epistemic trust is defined as an “openness to the reception of social knowledge that is regarded as personally relevant and of generalisable significance” (Fonagy et al., 2019, p.95). The authors suggest that people with BPD also have an impairment in epistemic trust which inhibits their capacity to benefit from the social environment (Fonagy et al., 2015). They suggest people with BPD are more mistrustful of others due to an adaptive consequence of their social learning environment (Fonagy et al., 2017). The authors go on to propose that the reason several psychotherapeutic approaches are effective for people with BPD is due to them being coherent, consistent, and continuous, with a focus on good communication between the therapist and patient, as this process helps to restore epistemic trust, which is, in their view, the crucial ingredient in improving interpersonal relating (Fonagy et al., 2015).

Biosocial Theory

An alternative theory of the development of interpersonal difficulties in BPD is the biosocial theory proposed by Linehan (1993). Linehan (1993) suggests that BPD arises from the combination of biological vulnerabilities, including heightened emotional sensitivity and impulsivity, and emotionally invalidating environments in childhood. Emotionally invalidating environments are defined as those that “intermittently reinforce extreme expressions of emotion and simultaneously communicate to the child that such emotional displays are unwarranted and that emotions should be coped with internally and without parental support” (Crowell et al., 2009, pp. 496). This process contributes to the development of difficulties in the interpretation, communication, and regulation of emotions (Crowell, et al., 2009). The child then learns to manage their emotions by using impulsive behaviour, that is behaviour which is socially inappropriate or maladaptive, which could lessen trust and increase conflict in the child-caregiver relationship (Crowell et al., 2009). Following these experiences self-protective cognitions are formed regarding the self and other (Beck & Freeman, 1990; Crowell et al., 2009). It is possible then that poor emotional regulation skills, difficulties with impulse control and unhelpful cognitions regarding the self and other impact on the ability to form and maintain social relationships, negatively affecting satisfaction in relationships and the experience of loneliness in BPD.

Linehan went on to develop DBT as a therapeutic treatment model for people with BPD (Linehan, 1993), which strives to support people to use both acceptance and change-orientated strategies and focuses on emotion regulation and interpersonal effectiveness skills (Chapman, 2006).

What are the Factors that influence Social Dissatisfaction in BPD?

The theories discussed above aim to provide an explanation for the interpersonal difficulties experienced by people with BPD. In addition to these overarching theories, it is necessary to

understand what is known from the current literature about the factors that may influence the experience of loneliness in people with BPD. The below synthesises relevant findings on factors that influence social dissatisfaction in people with BPD and therefore may also play a role in their experience of loneliness. From this, a model of social dissatisfaction in BPD is proposed.

Social Networks

People with BPD have smaller social networks than people without BPD and rate their networks as less supportive and less satisfying (Beeney et al., 2018), and as containing more criticism, conflict, and ruptures (Lazarus & Cheavens, 2017). In addition, people with BPD characterise their social interactions more negatively than the general population, describing them as “disagreeable, ambivalent, angry, empty and sad” (Stepp et al., 2009, pp.484). It has also been proposed that people with BPD experience conflict in their networks on social media, with more frequent ‘unfriending’ and ‘blocking’ when compared to healthy controls (Ooi et al., 2020).

Along with reporting fewer social contacts, people with BPD were found to be less centrally integrated in their social networks, i.e., those who they were most closely linked with were on the periphery of their social network and less socially connected to others in the network (Beeney et al., 2018). Finally, in terms of social network makeup, the networks of people with BPD included more ex-romantic partners than people without BPD (Clifton et al., 2007). The authors do not provide an explanation for this; however, it is worth noting that people with BPD have a strong wish to escape abandonment (APA, 2013) which may be a factor in maintaining these relationships and the inherent conflict within networks. Due to the self-report nature of these studies conclusions cannot be drawn about whether this reflects a deficit in social support or the perception of social support in people with BPD.

Social Rejection

Rejection Sensitivity

Rejection sensitivity, which is defined as “the disposition to anxiously expect, readily perceive and intensely react to rejection” (Downey et al., 2004, p. 668) is a concept that has been repeatedly linked to social dysfunction in BPD (Bungert et al., 2015; Lazarus et al., 2016; Thome et al., 2016). BPD symptoms have been associated with more frequent perceptions of rejection, and less frequent perceptions of acceptance and belonging (Lazarus et al., 2018; Wrege et al., 2019). In a study investigating rejection sensitivity in BPD, anxiety disorders and healthy controls, people with BPD were found to score higher on the Rejection Sensitivity Questionnaire, than any other group (Downey & Feldman, 1996; Staebler et al., 2011).

Several studies have involved the use of *Cyberball* (Williams & Jarvis, 2006), a virtual ball-tossing game designed to manipulate certain variables such as exclusion (Lawrence et al., 2011; Renneberg et al., 2012). The game is designed to lead participants to believe they are playing a game of catch with other players, however in reality the other players are controlled by the programmer (Williams & Jarvis, 2006). Crucially, the amount of inclusion can be controlled by the programmer, which can then provide a simulated experience of inclusion or exclusion to the participant (Williams & Jarvis, 2006). In a study by Staebler et al. (2011), 18 women with BPD and 17 control participants played *Cyberball* whilst being told to practice their mental-visualisation skills. Each participant was randomly assigned to an inclusion or exclusion condition, which dictated how many times the ball was thrown to them (Staebler et al., 2011). The authors found that even in the inclusion condition, participants with BPD felt more excluded than healthy controls (Staebler et al., 2011), however the small sample size in this study, and the virtual nature, are worth taking into consideration.

In another study using *Cyberball* with people with BPD, researchers added an ‘over-inclusion’ experimental condition, during which participants would be thrown the ball more frequently. Their results suggested that people with BPD experienced lower levels of social connection in both the inclusion and exclusion condition when compared to healthy controls (De Panfilis et al., 2015). Only in conditions where people with BPD were over-included did they reduce their negative emotions to levels more comparable with controls; however over-included

participants with BPD still demonstrated lower feelings of social connection than over-included controls (De Panfilis et al., 2015). The authors concluded that people with BPD may hold extreme, idealised views about interpersonal inclusion, which may mean even 'including situations' feel rejecting (De Panfilis et al., 2015).

Emotional Response following Perceived Rejection

People with BPD have been found to experience higher levels of negative affect after a perceived rejection when compared to healthy controls. Affect included hostility, fear, guilt, sadness (Lazarus et al., 2018) and rage/anger (Berenson et al., 2011). These findings were replicated by Hepp et al. (2018) who also found positive associations between BPD and hostility, sadness, and fear when individuals with BPD experienced rejection. Stiglmayr et al. (2005) explored the precipitating events to adverse emotional reactions in people with BPD. The authors found that in 40% of their participants, the events that preceded negative emotional reactions included 'rejection', 'being alone' and 'failure' suggesting perceived rejection is a highly common preceding event to negative affect in people with BPD. This study relied on self-report data from participants, meaning participants were required to rate their level of affect and the preceding event that had caused the affect. This method may have resulted in inaccuracies based on differences in reporting styles and ability to recognise emotions, which is commonly noted as an area of difficulty in BPD (Bateman & Fonagy, 2004; Crowell et al., 2009).

Behavioural Response following Perceived Rejection

Not only have people with BPD been found to perceive rejection more readily and have higher levels of negative affect after rejection; they have also been found to demonstrate more unhelpful behavioural responses following an experience of perceived rejection (Beeney et al., 2014; Seidl et al., 2020). In response to a simulated social rejection situation, participants with BPD demonstrated divergent neural states when compared to people with major depressive disorder (MDD), namely

greater left frontal electroencephalogram (EEG) asymmetry, indicating approach tendencies such as hostility, whereas participants with MDD demonstrated greater right EEG asymmetry indicating withdrawal tendencies (Beeney et al., 2014). Their findings suggest that when people with BPD feel rejected this then prompts a motivational state for approach behaviours such as hostile and impulsive maladaptive behaviours (Beeney et al., 2014). It is important to note this study did not provide a control group and so conclusions are not able to be drawn about how people with BPD compare to healthy controls in this area.

Attitudes of Others

Due to the interpersonal nature of the difficulties in BPD, it is also important to think about the role others play in contributing to social dissatisfaction in BPD. Several studies have commented on the negative attitudes towards people with BPD, even amongst mental health professionals. In a classic study by Lewis and Appleby (1988) a sample of psychiatrists were asked to indicate their attitudes to several case vignettes. Patients who had been given a diagnosis of personality disorder were seen as “more difficult and less deserving of care” than participants without this diagnosis (Lewis & Appleby, 1988, p.44). Along with this, participants with a personality disorder were regarded as “manipulative, attention-seeking, annoying and in control of their suicidal urges” (Lewis & Appleby, 1988, p.44). This study was replicated more recently, however this time the views of psychiatry trainees were assessed (Chartonas et al., 2017). The replication continued to find evidence of more negative attitudes towards people with personality disorders than people with a diagnosis of depression (Chartonas et al., 2017), however other research has suggested that with education, attitudes are improving (Black et al., 2011). These studies recruited professionals working in clinical settings and so findings cannot be generalised to a non-treatment seeking BPD population, or indeed non-mental health professionals.

Stigma and Lack of Understanding

In 2003 the National Institute for Mental Health in England (NIMHE) released a document entitled *Personality Disorder: No Longer a Diagnosis of Exclusion*. This provided policy implementation guidance for professionals and services to improve access to treatment for people with personality disorders, which was in recognition that historically, people with a personality disorder diagnosis have been excluded from services, in part due to a lack of awareness and negative attitudes from professionals (NIMHE, 2003).

It is perhaps unsurprising then that the BPD diagnosis has attracted some controversy, with many experiencing the label as stigmatising (Campbell et al., 2020). One of the long-standing debates is centred around whether personality pathology should be thought of as dimensional rather than categorical (Hopwood et al., 2018). In light of this, the International Classification of Diseases, an alternative classification model to the DSM, has plans to replace categorical personality disorders with a severity gradient and five trait domains in its next edition (World Health Organisation [WHO], 2018). In addition, there are also feminist critiques of BPD, which suggest that the diagnosis wrongly pathologizes reasonable, adaptive reactions of survivors, as it is often applied to females who have experienced abuse (Shaw & Proctor, 2005).

Further to this, it seems there remains a lack of understanding of BPD in both the professional (Kulacaoglu & Kose, 2018) and public realm (Rice-Oxley & Johnson, 2020). Although there has been an increase in mental awareness campaigns in recent years, BPD remains one of the lesser-known and talked about conditions (Rice-Oxley & Johnson, 2020), despite the prevalence of people with BPD in mental health services (De Girolama & Reich, 1993; Moran et al., 2000).

Expectations of Rejection

Recent research has suggested that people with BPD have lower expectations of being socially accepted than people without BPD, they tend to report more failed past relationships, and predict that future interactions will be negative (Hauschild et al., 2018; Liebke et al., 2018). In a study which used computer-controlled avatars to represent real human players in a trust game, researchers

measured the expectations of participants after receiving feedback signalling either acceptance or rejection (Liebke et al., 2018). Not only did participants with BPD score lower than healthy controls on their expectations of social acceptance; they were also actively less cooperative towards the avatars after receiving feedback of social acceptance and did not adjust their expectations (Liebke et al., 2018). Lazarus et al. (2016) also linked expectations of rejection to social dissatisfaction in BPD, suggesting “the tendency to expect and perceive rejection may amplify fears of abandonment, impulsivity and anger experienced at high levels of BPD features, ultimately eroding perceptions of social support and satisfaction” (p.65). However, taking into account the attitudes of others and the stigma associated with the condition, it is also possible that expectations of relationships have adapted in response to difficulties in interpersonal relationships.

Emotion Recognition

There have been conflicting findings on the ability of people with BPD to recognise emotions in others, with some studies suggesting impairments in this area (Bland et al., 2004; Levine et al., 1997) and others finding an enhanced sensitivity in recognising emotions when compared to a control group (Lynch et al., 2006; Wagner & Linehan, 1999). Trait emotional intelligence (TEI), the ability to understand emotions in both the self and others, has also been found to be lower than that of healthy controls in a sample of people with BPD (Sinclair & Feigenbaum, 2012).

An explanation for the discrepancy in findings may be that experiencing rejection interferes with the ability to recognise emotions, causing people with BPD to perceive neutral facial expressions more negatively (Savage & Lenzenweger, 2018). Using the ‘Reading the Mind in the Eyes’ test, which measures the capacity to discriminate facial expressions by focusing on the eyes (Baron-Cohen et al., 2001) researchers found that after a virtually constructed social exclusion event, participants with higher scores of BPD pathology were more likely to rate neutral facial expressions more negatively (Savage & Lenzenweger, 2018). These findings are also in line with previous suggestions that people with BPD have a negative bias towards neutral faces and are more likely to

rate them as more rejecting and less friendly than healthy controls (Fenske et al., 2015; Meyer et al., 2004).

It may also be the case that people with BPD are more sensitive to recognising angry or threatening faces, due to experiencing more threatening situations, and this could make them more likely to have false-positive responses to neutral facial expressions (Fenske et al., 2015).

Hyper-mentalizing

In a study examining mentalizing in adolescents with BPD traits, researchers suggested 'hyper-mentalizing' (the over-interpretation of mental state reasoning) was strongly associated with BPD (Sharp et al., 2011). Researchers found that BPD traits were associated with making over-elaborate inferences that resulted in incorrect assumptions. The authors go on to suggest that the process of hyper-mentalizing causes the individual to over-interpret social cues which then leads to anxious ruminations thereby becoming a vicious cycle (Sharp et al., 2011). These findings have also been replicated more recently on an Italian sample (Somma et al., 2019), however as both studies used a sample of adolescents, caution should be taken when generalising to adults with BPD.

Model of Social Dissatisfaction in BPD

Considering these findings from empirical research, a model of social dissatisfaction in people with BPD is proposed (see Figure 1). Several theories aid the understanding of interpersonal difficulties in BPD. Biosocial theory explains how individuals with BPD have heightened affect and impulsivity and have likely experienced an emotionally invalidating environment (Linehan, 1993). Attachment theory suggests that the way an individual relates to others is influenced by their attachment relationship with their primary caregiver (Bowlby, 1988). Findings suggest there is a strong association with BPD and insecure attachment, which is a pattern of relating characterised by a sense of longing for contact yet being fearful of rejection (Agrawal et al., 2004). In addition, difficulties with

mentalization, i.e., understanding the mental states of the self and others, has been found to be a deficit in people with BPD (Bateman & Fonagy, 2004) along with impairments in epistemic trust (Fonagy et al., 2015), likely impacting on the satisfaction gained from relationships. Finally, a high proportion of people with BPD report a history of interpersonal trauma (Westphal et al., 2013), which contributes towards the formation of maladaptive cognitions which then impact on relating to others (Ehlers & Clark, 2000).

Within this in mind, a vicious cycle could also be maintaining the experience of social dissatisfaction in BPD. Experiencing stigma and rejecting attitudes from others is likely to lead to higher expectations of rejection and in turn incorrect assumptions when faced with neutral stimuli. From there, rejection is more frequently perceived, leading to social dissatisfaction, contributing to the experience of negative affect and more conflictual behaviour. This in turn reinforces the negative attitudes from others and maintains the cycle of social dissatisfaction.

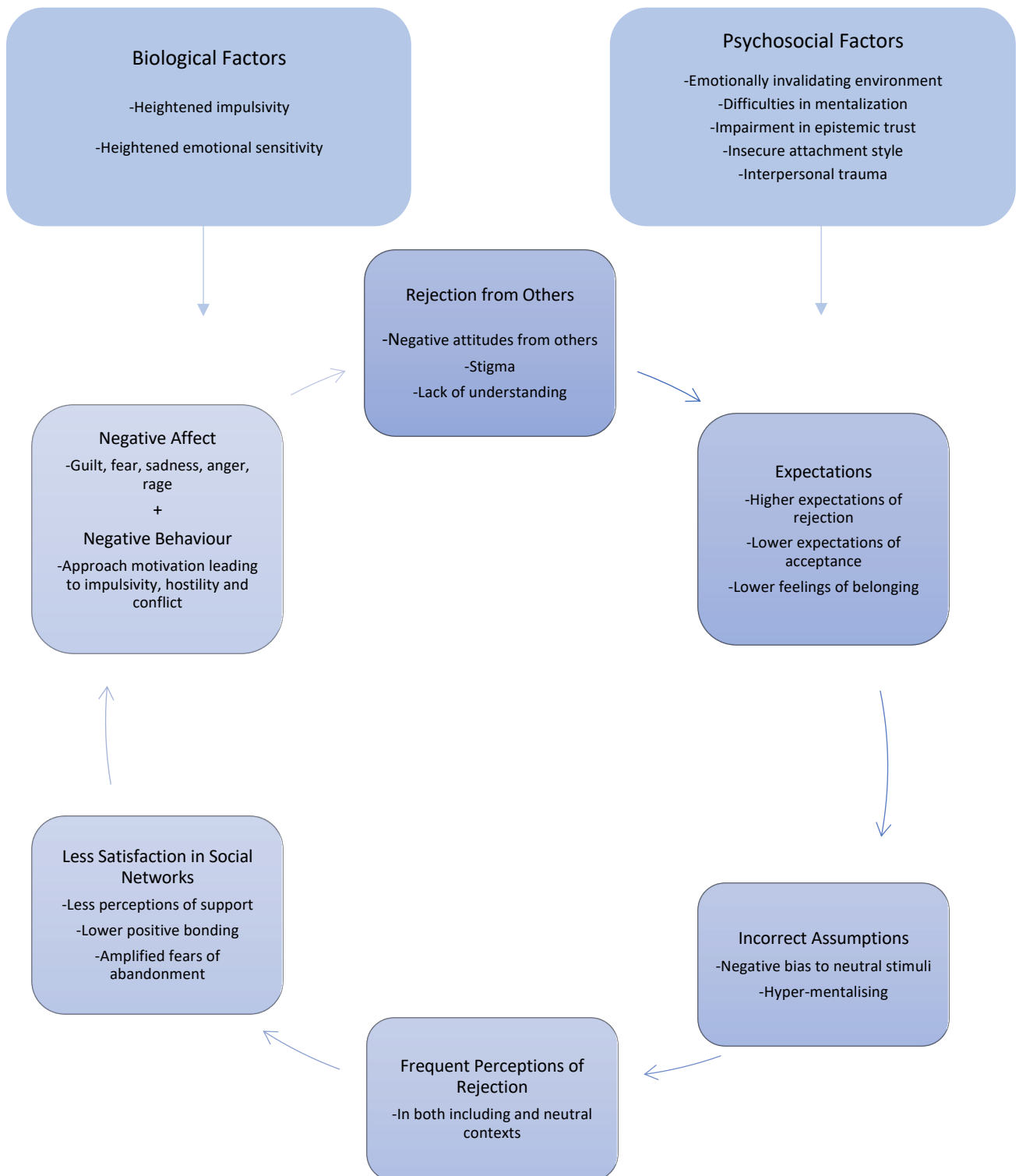
This model is important to consider as it summarises existing literature to suggest factors that maintain social dissatisfaction in BPD, which in turn may further the experience of loneliness.

Discussion

BPD is a serious mental health diagnosis in which interpersonal difficulties are a core feature (APA, 2013). Other features such as emotional dysregulation, self-harm, and suicidal behaviours often occur in an interpersonal context (Lazarus et al., 2018; Plener et al., 2015; Yen et al., 2020). In recent years, BPD has been associated with stronger feelings of loneliness when compared to the general population (Liebke et al., 2017). This is concerning as loneliness has a serious impact on health and wellbeing (Hawkley & Cacioppo, 2010), and a thwarted sense of belonging is a risk factor for suicide (Joiner, 2015). Due to the impact of COVID-19, the amount of time spent with others has vastly

Figure 1

Model of Social Dissatisfaction in Borderline Personality Disorder



changed (Sandford, 2020) and individuals with mental health conditions are particularly at risk of increased feelings of loneliness (Cacioppo et al., 2015; Saltzman et al., 2020).

As relatively few studies have explored loneliness in BPD, it is necessary to consult the literature on interpersonal factors in BPD. Research has suggested people with BPD are more sensitive to rejection, experience lower levels of acceptance, are more likely to experience negative affect, and engage in maladaptive behavioural responses when they feel rejected (Hepp et al., 2018; Lazarus et al., 2018; Staebler et al., 2011; Stiglmayr, et al., 2005). In addition, people with BPD experience feelings of rejection in inclusion contexts and feel less socially connected than controls in over-inclusion contexts (De Panfilis et al., 2015; Staebler et al., 2011). This is particularly pertinent as people with BPD who have prior experience of social exclusion are more likely to experience more negative relationships, lower positive bonding with others and lower positive group alliances (Euler et al., 2018). It is important to also consider that BPD remains little-known publicly (Rice-Oxley & Johnson, 2020) and has been subject to stigma (Campbell et al., 2020) and the negative attitudes of professionals (Lewis & Appleby, 1998).

Intriguingly, it does seem that there is some overlap between the literature on loneliness and the literature on interpersonal factors in BPD. For example, being highly sensitive to non-verbal cues and having a negative bias towards neutral responses has been attributed to experiencing loneliness in the loneliness literature (Gardner et al., 2005; Pickett & Gardner, 2005), and to BPD in the psychiatric literature (Fenske et al., 2015; Meyer et al., 2004; Savage & Lenzenweger, 2018). Furthermore, research suggests lonely individuals are less satisfied by their relationships and are more mistrustful of others (Hawkley et al., 2007; Rotenberg et al., 2004). Again, this is also represented in BPD research, with people with BPD being suggested to be less satisfied in their social networks (Lazarus & Cheavens, 2017) and more mistrustful of others due to an adaptive consequence of their social learning environment (Fonagy et al., 2017). This suggests interpersonal cognitions and reactions for both lonely individuals and people with BPD may form as an adaptive response to their social experiences with others.

Gaps in the Literature

After considering what is known from empirical research it is helpful to highlight the gaps in the literature.

The Experience of Loneliness in BPD

As discussed above, research has explored interpersonal factors in BPD, mainly focusing on the concept of rejection sensitivity and more recently looking at the social networks of people with BPD. Although some attempts in recent years have been made to understand loneliness in people with BPD, this experience remains largely unknown.

How did COVID-19 affect the Experience of Loneliness in BPD?

There has been much concern about the social impact of the current global pandemic, and in particular the rise in loneliness, in both the media and academic literature (Bu et al., 2020; Delaney, 2020; Wynn, 2020). Currently, to the author's knowledge, there is no known research that has investigated the effects of the pandemic on the experience of loneliness in people with BPD. This is particularly important, as this population is known to be at higher risk of loneliness than the general population, and therefore particularly vulnerable to loneliness during a period of forced isolation and social distancing.

Loneliness versus BPD

As mentioned above, there seems to be a commonality between some of the interpersonal difficulties faced by lonely individuals and those with BPD (Fonagy et al., 2017; Hawkley et al., 2007; Lazarus & Cheavens, 2017; Rotenberg et al., 2004). More research is required to understand whether factors previously attributed to BPD - such as being highly sensitive to rejection - could in fact

be attributed to the experience of loneliness, and thus, rather than pathologizing these concepts, they could be better recognised as an adaptive coping strategy.

Views of Others

Due to the relational context of loneliness, and indeed many of the symptoms experienced by those with BPD, is it important to understand the role of the social contacts of people with BPD to complete the picture. For example, how do they experience being friends with someone with BPD? How much understanding do they have of BPD? And how do they respond to people with BPD? These answers would be important in understanding the role others play in the experience of loneliness in BPD.

How do Psychologists Research Interpersonal Difficulties in BPD?

There are a variety of ways in which researchers have examined the interpersonal difficulties of people with BPD, ranging from quantitative research using measures, network analysis, or virtually constructed replications of social experiences, through to qualitative studies using diary entries or narrative phenomenological analysis. Due to the limited research on how people with BPD experience loneliness it is proposed that it is of high importance to hear the perspectives of people with lived experience of BPD in order to shape and refine our understanding. In addition, the global pandemic has brought with it unprecedented social changes to society. As mentioned previously, no known published research has explored how people with BPD have experienced the pandemic in relation to the experience of loneliness. As this is an unparalleled event it is fitting to explore how this has been experienced by people with BPD by hearing directly from them.

In order to bridge this gap, the current research study will use a framework analysis (Ritchie & Spencer, 1994) to understand how people with BPD experience loneliness, both before and during COVID-19. Framework analyses involve a structured sequence of steps for identifying themes in qualitative data in a systematic fashion (Ritchie & Spencer, 1994). This methodology allows the

researcher to explore inductive ideas that come directly from the participants and also deductive ideas informed by the pre-existing theories of interpersonal difficulties in BPD (Ritchie & Spencer, 1994).

Summary and Aims of the Thesis

In summary, the research study aims to understand how people with BPD experience loneliness, both before and during COVID-19. This review has explored the key concepts in detail including BPD, loneliness and the current context of COVID-19. In addition, the review has summarised the limited empirical research on loneliness in BPD and has also considered wider theories on interpersonal difficulties in BPD including attachment theory, mentalization, epistemic trust and biosocial theory. The review continued to synthesise empirical research on interpersonal factors associated with social dissatisfaction in people with BPD and from this proposed a model of social dissatisfaction in BPD. Finally, gaps in the current literature have been highlighted, leading to the importance of further research to understand how people with BPD experience loneliness, both before and during COVID-19. The study plans to employ a framework analysis to ensure there is the potential for new understanding from the qualitative data, whilst also considering what is known from the current evidence-base for interpersonal difficulties in BPD.

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Part 2: Empirical Paper

'An Emptiness of Connections':

**The Experience of Loneliness in Borderline Personality Disorder, both Before and During the
Coronavirus Pandemic**

Abstract

Introduction People with borderline personality disorder (BPD) report higher levels of loneliness than the general population (Liebke et al., 2017), yet little is understood about how they experience loneliness or what helps them to feel more connected to others.

Aims This qualitative study explores the experience of loneliness in people with BPD both before and during the coronavirus (COVID-19) pandemic.

Methods Twenty participants, who self-reported that they had received a diagnosis of BPD, were recruited via social media and interviewed using a semi-structured interview. Data was analysed using a framework analysis approach.

Results Eight main themes were identified that described elements of participants' experience of loneliness, both before and during COVID-19. Participants described loneliness as a challenging experience which involved balancing the fears and cravings of connection with others. The pandemic reduced access to coping strategies and reinforced anxieties about the self and others.

Conclusions This study complements and extends existing research in loneliness and BPD and offers a framework of themes to understand this experience. Future investigative research could build on the themes identified in this study.

Introduction

Loneliness

Loneliness is defined as “a distressing feeling that accompanies the perception that one’s social needs are not being met by the quantity, or especially the quality, of one’s social relationships” (Hawkley & Cacioppo, 2010, pp.218). Therefore, loneliness can be thought of as the feeling of being alone, rather than objectively being alone or being social isolated (Hawkley & Cacioppo, 2010). This

emphasises the subjective nature of the experience of loneliness, which may go some way to explaining why those who feel alone do not spend more time alone than those who feel more connected (Cacioppo & Patrick, 2008).

From an evolutionary psychology perspective, the desire to affiliate and be part of a group was important to increase survival chances (Schacter, 1959). It has been suggested that loneliness may have formed as a 'social pain' to protect people from social isolation; in a similar way that physical pain functions to protect people from physical dangers (Eisenberger et al., 2003). In contrast, feeling socially connected has been linked to experiencing less agitation and stress (Cacioppo & Patrick, 2008). In modern society, Western cultures have been described as individualistic rather than collectivist in nature, prioritising personal needs over connectedness and interdependence (Krassner et al., 2017; Hamamura, 2012). In individualistic cultures, it is suggested that loneliness can be stigmatised and viewed as being 'needy' or neurotic, whereas time alone is more positively perceived as an act of independence and self-care (Cacioppo & Patrick, 2008). Furthermore, the way of life has changed over the years, with more people moving away from their home towns to larger cities for work and study; and the proportion of people living alone rising (Sharfman & Cobb, 2021). A recent report by the UK government suggested 'movers' to larger cities experienced more loneliness, whereas those who stayed in their home towns reported stronger social connections (Papoutsaki et al., 2020).

In addition to the changing nature of society and social patterns, experiencing loneliness can change social cognition and cause individuals to act in ways less likely to invite connection (Cacioppo & Patrick, 2008). Lonely individuals may form confirmatory biases that are self-protective but also potentially self-defeating, for example believing others are untrustworthy and in turn withdrawing from social interactions, thus creating a vicious cycle (Cacioppo & Hawley, 2009). Studies suggest lonely individuals perceive a nurturing response from a friend as less fulfilling than hoped for (Hawley et al., 2007) and are more distrustful and less accepting of potential new friendships (Rotenberg et al., 2004; Rotenberg & Kmill, 1992). Along with this, people reporting more loneliness

are highly focused on social connection and rejection cues, yet are less able to read facial expressions accurately, with a bias towards interpreting them negatively (Gardner et al., 2005; Pickett & Gardner, 2005).

Lonely individuals have also been found to be painfully aware that their social needs are not being met, but at the same time believing they have little control over their ability to fulfil their social needs (Solano, 1987). In addition, lonely individuals have been found to be more willing to accept social exploitation, even when they are aware they are being treated unfairly (Cacioppo & Patrick, 2008). This could suggest they are less discriminating in whom they spend their time with, which may reinforce further feelings of mistrust in others, again leading to a vicious cycle (Cacioppo & Patrick, 2008).

Loneliness and Physical Health

Researchers have discovered a relationship between loneliness and physical health difficulties (Malcolm et al., 2019; Yanguas et al., 2018). Lonely people have been found to be at elevated risk of coronary heart disease and cardiovascular problems (Caspi et al., 2006; Herlitz et al., 1998; Orth-Gomér et al., 1988; Sorkin et al., 2002;). Loneliness has also been linked to breast cancer (Fox et al., 1994), Alzheimer's disease (Wilson et al., 2007) and increased susceptibility to infectious diseases (Pressman et al., 2005; Steptoe et al., 2004). In addition, both loneliness and social isolation have been found to be risk factors for mortality (Holt-Lunstad et al., 2015). The exact mechanism between loneliness and physical health remains unclear, although some studies propose a link between loneliness, stress, and immune dysregulation (Hawkey et al., 2007). In addition, studies have suggested lonely individuals have an impaired ability to self-regulate, with individuals who feel excluded making more unhealthy food choices and giving up sooner on frustrating tasks (Baumeister et al., 2005). This may also contribute towards significant consequences on physical health and wellbeing (Cacioppo & Hawkey, 2009).

Loneliness and Mental Health

Along with physical health, loneliness is a predictor of more severe mental health symptoms and poorer self-rated recovery in a people who have experienced a mental health crisis (Wang et al., 2020). The same study also proposed that the perception of being alone (loneliness) was a greater predictor of mental health outcomes than objectively being alone (social isolation). Many studies have focused on the link between depression and loneliness (Adams et al., 2004; Alpass & Neville, 2003; Segrin, 1998) with loneliness being found to predict depressive symptoms (Cacioppo et al., 2010). A recent meta-synthesis suggests a vicious cycle between depression and loneliness in young people, with depression prompting withdrawal and a lack of confiding in others, leading to a sense of disconnection and loneliness which then can perpetuate depressive symptoms (Achterbergh et al., 2020).

Along with depression, loneliness has also been linked to psychosis (Lim et al., 2018), eating disorders (Levine, 2012), social anxiety (Lim et al., 2016) and borderline personality disorder (Liebke et al., 2017).

Borderline Personality Disorder

Borderline personality disorder (BPD) is a serious mental health difficulty characterised by difficulties in emotional regulation, social relationships, and an unstable sense of self (American Psychiatric Association [APA], 2013). People with BPD are at a heightened risk of suicide, with a risk of dying by suicide 45 times that of the general population (Chesney et al., 2014). There has been much focus on interpersonal difficulties in BPD, and in recent years studies have begun to explore the relationship between BPD and loneliness (Liebke et al., 2017; Nenov-Matt et al., 2020; Sagan 2017). People with BPD report higher levels of loneliness than the general population (Liebke et al., 2017; Nenov-Matt et al., 2020). Despite this, little is known about how people with BPD experience loneliness, or how this experience has been affected by the current global coronavirus (COVID-19) pandemic. This is important to explore as social disconnection, or the thwarted sense of belonging, has been proposed

as a key risk factor in why people die by suicide (Joiner, 2005), which is particularly pertinent for this clinical population. Therapeutic approaches for BPD may benefit from a deeper understanding of how loneliness is experienced by people with BPD in order to improve social connection and wellbeing.

COVID-19, Mental Health and Loneliness

Due to the profound changes to daily routines and social contact during the COVID-19 pandemic (HM Government, 2021) it would be remiss not to consider the impact on loneliness. Studies have found people with COVID-19 are more likely to have psychiatric illnesses and be lonelier (Li & Wang, 2020) which is in line with previous research suggesting lonely individuals are more susceptible to infectious diseases (Pressman et al., 2005; Steptoe et al., 2004). In addition, a recent longitudinal analysis of loneliness and anxiety during COVID-19 suggests younger people and those with a history of mental health difficulties expressed the highest levels of loneliness during the first few months of the pandemic (Varga et al., 2021).

To date, to the author's knowledge, only two studies have examined the impact of COVID-19 on people with BPD. One of which, a case study of a patient in Malaysia, found the patient experienced increased fears of abandonment and emptiness during the pandemic (Chong, 2020). The other proposed clinical hypotheses based on the current literature and suggested people with BPD were at increased risk during the pandemic due to their need for physical and emotional proximity to others to support them to regulate their emotions and protect from fears of abandonment (Preti et al., 2020).

Aims and Objectives

Therefore, to advance the literature on loneliness in BPD, both before and during the COVID-19 pandemic, a systematic, inductive investigation of loneliness in this population is required. As such, a qualitative approach was employed to allow for an exploration of the experience of loneliness in

BPD and the impact of COVID-19 on this experience. Specifically, this study used semi-structured interviews (Appendix A) to address the following questions:

- a. How do people with BPD experience loneliness?
- b. How did COVID-19 impact their experience of loneliness?

Methods

Overview

Adults living in the UK who had been diagnosed with BPD were invited via social media to contact the researcher to participate in an interview which included questions about their experience of loneliness and how the COVID-19 pandemic has impacted on this experience. All interviews took place between August-December 2020 during the COVID-19 pandemic in the UK.

Ethical Approval

Ethical approval was sought and approved by the UCL research committee (code: 18285/001; Appendix B).

Recruitment Procedure

Adults who had received a diagnosis of BPD were invited to participate in the research via social media. Advertisements were posted onto *Twitter* and BPD *Facebook* groups (Appendix C) with a description of the study and a link to the study website (Appendix D). The study website provided further information about the study and included the participant information sheet (PIS; Appendix E), a support document with details of self-support skills and support available if feeling distressed (Appendix F) and a contact email for the researcher to ask questions about the study or indicate interest in participating. When a potential participant emailed the researcher, the researcher again provided the participant with the PIS and support document to direct them to these and offered

them the opportunity to ask any questions. A consent form and demographics questionnaire (Appendix G) were emailed to the participants which were returned to the researcher prior to the interview commencing.

Participants

Adults were eligible to participate in the research if they met the following criteria:

1. Received a diagnosis of borderline personality disorder
2. Currently living in the UK
3. Aged 18 years or above
4. No current or previous diagnosis of psychosis or cognitive impairment

Table 1 provides an overview of the demographics of those who participated in the study. Thirty-six adults contacted the researcher asking to participate in the study or for further information. One did not meet criteria due to living outside of the UK. (Only those residing in the UK were invited to participate to control for cultural or contextual factors, such as different national responses to the COVID-19 pandemic, influencing the responses). Twelve did not respond following the initial email contact for reasons unknown and a further three contacted the researcher after the data collection period had been completed. The mean age of participants was 31.2 years, with 16 females, three males and one person who identified as 'agender'. All participants resided in the UK, spanning 14 counties. Participants reported varying levels of mental health support, with 11 under the care of NHS mental health services, eight discharged from services and one who had not received treatment for BPD from the NHS.

Design

The research design of this study was qualitative which allowed for the production of new ideas from the in-depth accounts of the personal experience of loneliness from individuals with a

Table 1*Participant Demographics*

Participant No.	Age at time of interview	Gender	Ethnicity	Sexual Orientation	Religion	Marital Status	Employment
P01	34	Female	Mixed/Multiple Ethnic Groups	Heterosexual	Other	Co-habiting	Freelance
P02	28	Female	White/White British	Other: Asexual	No Religion	Single	Health Care
P03	36	Male	White/White British	Heterosexual	No Religion	Married	Professional
P04	34	Female	Black/Black British/African/Caribbean	Heterosexual	Christian	Single	Health Care
P05	33	Female	White//White British	Other	Other	Single	Hospitality
P06	37	Female	White/White British	Heterosexual	No Religion	Married	Stay at home parent
P07	27	Female	White/White British	Heterosexual	Christian	Single	Professional
P08	27	Female	Asian/Asian British	Heterosexual	Muslim	Single	Freelance
P09	27	Female	White/White British	Other	No Religion	Single	Health Care
P10	48	Female	White/White British	Heterosexual	No Religion	Single	Unemployed
P11	28	Female	White/White British	Heterosexual	No Religion	Co-habiting	Stay at home parent
P12	30	Male	Black/Black British/African/Caribbean	Gay/Lesbian	Christian	In a relationship (separate households)	Student and Freelance
P13	41	Male	Asian/Asian British	Heterosexual	No Religion	Single	Freelance/ Professional
P14	31	Female	White/White British	Heterosexual	No Religion	Single	Unemployed
P15	30	Female	White/White British	Heterosexual	No Religion	Married	Professional
P16	26	Female	White/White British	Heterosexual	No Religion	Co-habiting	Professional
P17	29	Female	White/White British	Heterosexual	Christian	Single	Professional
P18	25	Agender	White/White British	Other: Queer	No Religion	In a relationship (separate households)	Student
P19	31	Female	White/White British	Gay/Lesbian	Christian	Co-habiting	Student
P20	22	Female	White/White British	Gay/Lesbian	Christian	Co-habiting	Student

diagnosis of BPD. Participants were interviewed using a semi-structured interview, designed in collaboration with the project supervisor JF who is a clinical psychologist and the clinical and strategic lead for personality disorder services in North East London NHS Foundation Trust.

Procedure

Participants were given the opportunity to ask questions before agreeing to be interviewed. The consent form required the participants to indicate their name, date of birth, General Practitioner (GP) and mental health team (if they were currently receiving treatment from one). It was explained, both verbally and in the PIS, that this information was taken as a safety precaution and the researcher would contact their GP and mental health team if safety concerns were raised during the interview.

A semi-structured interview format was used, allowing participants to elaborate on their experiences and for the researcher to check their understanding and enquire further into their personal descriptions. Interviews typically lasted about an hour, with all but one taking place over *Microsoft Teams*, and the remaining person requesting a telephone interview instead. At the end of the interview participants were thanked for their time and provided with a shopping voucher. Participants were also informed that those interested could find a summary of the results of the research on the research study webpage in September 2021.

Analytic Procedure

Just over half the interviews were transcribed by the researcher SP with the remaining nine transcribed by a research assistant. Each transcript was initially coded by the researcher (Appendix H), using the *Nvivo* program, and then a smaller sample were discussed with both supervisors JF and WT. Transcripts were analysed using framework analysis (Gale et al., 2013; Ritchie et al., 2003; Ritchie & Spencer, 1994). This approach was chosen as it offers a systematic process to qualitative data analysis and allows the researcher to be transparent in the analysis throughout. Framework

analysis also offers the opportunity for both inductive and deductive (data-driven) ideas to be considered in answering the research questions. Data from each transcript was charted into the framework matrix (Appendix I) and finally considered alongside existing literature.

The stages of framework analysis (Gale et al., 2013; Ritchie et al., 2003; Ritchie & Spencer, 1994) are as follows:

1. *Transcription*: Interviews are transcribed verbatim, in a format that allows them to be read several times and for notes to be made in the margins.
2. *Familiarisation*: This involves spending time reading the transcripts and listening to audio recordings multiple times to become familiar with the data. During this stage the researcher also reads any reflective notes made during the interviews.
3. *Coding*: The transcripts are read line by line and a label or 'code' is applied to the data. This aims to classify all the data so it can then be applied systematically to the rest of the dataset.
4. *Developing a working framework model*: After initial coding on the first few transcripts all researchers meet to agree a set of codes to apply to all transcripts. Codes can be grouped together, and this forms the working analytic framework.
5. *Applying the analytical framework*: The working analytic framework is applied to subsequent transcripts using the created codes and categories. Codes are assigned a number or abbreviation for ease.
6. *Charting data into the framework matrix*: This involves summarising the data from each transcript into the framework matrix.
7. *Interpreting the data*: Finally, the data is considered alongside existing literature, considering prior theoretical concepts and findings generated directly from the data.

Throughout the framework analysis, credibility checks were completed to ensure that interpretations of the data were fair and logical. A consensus approach was employed (Barker & Pistrang, 2005), whereby SP took the lead in the analysis, but discussed the data with supervisors JF

and WT and audited the framework against transcript data until agreeing a final set of themes and sub-themes. Respondent credibility checks were also completed to promote testimonial validity (Barker & Pistrang, 2005) by contacting participants via email to share the framework and welcome feedback on whether it adequately represented their views expressed in the interviews (Appendix J).

Disclosure of Researcher's Perspective

I am a White-British cis-female researcher who completed this research as part of my Doctor of Clinical Psychology training. I come from a relativist phenomenological stance. I have a background of working in secondary care adult mental health services with people with severe and enduring mental health difficulties. In my clinical experience I have been drawn to thinking about the way we as humans relate to one another, and the difficulties that come up when we struggle to connect. Due to this I am particularly interested in working with people with BPD to help them to understand their emotional experience and form more satisfying and meaningful relationships. Prior to the research I had a bracketing interview (Appendix K) to think about what had drawn me to this research and any preconceptions I might have about this topic or client group. One of my expectations from the research was that a history of interpersonal trauma would play a role in the experience of loneliness in people with BPD, however I was interested to find out more about this. Throughout the research I kept a reflexive journal to document thoughts, ideas and feelings following each interview in order to make myself conscious of this process. In the analysis process I was supported by my supervisors to be reflective on my own position and be thoughtful about how this might influence the analysis. Using framework analysis allowed me to be systematic and transparent in the analytic procedure and this was also supported through regular conversations with my supervisors. Despite all my attempts to be transparent about my position and the process I continue to work from the understanding that as the researcher I am an inherent part of the research and cannot remove myself entirely.

Results

The transcripts of the 20 participants were analysed using framework analysis (Gale et al., 2013; Ritchie et al., 2003; & Spencer, 1994). Eight themes were identified which were organised into two domains corresponding to the research questions (1) the experience of loneliness in people with BPD and (2) the experience of loneliness in BPD during COVID-19. Domains, themes, and sub-themes are summarised in Table 2. Quotes were incorporated into the title of themes in attempt to remain close to participants' language. Themes are presented below with illustrative quotations from those who participated.

Domain 1. The Experience of Loneliness in people with BPD

The themes in this domain concern how loneliness feels to those with BPD, the challenges that they face, the impact of the experience of loneliness, and the factors that help them to feel more connected to others.

1:1 "Standing on the Edge"

Many participants described a sense of feeling alone, even when they were with other people. Some made efforts to describe why this was – e.g., feeling caught up with their own thoughts or struggling to feel connected to others.

I could be surrounded by tons of people; I could still be in that moment and still not even be engaging in what's happening around me because I'm stuck in my own head. (P09)

Even when I was surrounded by people, I felt alone because I felt, I had difficulty making deep connections with people (P07)

Table 2*Framework of Domains, Themes and Sub-Themes*

Domain	Theme	Sub-Theme	Frequency (out of 20)
The Experience of Loneliness in people with BPD (1)	1.1 “Standing on the Edge”	Feeling alone with others	12
		Unable to find a solution	16
		Intensifies my emotions	15
		Enhancing the feeling of emptiness	15
	1.2 Fears about connection: “I’m Better off Alone”	I’m different and I do not belong	15
		Protecting others from me	17
		Protecting myself from others	17
	1.3 “I Crave that Intimacy”	Desire for closeness	11
		The struggle to be alone	14
	1.4 “Double-edged Sword”: Balancing the Fears and Cravings	Internal dialogue	16
		Social chameleon	14
		Tip of the iceberg	13
		Filling the void	16
	1.5 Outside Influences: “The Perfect Storm”	Stigma	15
		Intersectionality	9
		Previous experience of trauma	16
	1.6 Fostering Connection: “Learning to be Vulnerable”	Learning to understand myself	16
		Being accepted and understood by others	14
		Peer support “finding my tribe”	15
Finding a common ground		14	
Believing I have something to offer		13	
The Experience of Loneliness in BPD during COVID-19 (2)	2.1 Thrown “Off Balance”	Disruption to work/study	14
		Impact on family life/support network	15
		Changes to my mental health support	12
		Reduced and inconsistent contact with others	20
	2.2 From “Managing to Self-Destruct”	Magnifying fears of connection	16
		Lack of access to healthy coping strategies	18
		Falling back into harmful strategies	18

Most participants spoke about feeling powerless to change their feeling of loneliness or unable to “find a cure” (P08).

And I was always trying to think, how can I change this? How can I make this better? And I would think about that a lot, but just never really be able to get any further than just thinking about it (P11).

Several participants spoke about the link between their emotional experience and loneliness. Some people suggested “...loneliness makes mood swings worse” (P12) and can play a role in moments of crisis.

...the impulsive behaviours are the bits that people see. And the bits that need the treatment, or their reactions, not the loneliness, like they don't see why you got to that point, they just see you at that point, so like, if you're on the side of a bridge, they see you as on the side of a bridge, they don't see you as how you got from A to Z (P09).

Others described how feeling emotions more intensely than others can contribute to beliefs about being different, triggering further feelings of loneliness.

I think the intensity of the emotions we feel [contributes to loneliness], people are afraid to express that because they're afraid they might fear people, or people may fear them (P19).

Most participants described emptiness and loneliness as two separate – but linked – concepts, with loneliness being “an emptiness of connections” (P11), and disconnection from others that can then lead to feeling numb, empty and apathetic.

I think that the emptiness feeling often comes when I feel sort of disconnected from the world and from people. Where I feel that I'm sort of very much on the outside of things (P01).

I think they are different feelings, but the loneliness definitely exacerbates the hollow sensation (P03).

1:2 Fears about Connection: “I’m Better off Alone”

A sense of feeling different, other, and of not belonging dominated the participants accounts of loneliness, with some feeling that others were incapable of understanding them.

I just don't feel like anyone gets it and anyone gets me. Even my husband, I mean, I've known him for 20 years... it's because of the way that I think, it's so different to normal people, that I constantly feel on my own (P06).

Participants spoke about fears about themselves that held them back from connecting with others. Some of these included worrying they were too intense or a burden on others, others had concerns about having an angry outburst at their friends, whilst some felt a general sense of being ‘not good enough’ or ‘unlovable’.

I'd have these internal voices saying but you don't have anything to offer. You know, there's nothing good about you, you've got no value...I'm better off alone: people can't hurt me and I can't hurt other people (P14).

Along with fears about themselves, participants also spoke about a wish to protect themselves from potential hurt caused by others.

And it does feel like I can't open up about who I am and how I feel because I can't trust other people with it. I can't trust people to understand that. I certainly don't feel like I can trust them to care about it (P18).

1:3 “I Crave that Intimacy”

Despite the fear of connecting with others, many participants spoke about their desire to have close relationships and feel accepted and understood.

So like, you would long to have that person to speak to and to have that kind of relationship to offload and to be like 'this is the real me', like 'this is what I'm going through and this is, this is where I need the help, this is where I need support' and 'can we discuss this' (P20).

In addition, several participants spoke about how challenging it can be to spend time alone.

It's really difficult spending loads and loads of time by yourself... I would say that I could probably only spend like half a day by myself (P12).

I can't stand my own company. I don't find myself a very interesting person. I'm not one of these that can, if I if I go for a bath or something I like to have someone to talk to in the bath (P19).

1.4 "Double-Edged Sword": Balancing the Fears and Cravings

Participants attempted to balance both their fear of connection and craving for it. Many participants spoke about tuning into the facial reactions and body language of others to interpret their intentions. Others spoke about how they noticed an internal dialogue in their mind as they were speaking with others, that could be negative and distracting from the conversation, particularly if visual cues did not correspond with the person's words.

My internal dialogue is hypercritical and aggressively damaging at times...And it almost becomes a vicious cycle. Because, by definition, you're less good at picking up on social cues if you're not really paying attention to what's happening around you, because you're too busy listening to the internal dialogue so you miss social cues. And there is that feeling of awkwardness, it's not imagined because you're not paying attention (P03).

Several participants spoke about feeling the need to mirror the behaviour of others or become a “social chameleon” (P20) to be accepted. However, this process led them to feel less known by both themselves and others.

I really struggled with wanting to sort of be whoever everyone else wanted me to be, and so I would try and figure out what I thought other people wanted from me and try and be that person interacting with them rather than being myself (P02).

I'd always be like, almost like a social chameleon. In that I'd like, try and be really nice to everyone and everyone is my friend. But then I think that meant that I didn't feel like I had a full friend in anyone because like I just knew everyone, but I wasn't fully in anyone's group. And so I think that was partly where the loneliness feeling came from (P20).

One participant related this social mirroring to the experience of having an unstable sense of self, saying:

I think if you can't understand who you are then it's very difficult to relate to other people and therefore, you know, it's difficult to connect to people (P01).

Along with feeling the need to mirror others, many participants spoke about letting people in, but only so much. E.g., only showing them the “tip of the iceberg” (P09) rather than opening up completely.

I think it's just like a protective thing. Like, I just don't want people to fully see like what's going on... And, like, it's easier for me to keep people like, at that distance, rather than like, letting them in, and then getting hurt by them (P17).

Some people spoke about “filling the void” (P06) to feel less lonely. For some, this meant being less distinguishing about who they had contact with to escape feelings of loneliness. However,

participants acknowledged that this left them with emotional “scars” (P16) and further reduced their trust.

I think that kind of loneliness completely fed my, you know, my going towards kind of unhealthy relationships, and not even relationships, just unhealthy, casual sex with people was completely linked to my loneliness, because I couldn't stand myself. I couldn't stand kind of just being me, compared to when I'm with someone, and they're appreciating me and they're enjoying me (P16).

For others, filling the void caused by loneliness meant engaging in other potentially harmful behaviours such as “going out a lot, drinking, taking drugs, having sex with random people and shopping” (P01).

1.5 Outside Influences: The “Perfect Storm”

Participants spoke about influences outside of their control that had an impact on their experience of loneliness, causing a “perfect storm” (P03). Most people spoke about the effect of stigma on their experience of loneliness, leading them to be more guarded about their diagnosis and therefore feel disconnected from others.

Um, I, I don't tell people I have it. I will quite happily tell them I have generalised anxiety disorder, post-traumatic stress disorder and bulimia, but I will not tell them about this... Because if you say you have a personality disorder, everybody thinks you're a psychopath (P06).

Some also felt the stigma of BPD was present amongst mental health professionals, leading some people to be less trusting of accepting support.

I'm always told how clinicians feel like, it's like a controversial diagnosis, and that people with BPD are horrible and manipulative and difficult to treat (P15).

The intersectionality of other minority experiences also had an impact on loneliness for some. Participants spoke about issues of inclusion, such as not being able to follow group conversations due to a hearing impairment or being unable to physically access the community.

I can't actually walk so I'm actually; I've been stuck in my house since April last year. I haven't been outside apart from being in hospital. I haven't seen anybody since February apart from when I was in hospital (P10).

For some, the aspects of their identity that were minoritized, such as ethnicity, religion, gender, and sexuality, reinforced the experience of feeling “more different to others and more distant from the things other people seem to want” (P02) along with their fears of connecting to others.

...we live in a white British conservative area and there's no support networks here for us. There's no sort of community for us here, we just live in it, we're just a brown family living in a white, middle class sort of racist area, really, I'd say. And obviously, we've suffered a lot of racial discrimination over the years...So we're obviously never going to be important (P08).

Several participants spoke about past traumatic experiences impacting their patterns of relating to others and continuing the cycle of disconnection. Some spoke about learning it was safer to keep a distance from people, so you are not hurt, and others spoke of continuing to struggle to trust.

And then having carried that into adulthood um I didn't get seen when I needed to be seen as a kid like you know people aren't hearing, aren't seeing, aren't knowing what was going on. And I guess I still feel like that now. But at the time I just thought, well, why, why does nobody know that this is happening? Why is nobody paying attention to me? Is something wrong with me? Am I different? And I've just carried that forward till now, I guess (P18).

1.6 Fostering Connection: “Learning to be Vulnerable”

Participants also spoke about factors that promoted connection with others. One of which was learning to accept and understand themselves, through therapy or life experience.

I think I've definitely been using my [dialectical behaviour therapy (DBT)] skills so I split on people less. And I notice when I'm doing it more as well. And I can sort of say, actually, you know, people aren't wholly good or wholly bad. And yes, they've done, may have done something to upset you. But that doesn't mean that you need to cut them out of your life or to completely avoid them (P07).

And like, in recent years, I've got better being myself and being OK with that (P02).

Participants also spoke about how opening up to others, and in turn feeling understood helped to foster feelings of connection, both with friends and mental health professionals.

I think I kind of learned then from that, to like, let myself be more vulnerable with people and then I made some really close friends that I feel like actually know me and know like the depth is going on underneath (P20).

...I've had counselling throughout the years. And I found it helps with loneliness, because, because of the quality interaction with the therapist, more than the techniques that they use I guess if that makes sense...And that made me feel less lonely because that made me feel, that made me feel understood (P15).

Peer support was another source of connection to others, with many participants expressing a deeper understanding from those with similar experiences and others suggesting “nobody understands unless they have it” (P06).

...when I went to the [DBT] group, I felt less lonely because I was in a room of people, and I could say what I wanted to say, and they automatically got it. And it was that click, they may

have not had the same experience as me. But they automatically got how I got from A to Z. And they understood the chain that I went through. And that was when I realised how lonely I was beforehand (P09).

However, some were cautious about this, suggesting the need for safe boundaries and for both parties to be engaging in their own recovery.

Finding common ground with others was another way that participants found helped to foster connections with others. This included watching football, being part of a choir, dog walking, parenting and collectors' groups.

Yeah, so I'm quite social. But I'm socially awkward, I need a social prop, I think is the best way to describe it. So I had a brilliant time at the football with [son]. And because there's a set social framework, that there are, there were clear social rules, and it's okay to talk to strangers, at the football because you're talking about the football... I've got my safe social prop, we are at this place with these rules. And I'm away and I'm happy, I'll chat to people and I won't be lonely, because I'll just absolutely go all out there (P03).

Finally, participants spoke about how the belief that they have something to offer encouraged them to try to connect with others. Examples of this included through work, caring for children or pets and volunteering.

My career was a place I was needed by both adults and children. Leading to not feeling chronically alone (P14).

I got a kitten and she's been brilliant because at the beginning she needed me for everything. And she was always on top of me and it felt like having a purpose because she needed everything (P05).

Domain 2. The Experience of Loneliness in people with BPD during COVID-19

The themes in this domain examined the impact of the current pandemic on loneliness for people with BPD. This included the changes to daily life and how these influenced their thoughts, emotions, and behaviour.

2.1 Thrown “Off Balance”

During COVID-19, many participants spoke about a disruption to their employment and/or education.

So basically, a lot of my basically, my, my role is very face-to-face. And the biggest difference was obviously being told that we, you know, all face-to-face stuff is now gone, for now, it's now been suspended until further notice and that. Yeah, that, you know, the things have to be done via Zoom or Microsoft Teams (P04).

Alongside this, participants also experienced changes in their family lives and support networks, including coping with having their children at home, the mental and physical health of partners and family members, and lack of access to support networks.

Umm well my parents were always the ones who would look after her. But since this [lockdown] happened, I mean, my dad's got COPD. My mum's got epilepsy, so they can't kind of look after her at all. So since kind of lockdown happened, it has just been me and my daughter (P06).

Many participants spoke about changes to their mental health support, such as a move to remote appointments, long waiting times for treatment, and reduced contact with their mental health service.

So, the mental health system just collapsed during COVID[-19]. So, I had this urgent referral to [service name], which is some local mental health team. And that was in February. And it wasn't until, it was like, late July, until I heard from them again. And I had an assessment with them in late July. And they've sort of put me on the waiting list for trauma-focused CBT [Cognitive Behavioural Therapy]. And that hasn't come through yet. And so, they're expecting that to come through in December (P13).

All participants spoke about a reduction and/or an inconsistency in their contact with others. Some spoke about how in the early stages of lockdown contact increased with video calls and quizzes, however this quickly “dwindled down” (P17).

I was probably having a phone call or Zoom call with someone every day of the week to begin with. But then quite quickly that dissipated and became a lot less and still like some people I do speak to regularly, like I've got a friend who I have a phone call with pretty much every weekend - but less so during the week now. And so, it kind of peaked quite early on in lockdown (P02).

Others spoke about how challenging it was to have a reduction in physical presence and contact from others.

...just relying on phone contact has been really hard. Because you just you just want to feel that hug from somebody that that contact that that reassurance, that love (P19).

2.2 From “Managing to Self-Destruct”

For many, the pandemic reinforced fears about connecting with others. These included strengthening their belief that they are different from other people due to differing thoughts about, and responses to, the pandemic and intensifying fears of being abandoned by others.

And I was seeing her [counsellor] every week. And we were like talking so much about like trusting things and like trusting that she wasn't going to suddenly abandon me. ... And so then it just felt like a massive kick in the teeth when then in March, it was like, well, you can't trust the entire world. Because look at what's happened now (P20).

Significant changes to daily life meant most participants had reduced access to their usual coping strategies, such as meeting up with a close friend, going to the gym, or being around other people without interacting with them.

It has been really hard, right at the beginning of the pandemic when I was having a particularly difficult time when I was off work because I basically just really struggled to adjust to the change in routine and the loss of all of my usual coping strategies, which all involve being outside, apparently (P02).

With the lack of access to usual coping strategies and support networks, several participants spoke about falling into more harmful ways of coping. Some of these included withdrawing from others, self-harm, and over- or under-eating.

And for me because of lockdown, I've have had many moments where I've just been in bed for weeks, and I've not gone anywhere, or I've not gotten changed, I've not eaten, I've not dressed I've not, you know, it all just goes out the window (P08).

Discussion

This study aimed to provide a qualitative account of the experience of loneliness in people with BPD, both before and during COVID-19. The findings highlight the distress caused by loneliness, ways in which people with BPD try to balance the fears and cravings of connection, the impact of outside influences on loneliness, and the factors that help to foster connection. In addition, the findings

show that the pandemic caused significant disruptions to employment, education, mental health support, family, and support networks and that contact with others was reduced and inconsistent. Finally, the findings also suggest that the impact of the pandemic meant many previously held fears about the self and others were magnified and, with reduced access to usual coping strategies, many turned to more harmful methods of coping.

A key finding from the study was that loneliness can have an impact on other symptoms of BPD such as emptiness and emotional regulation. This is in agreement with previous research suggesting loneliness and emptiness are distinct concepts (Miller et al., 2020); however it furthers this by suggesting that the experience of loneliness can lead to, or enhance, feelings of emptiness in people with BPD. This is important to consider as the experience of chronic emptiness has been suggested as a significant marker of psychosocial impairment in people with BPD (Ellison et al., 2016; Elsner et al., 2018). The study also highlights that people with BPD struggle to know how to cope with, or 'fix', their experience of loneliness. Previous research on loneliness has found lonely people struggle to feel a sense of agency over their situation, suggesting this is not unique to people with BPD (Tankersley et al., 2007). However, feeling powerless to change one's social situation may contribute to a more intense emotional response and difficulty regulating these emotions.

Participants voiced their experience of both fearing and craving intimacy and connection. This seems concordant with the concept of insecure attachment (Bowlby, 1988), as people with this attachment style are suggested to be more likely to long for intimacy with others, whilst also being fearful of dependency and rejection (Agrawal et al., 2004). Some of the fears of connection included thoughts such as 'others will hurt me', 'others will abandon me' and 'others will not understand me'. Previous literature on loneliness suggests lonely individuals form beliefs that aim to be self-protective but become self-defeating by leading them to distance themselves from others (Cacioppo & Hawkley, 2009). This phenomenon is also present in the BPD literature, suggesting individuals with BPD form beliefs such as 'I'll be alone forever, no one will be there for me' to protect themselves from the pain of being abandoned by others (Beck & Freeman, 1990). Findings from this study

suggest other factors, such as experience of trauma, may reinforce or intensify this experience for people with BPD. Participants spoke about how their fears about themselves such as 'I'm different and do not belong' and fears about others, were formed and/or strengthened due to the experience of interpersonal trauma. This links to research that suggests traumatic experiences can also contribute to the formation of maladaptive cognitions (Ehlers & Clark, 2000). This suggests the experience of trauma adds an additional layer of challenge when trying to overcome loneliness, in that it increases fears about the self and others, making connection more threatening.

Furthermore, the sense of craving connection and intimacy with others was also present in the loneliness literature (Norris et al., 2004). However, the experience of this in people with BPD may be intensified due to difficulties tolerating being alone, which is a common feature of BPD (Dazzi, 1998). The intolerance of being alone has previously been found to be a distinct concept from loneliness (Miller et al., 2020), however further research is needed to ascertain whether tolerating being alone is linked to less intense cravings to be connected to others, thereby mitigating the experience of loneliness.

The findings of this study suggest ways in which people with BPD try to 'balance' their fears of connecting with their desire to have closer relationships. One example of this was by employing an internal dialogue to tune into the emotions and non-verbal cues of others, however at times this led to misinterpretation or distraction from the interaction itself. This finding is in line with mentalization theory and the idea that people with BPD 'hyper-mentalize' to connect with another person (Sharp et al., 2011). Mentalization-based treatment (MBT) is an evidence-based therapy designed to promote skills in mentalizing for people with BPD, i.e., thinking about their own and others' mental states, in order to improve interpersonal functioning (Bateman & Fonagy, 2004).

Further to this, previous research has suggested that people with BPD have a negative bias when interpreting non-verbal cues, often perceiving a neutral face in a negative manner (Savage & Lenzenweger, 2018). Interestingly, this corresponds with the loneliness literature, that also proposes lonely individuals have increased attention to social cues (Gardner et al., 2005) and negatively

perceive neutral facial expressions (Pickett & Gardner, 2005). This could suggest it is loneliness, rather than BPD, which leads to hyper-mentalizing and a bias towards negative interpretations. Further research would be required to understand whether these phenomena could be attributed to loneliness rather than BPD pathology.

Another way that people with BPD were found to balance fears and craving of connection was by adapting their interpersonal manner to suit others whilst also being careful about how much of their 'true selves' to reveal. This may in part be related to fears about themselves and others, such as fearing rejection due to not being 'good enough'. It may also be related to the experience of instability of self, a common symptom of BPD leading to disturbance in identity and self-concept (APA, 2013; Gold & Kyratsous, 2017). However, only one of the participants in this study commented on difficulties with self-identity impacting upon her ability to connect with others.

Participants spoke of 'filling the void' of loneliness, and for many this meant being less selective about their social contacts in efforts to feel less alone. Again, this is seen in the loneliness literature, with research suggesting lonely individuals are less distinguishing about whom they spend time with, and more willing to accept social exploitation than non-lonely people (Cacioppo & Patrick, 2008). It is likely that this pattern leads to confirming fears about others, leading to mistrust and withdrawal from others, thus continuing the loneliness cycle.

Outside influences were found to have an impact on the experience of loneliness, with many participants describing how the stigma associated with BPD caused them to be less forthcoming about their diagnosis due to concerns they would be perceived negatively. Unfortunately, this left people feeling not understood and furthered negative self-beliefs such as 'I am different'. Research suggests historically negative attitudes did exist amongst healthcare professionals, however with research and education this is improving (Black et al., 2011). Those with intersecting minority identities also spoke of the impact of this on loneliness, either through practical means, e.g., being unable to follow a group conversation due to a hearing impairment, or through reinforcing the sense of feeling 'other'. Recent research is in concordance with this, suggesting a higher proportion of

loneliness in some minority groups such as sexual orientation and gender identity diverse communities (Eres et al., 2020).

Along with the findings on the experience of loneliness, the study also highlights important considerations on factors that enhance connection in people with BPD. Understanding and accepting oneself was found to play a key role in fostering connection to others. Some participants made direct links with skills learnt in therapy, such as challenging thought distortions (Beck, 1963; Linehan, 1993) and learning to mentalize (Bateman & Fonagy, 2004) and how these contributed to more positive interactions with others, therefore promoting connection. Although the principle aims of psychological therapies are not specifically to reduce loneliness, both DBT (Linehan, 1993) and MBT (Bateman & Fonagy, 2004) have interpersonal elements designed to improve relating to others. Interestingly, for some participants, it was the relationship with the therapist and feeling understood by another that was the essential ingredient in tackling their feelings of loneliness. This could be explained through the concept of epistemic trust (Fonagy et al., 2015), the idea that a crucial mechanism of change in therapy is through the development of a trusting relationship with the therapist. Along with feeling understood by professionals, the findings also suggest that people with BPD valued having fewer, but more meaningful friendships with people they felt understood by, and this 'quality versus quantity' approach enabled them to feel less lonely. This finding mirrors that of other research that suggests people with BPD have smaller social networks than the general population (Beeney et al., 2018) however this study suggests that this may be in part through choice and provide benefits such as feeling safe and known.

The belief that you have something to offer, or a purpose, was found to be important in enabling participants to form connections with others. Many spoke about feeling more comfortable in the 'helping role' and others felt more content when in a role with a defined purpose and known behavioural expectations. Again, this falls in line with previous research on loneliness, which suggests altruism as a mechanism of connecting to others and providing the individual with a

'helper's high' (Cacioppo & Patrick, 2008; Dossey, 2018), producing feelings of comfort and connection.

Finding common ground with others was found to be another source of connection for people with BPD in this study. This included attending sporting events, religious groups, parenting groups and having a shared experience. Research suggests there are three forms of social connection: intimate, relational, and collective, that are important to tackle loneliness (Hawkey et al., 2005). This sub-theme seems to align with the idea of collective connectiveness, the sense of belonging to certain collectives (Hawkey et al., 2005) and the importance of feeling this sense of belonging in reducing feelings of loneliness.

The study also provided helpful insights into how the COVID-19 pandemic has influenced the experience of loneliness in people with BPD. Participants unanimously spoke about significant changes in their daily lives that were due to the pandemic. These included changes to their employment, education, support network, mental health care and contact with others. This is particularly pertinent as managing change and transitions has been proposed as especially challenging for people with BPD, with the National Institute for Health and Care Excellence (NICE) producing guidelines suggesting any changes to familiar arrangements, for example, time and location of mental health care appointments, could increase the risk of crises (2015).

The findings from this study suggest that during the COVID-19 pandemic fears about the self and others were amplified. Some described how negative self-beliefs increased, including thoughts such as 'I am different from others' due to different responses to, or beliefs about, the pandemic. Many spoke about intensified fears of being forgotten or abandoned by others, a key symptom in BPD (APA, 2013). This is concordant with findings from a published case study which discussed the impact of the pandemic on a young Malaysian woman with BPD (Chong, 2020) and found her fears of abandonment were heightened. As fears about connection were exaggerated, many discussed how their usual healthy ways of coping were less available to them, leading to an increased risk of them turning towards more harmful ways of coping, such as self-harm and withdrawal from others.

Clinical Implications

The framework provides a rationale for integrating discussions about loneliness into clinical practice. Firstly, this study suggests that loneliness is a distressing experience for people with BPD and one in which they feel a lack of agency. Services could support people with BPD by making concerted efforts to explore their experience of loneliness and understand the individual's fears about themselves and others that might impair their ability to connect. Related to this, professionals should keep in mind how their relationship with the service user may allow them to experience feeling understood by another, which they may have had no, or limited, experience of in the past, and support them to think about how to challenge previously held fears of connecting to others. In addition, services may be able to support service users in thinking about ways in which they can develop connection with others, such as through peer support, a sense of purpose and finding common ground.

Many participants spoke about how their crisis plans were unhelpful to them during the pandemic, as the suggested coping strategies were largely unavailable, and so this led them to resort to more harmful methods of coping. Services might benefit from creating crisis plans that incorporate contingency plans that consider situations when strategies cannot be accessed and build in a variety of means of coping strategies and support options, in order to reduce the risk of crises.

Limitations and Directions for Future Research

It is important to note that due to the qualitative nature of this study, the aim was not to infer generalisability, but rather to begin to explore ideas and concepts related to BPD and loneliness by listening to the accounts of a small sample of people.

Credibility checks were undertaken throughout the research, however service user consultation on the research process and interview schedule was not sought. This was largely due to

the need to adapt the study in light of the emerging pandemic and at this time the ability to access a service user group was limited.

The participants of the study were recruited via social media, which could mean others who were less confident, or less frequent, users of technology may have been missed. Due to the COVID-19 pandemic, plans to apply for NHS ethics and recruit from NHS services was not possible and therefore people were invited to participate if they had previously received a diagnosis of BPD. It was not possible, or perhaps ethical, to confirm this diagnosis and therefore for some participants this may not have been accurate. In addition, it may be that the topic of the research attracted people who had specific experience of loneliness and those who did not experience loneliness were less likely to apply. This may have contributed to a biased sample of participants.

All interviews were conducted during the time of the COVID-19 pandemic between August-December 2020. Participants were based across the UK and during this time the government introduced a 'tier system' to indicate the level of restrictions in each geographical area (HM Government, 2020). Due to this, some participants had fewer restrictions than others during the time of interviews which may have influenced their perspective and indeed their degree of loneliness. Furthermore, due to the timing of the study, participants were also asked to recall how they experienced loneliness prior to COVID-19. It is possible again that their current context skewed their perception of past events, and/or they experienced recall difficulties.

Whilst this study contributes to our understanding of loneliness in BPD, important questions remain. Participants in this study suggested that loneliness related to several aspects of their BPD pathology, including emotional regulation, experience of emptiness, instability of self, fear of abandonment and intolerance of aloneness. Further research is required to understand the mechanisms by which these concepts are related and the impact of loneliness on these symptoms.

Furthermore, due to the interpersonal nature of loneliness and indeed many symptoms of BPD, gathering qualitative data from the contacts of people with BPD, such as close friends and family members, would help to triangulate the current findings and provide suggestions on how

others experience relationships and connection with people with BPD. Many participants spoke about their fears that others will not be able to understand them which links to suggestions in the literature and media that BPD is not widely understood (Kulacaoglu & Kose, 2018; Rice-Oxley & Johnson, 2020). It would be useful to further explore the ability of others to understand the nature of BPD and associated emotional and interpersonal experiences. If it is the case that a lack of understanding exists, this would suggest more efforts need to be made to increase awareness and dispel stigma associated with this population. In addition, common symptoms of BPD include frequent outbursts of anger and self-harming behaviour (APA, 2013). Future research is required to understand how this impacts the friends and family of those with BPD and the influence of this on their relationships.

Additionally, there seems to be some overlap in the literature on loneliness and factors associated with BPD. For example, hypersensitivity to social cues and the tendency to form self-protective beliefs that become self-defeating have been attributed to loneliness in the loneliness literature (Cacioppo & Hawkley, 2009; Gardner et al., 2005) and BPD in the psychiatric literature (Beck & Freeman, 1990; Savage & Lenzenweger, 2018). Further research is required to understand whether some of the factors previously attributed to BPD pathology could be better understood as an adaptive response to the experience of loneliness.

Conclusion

This study explored the experience of loneliness in people with BPD, both before, and during, the COVID-19 pandemic. A framework analysis identified eight main themes that described the participants' experience of loneliness both during COVID-19 and prior to it. Findings have been considered against literature on loneliness and interpersonal difficulties in BPD. Clinical implications, limitations and directions for future research have been outlined.

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Part 3: Critical Appraisal

Introduction

This critical appraisal provides a reflection of my experience of conducting the literature review and empirical study and the challenges that I encountered. It considers the reasons I chose the research topic and the factors that influenced this, the challenges that I faced during the research including the impact of the coronavirus (COVID-19) pandemic and the conflict between being a clinician and researcher, before acknowledging some of the current controversies surrounding the diagnosis of borderline personality disorder (BPD).

Reflexivity

'Reflexivity' is a concept that refers to the researcher positioning themselves within a context and clearly describing the relationship between the participants and themselves (Dodgson, 2019). This involves exploring one's own biases, beliefs, values, and personal experiences and how these might impact on, and be impacted by, the research process (Berger, 2013). Reflexivity is widely recognised as crucial to qualitative research and has been suggested as one element in which a researcher can demonstrate quality and rigor in their work, and as the 'gold-standard' for trustworthiness (Teh & Lek, 2018).

One method of attending to reflexivity is by 'bracketing', a process by which the researcher attempts to set aside or 'bracket' their personal biases and assumptions from the research process (Fischer, 2009). Although this can be a valuable process, it is important to acknowledge that the researcher is an inherent part of the research process and can never remove themselves entirely (Tufford & Newman, 2012). Rather, bracketing should be an ongoing process, assisting the researcher to bring to awareness their personal context and hold this in mind throughout the entire research process, considering how this may influence their thoughts and decisions throughout (Ahern, 1999).

Keeping this in mind, I completed a bracketing interview (Appendix K) with a colleague who was not involved with the research prior to beginning the empirical study. In this interview I discussed what had drawn me to the research, my thoughts and experience of the topic and also any assumptions I had about what I might find. Alongside this, in line with recommendations from Ahern (1999), I kept a reflexive journal where I made notes about thoughts and feelings throughout the research process. In addition, following each participant interview I made 'field notes' which included any thoughts, feelings or contextual considerations that came up for me at the time (Phillippi & Lauderdale, 2018). Regular, ongoing conversations with my supervisors were also beneficial to allow me to reflect on why I was making certain decisions and asking participants particular questions or focusing on certain responses.

Choosing to Study Loneliness in Borderline Personality Disorder

Keeping this in mind, it may be helpful for me to elaborate on the context in which I came to choose the research topic. I began my clinical career in the National Health Service (NHS) almost ten years ago, with my first role as an assistant practitioner in a specialist service in North London. The service was a day centre for adults in the borough with severe and enduring mental health needs and was founded on the principles of the therapeutic community (TC) model (Jones, 1956). This term was first used to describe TCs in the United Kingdom (UK) during the 1940s (Jones, 1956), and although these are less common now, several remain, usually to treat people with personality disorders or forensic histories (Pearce & Pickard, 2013). TCs are structured, psychologically informed environments and work on the premise that people need to re-experience a supportive community to repair maladaptive patterns of relating and learn from past relational difficulties (Stevens, 2012). This role sparked my interest in working with people with personality disorders and the interpersonal difficulties they faced. In addition, I witnessed the therapeutic nature of belonging to a 'community' and the importance of feeling understood by others. I also saw how learning to do this in a supportive environment could allow individuals to develop this experience outside of the TC.

This experience undoubtedly influenced my development as a clinician and my interests as a researcher.

As my career has progressed, I have encountered many different therapeutic models, many of which focus on individual therapy, such as cognitive behavioural therapy (Beck, 1964), or a combination of individual and group therapy, such as dialectical behaviour therapy ([DBT] Linehan, 1993). I was struck by how widely different these were from the 24-hour, 7-days-per-week approach of a TC (Pearce & Pickard, 2013).

Alongside this clinical experience, I have also worked in several services which have been highly 'risk-focused' when working with people with BPD. This is understandable of course, due to the high occurrence of self-harming behaviours and suicidality in this clinical population (American Psychiatric Association [APA], 2013), however this led me to become interested in the factors that contribute to crises such as the quality of, and satisfaction with, interpersonal relationships, as I had witnessed first-hand the protective nature of relationships in the TC. During the semi-structured interviews one of the participants voiced her reflections on this:

...and yeah, loneliness, I think it's not talked about because the impulsivity, like the impulsive behaviours are the bits that people see. And the bits that need the treatment, or their reactions, not the loneliness, like they don't see why you got to that point, they just see you at that point, to like, if you're on the side of a bridge, they see you as on the side of a bridge, they don't see you as how you got from A to Z. And the process that's in that, and that's what no one sees you know (P09).

I am mindful that these experiences have influenced my beliefs about the importance of connection and satisfaction with relationships. I was cautious to pay attention to moments when participants shared thoughts or experiences that did not fit with my previous assumptions, such as when one participant spoke about feeling less lonely when around animals:

I got a kitten and she's been brilliant because at the beginning she needed me for everything. And she was always on top of me and it felt like having a purpose because she needed everything (P05).

This is not something I had considered in this context, and so it challenged my assumptions, leading me to think about how connection can be experienced in different ways for different people.

Challenges Encountered

COVID-19

Perhaps the most significant challenge I faced during the research process was the impact of the COVID-19 pandemic. This touched many aspects of the research including applying for ethical approval, recruitment, and meeting with participants. Originally, I had planned to apply for NHS ethics, which would have allowed me to advertise the study in NHS personality disorder services and recruit participants directly from these. Unfortunately, this was not possible due to the NHS understandably prioritising research on COVID-19, and so I adapted the study to recruit participants via social media. This meant I was not able to consult a service user group regarding different aspects of the research process, such as the semi-structured interview schedule, as I had planned to do to include those who the research is about, in an effort to do 'with' rather than 'to' (Boote et al., 2015; Hoddinott et al., 2018).

Another consideration was the lack of contact I would have with each participants' mental health team if there were concerns raised about their safety. I mitigated this by requiring details of their mental health team, or General Practitioner (GP) if they were not connected to a mental health service, to participate in the research. In hindsight, this allowed me to speak to a variety of people with BPD, including those connected to services, those previously connected to services and those who have never sought treatment. However, it also meant that I was unable to verify if participants

had received a diagnosis of BPD from a UK professional. In addition, I was aware my level of anxiety was raised each time I met with a participant as I was holding in mind a crisis plan in case they made a disclosure of risk.

In addition, the format of interviews changed from being planned to take place in person to being conducted remotely via *Microsoft Teams*. Again, this had some unintended benefits and allowed me to interview people from a wide geographical area across the UK. However, I wondered if there was anything 'lost' by speaking via this method and whether it impacted on my conversations. Also, more practically, I was aware that by recruiting via social media there may be many people excluded from the research, such as those who do not use the internet or are not part of online BPD support groups.

Along with the changes to practicalities, I was aware that I was asking people to consider their experience of loneliness during a context where people were being asked to stay at home and drastically reduce their contact with others (Sandford, 2020). After discussions with my supervisor, it was decided to adapt the study to include this context, in an attempt to not only understand the experience of loneliness in BPD, but also how this is experienced during the current pandemic. I was concerned that thinking about loneliness in the context of COVID-19 may skew participants' memories of their prior experiences, as research suggests adversity and stress can both blunt and enhance recollection (Neugebauer & Ng, 1990). Nonetheless, this was unavoidable and the pandemic offered a unique opportunity to understand the experience of loneliness faced by people with BPD during this time.

Clinician versus Researcher

Another challenge I encountered during the research was stepping away from my role as a clinician and into my role as a researcher. The scientist-practitioner model is founded on the idea that a clinical psychologist should be well practiced in both clinical and research settings (Jones & Mehr, 2007), however in truth my career has lent more towards clinical experience. During the interviews

with participants, I noticed myself at times normalising their experience or summarising their response to ensure I had understood them correctly. These qualities tend to lend themselves more to a clinical interview rather than a research interview; however, I also felt drawn to ensure I was attending to rapport building and understanding the participant correctly in order to enhance our discussion and therefore improve the quality of the research. I wondered whether I felt a pressure to guarantee I was representing their true experience and that my desire to understand them stemmed from this. After I had finalised the framework of themes and sub-themes, I wrote the following comment in my reflexive journal:

It's interesting that 'being accepted and understood by others' was a sub-theme in Fostering Connection: "Learning to be Vulnerable". How did this impact the interviews? Did I make people feel understood? How did our conversation together impact their personal experience of loneliness? Would I have created this sub-theme if I felt I had not adequately made someone feel understood? (Reflexive Journal).

During an early interview a participant described his experience of living in a different country during his childhood and feeling lonely due to a lack of control over when his next meaningful contact with someone would be. Later in the interview he described the lack of control he felt over seeing his friends due to COVID-19 restrictions. Perhaps speaking more from my clinician role I reflected back the link between the two experiences and the powerlessness he felt in both. The participant then commented:

Yeah, yeah. massively actually, you've articulated that really well for me (P03).

After I completed that interview I wrote the following field note:

Is it more ethical to provide a reflection/observation/link or not? By not providing this am I withholding something that could be helpful? By providing this am I interfering with the research? Or providing something that they have not signed up for? (Field Note 3).

This conflict came into my awareness again when speaking with a participant in a later interview who said the following:

...there's certain things I don't admit to myself as I don't want to fall down a rabbit hole of feelings and things I can't regulate (P14).

This highlighted to me the danger of making a reflection to a participant, especially if this is uninvited.

Tensions between being a clinician and a researcher are not uncommon, with this providing both benefits and ethical challenges (Hay-Smith et al., 2016). Benefits can include an increased clinical relevance of research questions and being more trusted by participants which in turn can encourage their participation (Hay-Smith et al., 2016). However, as I experienced, clinicians can feel an ingrained orientation to a patient's needs, which can be challenging to balance both participant needs and producing high-quality research (Borbasi et al., 2005; Holloway & Wheeler, 1995). Looking back, I feel my clinical skills enhanced my ability to have difficult and, at times, emotional conversations with participants. If I had not attended to rapport building and attempted to make participants feel understood the conversations may have been restricted or shallow. Also, as mentioned earlier, I was conscious of attending to risk monitoring throughout the interviews which may have increased my desire to build rapport and ensure they left the conversation feeling heard and understood, rather than frustrated or further disconnected.

Controversy over BPD diagnosis

In choosing to research loneliness in BPD I was mindful that I was using a diagnostic label that has attracted controversy and debate (Campbell et al., 2020). I felt in a 'catch-22' wanting to provide more research and understanding to a widely stigmatised condition, however, to do that I was required to use a diagnostic label which, for many, is experienced as stigmatising (Campbell et al.,

2020). One of the participants in the study summarised the stigma of the condition very well when she said:

Like, it's not like depression, [or] anxiety, where people say, like, "oh, you know, mental health is okay now". And I'm like, erm, I mean, the title they've given, I know, they tend to call it BPD in the States, but the title I have here is EUPD [emotionally unstable personality disorder]. Which I suppose you'll know what that stands for. And I don't really want to have to say to anybody, I have emotionally unstable personality disorder, because that makes me sound dangerous, to be honest. And I've never been a danger to anyone but myself... I've heard that emotional regulation disorder [has been] put forward and think that would be a lot better. Really, like it gives me a chance to sort of explain what that means and how that affects me. And, I mean, I can understand why they've called it 'emotionally unstable', but I mean, what image does that portray to the general person? Like it doesn't sound good. And then yeah, I think it's about time that they called it something else really... Got it hard enough as it is without having such a stupid name (P18).

One of the long-standing debates is centred around whether personality pathology should be thought of as dimensional rather than categorical (Hopwood et al., 2018). In recognition of this the International Classification of Diseases has plans to replace categorical personality disorders with a severity gradient and five trait domains in its newest edition (World Health Organisation [WHO], 2018). However, despite this change, many feel the term 'personality disorder' is stigmatising as it suggests there is something maladaptive about their personality and that therefore implies there is something wrong with who they are as a person (Mind, 2020).

The topic of stigma came up many times in my interviews as participants reflected on their experience of this and the relationship between stigma and loneliness. Alongside this, I noticed at the start of interviews I was often asked why I was interested in doing this research and speaking with people with BPD.

I was asked again this week about why I was doing this research and met with surprise when I responded that I was interested in BPD and keen to work in this area once qualified. It makes me sad to think that people assume professionals/researchers/therapists are not interested in them because of their diagnosis and it's a surprise to them to hear otherwise. It makes me wonder about the experiences people with BPD have had which have contributed to forming these beliefs. Even I am aware that when I tell friends/family about my research they have often never heard of the terms BPD or EUPD. How hard must it be to explain your diagnosis to someone when you already feel vulnerable about it and have concerns about how well it will be received/understood (Reflexive Journal).

I also held in mind trauma perspectives that suggest BPD is a reasonable response to traumatic experiences, suggesting psychologists should ask 'what happened to you' rather than 'what is wrong with you' (Johnstone & Boyle, 2018). In addition, I was also aware of feminist critiques to BPD, suggesting that as this diagnosis is often applied to females who have experienced abuse it wrongly pathologizes reasonable reactions of survivors (Shaw & Proctor, 2005).

Despite the critiques, without diagnoses people would struggle to access to evidence-based treatment that could help reduce distress and improve their quality of life (Campbell et al., 2020). This research has made me think about where I position myself in the debate and the complexities within it. I have come to agree that we should have a diagnostic label for people with the symptoms of BPD, as it has also been established that this is a separate condition to others such as Complex Post-Traumatic Stress Disorder (Cloitre et al., 2014), however I would be in favour of consulting those with lived experience in changing the label to something that does not suggest fault with one's personality.

Conclusion

In conclusion I have been challenged, intrigued, and engaged during the process of this research. The research has grown and developed from first ideas and has been adapted to include the current context of the pandemic. It has not escaped me that as the researcher I have been studying loneliness at a time in my life where I am apart from my social connections like never before. The research has provided me with an immense gratitude for my ability to experience satisfaction in my relationships and connection with others. It has furthered my interest in qualitative research and working clinically with people with BPD and the importance of attending to their experience of loneliness.

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Appendices

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Appendix A: Semi Structured interviews

Sample Questions for Semi-Structured interviews

I am going to start by asking you about your current situation in terms of social contact during this period due to covid, then we will go on to talk about your experiences of loneliness before and during covid social distancing requirements.

What is your current living situation in relation to coronavirus? (e.g. vulnerable category, only going out for food/exercise/essential work/medicine, visiting family/friends)
Are you following social distancing guidelines when you leave the home?
If you have been isolating fully, how long have you been doing this?
Is there anyone living in your home with you at present?
How often do you communicate with others: phone/internet/over the back fence/when outdoors (during exercising or queuing?)/people at home?
How has your communication changed since the pandemic?

Now I am going to move on to your experiences of loneliness. We will start with questions about loneliness before the covid-pandemic then move on to now.

Was loneliness a familiar feeling for you?
What does loneliness feel like for you?
What did you do when you noticed you were feeling lonely?
Did you feel lonely even when you were with other people?
When did you feel the loneliest?
When did you feel the least lonely?
What was happening that might have caused you to feel lonely?
What stopped/prevented you from feeling lonely?
Did you notice you felt lonelier in certain situations or after certain events?
Is there any way in which your relationships might have contributed to your experience of loneliness?

Now I would like you to think about your current experiences of loneliness during covid and the social distancing requirements.

Can you describe your experience of loneliness since the coronavirus pandemic and social distancing requirements? What has changed? What is the same?
What has helped (or might help) you to feel less lonely during this time?

Appendix B: Ethical Approval

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH



17th July 2020

Dr Janet Feigenbaum
Research Department of Clinical, Educational and Health Psychology
UCL

Cc: Samantha Pogue, Trainee Clinical Psychologist

Dear Dr Feigenbaum

Notification of Ethics Approval with Provisos

Project ID/Title: 18285/001: An exploration of the experience of loneliness before and during the coronavirus (covid-19) pandemic in people with borderline personality disorder (BPD)

Further to your satisfactory responses to the Committee's comments, I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC until **17th July 2021**.

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research

You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'
<http://ethics.grad.ucl.ac.uk/responsibilities.php>

Adverse Event Reporting – Serious and Non-Serious

It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research

Office of the Vice Provost Research, 2 Taviton Street
University College London
Tel: +44 (0)20 7679 8717
Email: ethics@ucl.ac.uk
<http://ethics.grad.ucl.ac.uk/>

i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research: <https://www.ucl.ac.uk/srs/file/579>
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely



Professor Lynn Ang
Joint Chair, UCL Research Ethics Committee

Appendix C: Recruitment Advertisement



Looking for volunteers to take part in exciting new research in partnership with UCL

Currently recruiting people who have been diagnosed with
'Borderline Personality Disorder'
to be interviewed about
their Experience of Loneliness
during the Coronavirus (covid-19) Pandemic

For further information, to download the participant information sheet and to contact the researcher please go to the study website at: <https://samanthapogue18.wixsite.com/lonelinessinbpd>

Image Source: Flickr, Attila Siha

Please get in touch if:

- You are 18yrs or above
- You have received a diagnosis of 'borderline personality disorder'
- You have access to a computer and the internet at home
- You are willing to speak about your personal experience of loneliness both before and during the coronavirus pandemic
- You live in the UK

Interviews will take place with a trainee clinical psychologist using Microsoft Teams or Zoom

All participants will be thanked for their time with a £12.50 Waitrose/Sainsburys or Tesco Voucher



Appendix D: Study Website

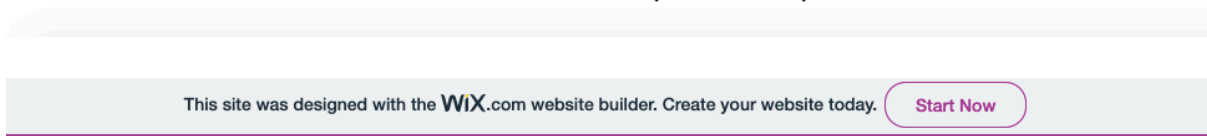


Research Study

Research Department of Clinical, Educational and Health Psychology
University College London (UCL)

[Home](#) [About the Researcher](#) [The Research Study](#) [Participant Information Sheet](#) [Support](#) [Study Findings](#) [Get in Touch](#)

Loneliness in people with Borderline Personality Disorder (BPD)



Before & During the Coronavirus Pandemic (Covid-19)

University College London (UCL)



Appendix E: Participant Information Sheet



Participant Information Sheet

UCL Research Ethics Committee Approval ID Number: 18258/001

Title of Study:

An Exploration of the Experience of Loneliness both before and during the Coronavirus (covid-19) Pandemic in people with Borderline Personality Disorder

Department: Research Department of Clinical, Educational and Health Psychology

Name and Contact Details of the Researcher: Samantha Pogue samantha.pogue.18@ucl.ac.uk

Name and Contact Details of the Principal Researcher: Dr Janet Feigenbaum j.feigenbaum@ucl.ac.uk

1. Invitation Paragraph

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask the researcher (Samantha Pogue) if there is anything that is not clear or if you would like any additional information. Take time to decide whether you or not you wish to take part. Thank you for reading this.

2. What is the project's purpose?

Research has shown that people with a diagnosis of Borderline Personality Disorder (BPD) may experience feelings of loneliness. This research aims to understand the experience of loneliness in people with Borderline Personality Disorder (BPD) particularly during the coronavirus (covid-19) pandemic. The current government guidance is likely to mean your usual ways of social contact have changed. The project aims to add to our current understanding of the experience of loneliness in people with BPD, in the hope that it will contribute to future developments in clinical interventions for periods of forced or encouraged social distancing.

3. Why have I been chosen?

The project is hoping to recruit between 12 and 16 people for individual interviews. The project is looking for people who meet the following criteria:

- identify as having Borderline Personality Disorder
- are 18 years or above
- fluent in English language
- computer literate (able to use a computer as the interview will take place on Microsoft Teams)
- currently living in the UK
- no current or previous diagnosis of psychosis
- no current or previous diagnosis of a cognitive impairment

4. Do I have to take part?

It is up to you to decide whether or not to take part and it is entirely voluntary. If you choose not to participate there will be no penalty. If you agree to take part and then change your mind you may discontinue participation at any time without penalty. If you do decide to take part you will be asked to



complete a consent form (see other attached document). If you decide to withdraw you will be asked what you wish to happen to the information you have provided up to that point. Even part way through the interview you may decide to stop and your interview will be deleted with no negative consequences to you in any way.

5. What will happen to me if I take part?

If you decide to take part you can let Samantha know via email (samantha.pogue.18@ucl.ac.uk) and she will arrange a time to meet you via Microsoft Teams that is convenient for you. At the start of that meeting you will have the opportunity to ask Samantha any further questions about the research before you continue. Samantha will ask you to share your signed consent form with her via the SharePoint function on Microsoft Teams (and she can guide you through this on your call). Your name on the consent form will be replaced with a number before the consent form is stored on a secure UCL computer site to protect your confidentiality.

As we know that some people with a diagnosis of BPD may at times be at risk of self-harm, we will ask for the contact details of your GP and also your mental health team (if you have one). We will not make any contact with your GP and/or mental health team unless we are concerned about your safety during any communication (emails, the interview, by phone) you have with us. Once the study is complete, we will delete your personal information.

The interview will last approximately one hour and will be recorded. Samantha will ask you questions about your experience of loneliness before and during the coronavirus pandemic. Once the interview has been transcribed the recording will be deleted. During the interview Samantha will not ask you to verbalise your full name and will only use your first name to protect your confidentiality.

Samantha will contact you after she has transcribed your interview to ask you to confirm that her report accurately represents the discussion you had with her during your interview and if there is anything you wish to add. You are not required to read the transcript or comment/add anything, this is your decision.

Samantha may also contact you again if there are further changes to the lockdown restrictions (if within the time frame of this study – which will end in January 2021) to invite you to participate in a follow-up interview, however this is entirely voluntary as well.

You will be reimbursed for your time with a £12.50 John Lewis & Partners e-voucher for each interview you participate in, which will be sent to your email address.

At the end of the research you will be contacted via email to comment on the themes generated from all the transcripts for a final opinion check and comments if you wish to give any. Please note this is also entirely voluntary.

6. Will I be recorded and how will the recorded media be used?

Your interview with Samantha will be recorded on Microsoft Teams (via UCL secure computer) and you may choose to be visible and see Samantha (video recording) or you may choose to have an audio recording, depending on your preferences. This will be securely stored in the UCL data safe haven. Once the interview has been transcribed the recording will be deleted and the transcription will be stored in the UCL data safe haven. The recording will not be seen/heard by anyone other than the researcher.

7. What are the possible disadvantages and risks of taking part?



It is possible that you might feel distressed by discussing your experience of loneliness. If this happens you can leave the interview at any point and are not obliged to stay for the full session. You will be emailed a handout with suggestions for managing distress at least two days before the scheduled interview. You will be asked before the interview if you have any questions about the managing distress handout. If you feel at risk before, during or after the interview Samantha will support you to access local services for support. The managing distress sheet also gives you additional contact information for the Samaritans and other mental health helplines.

8. What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will contribute to important research that aims to further our understanding of the experience of loneliness in people with BPD, particularly during periods of social distancing, in order to look at developing effective interventions for people with BPD in the future both for loneliness at all times and loneliness during enforced social isolation/distancing.

9. What if something goes wrong?

If you have a concern about any aspect of this study, you may email the chief Investigator, Dr Janet Feigenbaum (Associate Professor, Research Department of Clinical, Educational and Health Psychology, University College London) at j.feigenbaum@ucl.ac.uk

If you feel your concern has not been handled to your satisfaction then you can contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk

10. Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. Once the study is complete your email address and any other person information you provided will be deleted from the computer used in the study. All information held about you (i.e. email address, GP contact details will be only accessed through secure university email computers which meet full security measures as required by the government to protect you). You will not be able to be identified in any ensuing reports or publications.

11. Limits to confidentiality

Please note that confidentiality will be maintained as far as it is possible, unless during your contact with the researcher they become concerned for your safety or the safety of someone else. If this happens the researcher will then ask to inform relevant agencies of this, including your GP and mental health care team (if you have one). This is to ensure your safety and the safety of others. You may also reveal details about your circumstances that are unique to you. Please be aware this has the potential to identify you and you may choose not to include some personal information in the interview with Samantha.

12. What will happen to the results of the research project?

The results will be written into a thesis as part of a Doctorate of Clinical Psychology Research Project. It is possible that the findings might be used in publications or conferences in the future. However, no



identifying information will be included in any publication or transcript. The results of the study will also be summarised on the study's webpage which you will be able to access if you wish.

13. Who is organising and funding the research?

The research has been organised by Samantha Pogue, a trainee clinical psychologist at University College London (UCL), under the supervision of Associate Professor Janet Feigenbaum, a clinical psychologist and expert in the provision of psychological therapies for those with a personality disorder. The research is funded by UCL.

16. Contact for further information

If you have any questions or would like any further information, please get in touch with the researcher:

Samantha Pogue
samantha.pogue.18@ucl.ac.uk

Local Data Protection Privacy Notice

Notice: The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in health and care research studies, click [here](#)

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The lawful basis that will be used to process your personal data are: 'Public task' for personal data, and 'Research purposes' for special category data.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data, you provide we will undertake this and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Thank you for reading this information sheet and for considering taking part in this research study.

Appendix F: Support Document

Self Help and Support

Visualisation

This is a quick way of getting away from a situation without physically leaving.

- Imagine yourself walking to a door.

- Open the door and walk down the 3 steps, taking a deep breath for each of the steps.

- You walk into an environment where you feel relaxed and calm. This could be a familiar place, a happy memory, or somewhere in your dream.

- ✿ **What can you see?**
- ✿ **What can you hear?**
- ✿ **What can you smell?**
- ✿ **What can you touch?**

Spend a few minutes in this place, enjoying the feeling of relaxation.

When you feel ready, start to make your way back up the three steps, take a breath for each of the three steps. Make your way back through the door and back into the present.

Mindfulness - “Leaves on a Stream” Exercise

- (1) Sit in a comfortable position and either close your eyes or rest them gently on a fixed spot in the room.

- (2) Visualize yourself sitting beside a gently flowing stream with leaves floating along the surface of the water. Pause 10 seconds.

- (3) For the next few minutes, take each thought that enters your mind and place it on a leaf... let it float by. Do this with each thought – pleasurable, painful, or neutral. Even if you have joyous or enthusiastic thoughts, place them on a leaf and let them float by.

- (4) If your thoughts momentarily stop, continue to watch the stream. Sooner or later, your thoughts will start up again. Pause 20 seconds.

- (5) Allow the stream to flow at its own pace. Don't try to speed it up and rush your thoughts along. You're not trying to rush the leaves along or “get rid” of your thoughts. You are allowing them to come and go at their own pace.

(6) If your mind says “This is dumb,” “I’m bored,” or “I’m not doing this right” place those thoughts on leaves, too, and let them pass. Pause 20 seconds.

(7) If a leaf gets stuck, allow it to hang around until it’s ready to float by. If the thought comes up again, watch it float by another time. Pause 20 seconds.

(8) If a difficult or painful feeling arises, simply acknowledge it. Say to yourself, “I notice myself having a feeling of boredom/impatience/frustration.” Place those thoughts on leaves and allow them float along.

(9) From time to time, your thoughts may hook you and distract you from being fully present in this exercise. This is normal. As soon as you realize that you have become side-tracked, gently bring your attention back to the visualization exercise.

Distraction Techniques

These are some ideas for helping people delay or avoid self-harm that you might wish to consider- they’ve been suggested by people who self-harm. Some ideas might seem ridiculous, but others might work. Different people find that different things help, and it isn’t failure if you try something and it doesn’t help. You will be able to add things which you have discovered.

Expressing Feelings

Letting it out PHYSICALLY

- ✧ Scream as loud as you can
- ✧ Hit a cushion/punch bag/throw a cushion against a wall
- ✧ **Smash** a water melon
- ✧ Kick a football against a wall
- ✧ **Squeeze** a stress ball
- ✧ **Tear up** a newspaper/phone directory
- ✧ Play loud music and dance energetically- be as wild as you like
- ✧ Draw on the place you want to cut with red marker pen, fake blood or watered down food colouring
- ✧ *Write words* on yourself with red marker pen
- ✧ Spend some **energy**- go for a walk/swim/go to gym/ride a bike/go running.

Trying to work out how you are feeling....

- ✧ Ask yourself 'Do I feel ANGRY'? 'Do I feel anxious'? 'What about?'
- ✧ Ask yourself 'What would the razor blade say if it could talk to me?'
- ✧ **Write a letter** to someone you're angry with (hurt by etc.) saying how you feel
(NO need to send it).
- ✧ Write a list of your **achievements**
- ✧ Write a letter to yourself saying 'I love you because.....'
- ✧ **Make a list** of things you're thankful for
- ✧ Make a wish list



Talking about it...

- ✧ Talk to a **friend**
- ✧ Call the Samaritans or other helpline (see below)
- ✧ Allow yourself to **cry** (if you can)



Using your Creativity

- ✧ Draw / paint / collage/ paper mache / finger paint / sculpt in clay- to express what you want to do or what you are feeling
- ✧ Write a poem / **story** / song / joke / autobiography / parody / musical
- ✧ Write a **DIARY** / journal / read old diaries (unless there might be triggers)
- ✧ Go to Facebook.com and write an online journal
- ✧ **Scribble** a word again and again to say how you're feeling e.g. 'lonely', 'angry'
- ✧ Deface a magazine (preferably your own)
- ✧ Paint with **red paint** using your fingers
- ✧ Draw yourself in MS office
- ✧ Write a message in a self-harm newsgroup on the internet
- ✧ *Take some photos*



- ✧ Play an **instrument** / Sing to music as LOUD as you can
- ✧ Put on music which *expresses* how you are feeling
- ✧ Write out the **soundtrack** to your life if it were a film
- ✧ Imagine a colour which expresses your feelings then change it in your mind to another colour
- ✧ Make a **memory box** / scrapbook
- ✧ Write an **alternative** ending to a story
- ✧ Watch a foreign language channel and make up your own interpretations
- ✧ **Create** your own cartoon characters / legends
- ✧ Create a SECRET CODE

Self-Soothe with the Five Senses

Things You See

Make a part of your room look just the way you want it to. Look at nature around you. Watch stars, the moon, sunrise or sunset. Look at pictures or a poster that you like. Take a walk in a park or in your neighbourhood. Really look at and notice what is nice.

What You Hear

Listen to relaxing, soothing, or energetic music. Pay attention to the sounds of nature (waves, birds, rain, and leaves rustling). Sing your favourite songs. Hum a soothing tune. Learn to play an instrument. Call a friend. Listen to your cat purr.

Odours You Smell

Use your favourite aftershave, cologne, or perfume. Put potpourri in a bowl in your room. Boil cinnamon sticks. Bake cookies, cake or bread. Smell roses. Be mindful of the smells of nature; try smelling a pinecone.

Foods You Taste

Have a good meal. Have a favourite soothing drink such as herbal tea or hot chocolate. Treat yourself to dessert. Sample ice cream flavours. Chew your favourite gum or candy. Really taste the food you eat. Eat one thing mindfully.

Things You Touch

Pet your dog or cat. Take a bubble bath. Put clean sheets on the bed. Soak your feet. Put lotion on. Put a cold compress on your forehead. Sink into a really comfortable chair in your home. Brush your hair for a long time. Hug someone. Hold a pinecone. Hold a basketball, football, or baseball.

Contacts for further support

If you are currently under the care of a local mental health team you might find it helpful to contact your therapist/worker. Alternatively you may find it helpful to contact your GP if your distress is ongoing after participating in the study.

If you want feel you would like to speak to someone about the way you feel you can call the **Samaritans** on **08457 90 90 90** or visit their website at <http://www.samaritans.org>. They provide a confidential listening service.

There are also additional listening services available including:

CALM (the campaign against living miserably) who provide support via a helpline, webchat and website. You can call them on 0800 58 58 58 or visit their website at www.thecalmzone.net

HOPELineUK who provide confidential support and advice service for anyone under the age of 35yrs having thoughts of suicide. Calls are free. Texts cost standard rates. They aim to reply to emails within 24 hours. You can call them on 0800 068 41 41; text on 07860039967 and visit their website at <https://papyrus-uk.org/hopelineuk/>

Support Line who provide a confidential telephone helpline offering emotional support to any individual on any issue. It's particularly aimed at people who are isolated, at risk, vulnerable and victims of any form of abuse. You can call them on 01708 765 200 or visit their website at www.supportline.org.uk

Self-Injury Support who provide a phone, email, text and webchat support service to women and girls affected by self-injury. Their website also includes many free resources. Self-Injury Helpline - 0808 800 8088 – open Wednesdays and Thursdays from 7pm – 9:30pm.

If you need help immediately and are in an emergency, you can call the emergency services on 999.

Appendix G: Consent Form and Demographics Questionnaire

RESEARCH DEPARTMENT OF CLINICAL,
EDUCATIONAL & HEALTH PSYCHOLOGY
UNIVERSITY COLLEGE LONDON



An Exploration of the Experience of Loneliness before and during the Coronavirus (covid-19) Pandemic in people with Borderline Personality Disorder (BPD) CONSENT FORM

Please complete this form after you have read the Participant Information Sheet.

Department: Research Department of Clinical, Educational and Health Psychology

Name and Contact Details of the Researcher(s): Samantha Pogue, Trainee Clinical Psychologist: samantha.pogue.18@ucl.ac.uk

Name and Contact Details of the Principal Researcher: Dr Janet Feigenbaum, Associate Professor: j.feigenbaum@ucl.ac.uk

Name and Contact Details of the UCL Data Protection Officer: Alexandra Potts data-protection@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee: Project ID number: 18285/001

Thank you for considering taking part in this research. If you have any questions arising from the Information Sheet please ask the researcher before you decide whether to take part.

I confirm that I understand that by inserting a X in each box below I am consenting to this element of the study. I understand that it will be assumed that any uncrossed boxes mean that I DO NOT consent to that part of the study.

This form will be stored on the UCL data safe haven. This will ensure that your personal details remain secure. Thank you.

Required:

I confirm that I have read and understand the Participant Information Sheet for the above study and have had the opportunity to have any questions about this answered.

I understand that my participation is voluntary.

I understand that information may be shared with my GP or mental health care team if the researcher is concerned about my safety.

I understand that the data from this study will be held for a period of 10 years under the UCL data protection procedures.

I understand I can withdraw at any time without giving a reason and the data I have provided up to that point will be deleted unless I agree otherwise.

I understand how to lodge a complaint should I wish to do so.

I understand and agree that the interview will be recorded on the video/audio system Microsoft Teams

I agree to take part in the above study.



Optional:

I agree to be contacted after the data from the study has been analysed via email to confirm it represents the information I provided.

I agree to be contacted again after further changes to lockdown restrictions for a follow-up interview.

Please complete the information below and return at the start of your interview with Samantha via SharePoint on Microsoft Teams to indicate your consent (Samantha will guide you through how to do this).

NAME	
DATE	
DATE OF BIRTH	
GP NAME AND ADDRESS	
MENTAL HEALTH CARE TEAM (IF YOU HAVE ONE)	



Demographic Information

Optional: If you are willing to complete this form please highlight/bold the responses that best describes how you think of yourself

1. Gender
 - a. Female
 - b. Male
 - c. If you would prefer to use your own term please write here: _____
 - d. Prefer not to say

2. Age
 - a. 18-24yrs
 - b. 25-29yrs
 - c. 30-39yrs
 - d. 40-49yrs
 - e. 50-59yrs
 - f. 60-64yrs
 - g. 65yrs+

3. Ethnicity
 - a. Asian/Asian British
 - b. Black/Black British/African/Caribbean
 - c. Mixed/Multiple Ethnic Groups
 - d. White/White British
 - e. Other: _____

4. Sexual Orientation
 - a. Heterosexual/Straight
 - b. Gay/Lesbian
 - c. Bisexual
 - d. Other
 - e. Prefer not to say

5. Religion or Belief
 - a. No Religion
 - b. Buddhist
 - c. Christian
 - d. Hindu
 - e. Jewish
 - f. Muslim
 - g. Sikh
 - h. Any other religion
 - i. Prefer not to say

**RESEARCH DEPARTMENT OF CLINICAL,
EDUCATIONAL & HEALTH PSYCHOLOGY
UNIVERSITY COLLEGE LONDON**



6. Marital Status
 - a. Single
 - b. In a relationship but living in separate households
 - c. Co-habiting
 - d. Married
 - e. Widowed
 - f. Divorced

7. Do you currently have caring responsibilities?
 - a. Yes
 - b. No

Thank you for taking the time to complete this information.
This will be kept confidential and will be kept separately to your
consent form.

Appendix H: Example Coded Transcript

Transcript for P17	Initial Codes	Framework
<p>P17: Um because you just feel... It's hard like and like you want that so much but you don't have that anywhere. And then you're just completely isolated in your thoughts and your feelings. So like, you would long to have that person to speak to and to have that kind of relationship to offload and to be like "this is the real me", like "this is what I'm going through and this is, this is where I need the help, this is, this is where I need support" and "can we discuss this". But at the same time you, you can't get to that point. In your head, you can, and you know, this is what you need, but you just physically can't do that. And then it just makes you feel even more alone because you literally just sat with yourself. And like you can't, it's like there's a</p>	<p>Wanting close relationships. Sadness at lack of closeness?</p> <p>Difficulty being alone and managing thoughts and emotions</p> <p>Desire for close, honest connections with others.</p> <p>Craving vulnerability but too risky?</p> <p>Lack of ability to make deeper connections. Sense of feeling held back.</p> <p>Difficulty spending time alone</p>	<p>1.3 I Crave that Intimacy – Desire for closeness</p> <p>1.3 I Crave that Intimacy -Struggle to be alone</p> <p>1.3 I Crave that Intimacy – Desire for closeness</p> <p>1.1 Standing on the Edge - Unable to find a solution</p> <p>1.3 I Crave that Intimacy -Struggle to be alone</p>

<p>massive barrier and you're like in this bubble. And like you know all the things you need to do but you literally can't get past that bubble. And it's like, it's like stopping you, it's like you're in like a bungee rope and you just can't get further than you need to, you can try every time and get a little bit further. That one of them things that I can't remember when you was at school, like it was Velcro to the back of an inflatable wall and you'd try and get further each time. But you can just never get off it, you never get past.</p> <p>SP: And what do you think it is that holds you back?</p> <p>P17: <u>Trust</u>. Like, I know that. Um, like, in terms of like, my CPA, for example, I wouldn't, I wouldn't- I</p>	<p>Aware of what to do but feeling held back, unable to change.</p> <p>Powerless to change or control</p> <p>Powerless to change or control</p> <p>Struggle to trust others. Concerns over getting hurt? Needing to protect self?</p>	<p>1.1 Standing on the Edge - Unable to find a solution</p> <p>1.1 Standing on the Edge - Unable to find a solution</p> <p>1.1 Standing on the Edge - Unable to find a solution</p> <p>1.2 Fears about Connection: "I'm better off alone" - Protecting myself from others</p>
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Appendix I: Example of Framework Analysis

1.5 Outside Influences: The “Perfect Storm”

ID	Stigma	Intersectionality	Experience of Trauma
P08	<p><i>I know, obviously, BPD it's worse, you know, you know, people with BPD, they just, you're lucky if you get a chance from somebody, like somebody you like with BPD, you know, you're very lucky.</i></p>	<p><i>I suppose, or BME communities where like our family, we don't have any family or friends near us. Or, you know, so you know, we live in a white British conservative area, and there's no support networks here for us. There's no sort of community for us here, we just live in it, we're just a brown family living in a white, middle class sort of racist area, really, I'd say. And obviously, we'd suffered a lot of recent discrimination over the years.</i></p>	
P09	<p><i>I think the stigma, like even from some professionals, like within my care, you know, like I was told many times if I wanted to kill myself I could. I knew where the door was.</i></p>	<p><i>I was like well preferably individual because, again, you put me in a group of people and they're all talking I have no idea what's going on. I can't follow the conversation.</i></p>	
P10	<p><i>I think there's a stigma about mental health full stop. Like I did go through, I did do psychology at one point, and I did psychotherapy for a couple of years. And nobody knew I went to psychotherapy. And I went to twice a week and I used to hide that.</i></p>	<p><i>I can't actually walk, so I'm actually, I've been stuck in my house since April last year. I haven't been outside apart from being in hospital. I haven't seen anybody since February apart from when I was in hospital.</i></p>	<p><i>It came, because of, well, I was abused when I was younger that nobody knows about, well a couple people know about it wasn't family related. And I was terrified that my mum would find out so I would always make any excuse to avoid, I could be in a room full of people be on my own. I would do everything to avoid social circles.</i></p>

Appendix J: Respondent Credibility Checks

Summary of Interview - Sent Items

Message

Delete Reply Reply to All Forward Attachment Meeting Move Junk Rules Read/Unread Categorise Follow Up Share to Teams Send to OneNote

Summary of Interview

Pogue, Samantha Tuesday, 20 April 2021 at 12:52

To: [Redacted]

Summary of Intervie...
42.6 KB

[Download All](#) [Preview All](#)

You replied to this message on 20/04/2021, 12:52.

Dear [Redacted]

I hope you are well and are enjoying the easing of lockdown!

I'm emailing as you took part in an interview with me last year about your experience of loneliness. I've attached a summary of the main themes and sub-themes that came out of all of the interviews, and some quotes from your interview that support these. It is password protected so I will send the password to you in a separate email.

I would like to invite you to give feedback on the summary, but there is no obligation to do so if you would prefer not to. If you would like to feedback, I would be grateful if you could do this via email by 4th May.

There are three broad questions below:

1. **How accurate is the summary**
2. **Is there anything that needs changing?**
3. **Is there anything that should be added?**

If you have any questions please let me know.

Thank you again so much for contributing to my research!

Very best wishes,
Samantha

Samantha Pogue
Trainee Clinical Psychologist

P01: Summary of Interview

Here is a summary of all the interviews I have now completed. Below is the common themes and sub-themes that came out of these interviews. The themes are in **bold** and the sub-themes are in **blue** and **red**.

Some of these we discussed in our conversation and others we did not discuss or might not be relevant to your experience.

The **blue** sub-themes are the ones that came up during our interview and I have added quotes from you that fit these below. If you think I might have misunderstood what you were saying, please feel free to let me know.

In **red** are sub-themes that other people spoke about but we did not. It might be that these apply to you, but we didn't get round to speaking about them, or it might be that you have a different experience. Please feel free to comment on these if you wish.

Experience of Loneliness in BPD

Theme 1: Alone and Powerless

Alone with Others: You spoke about feeling alone even when with other people.

BPD in itself can be a very isolating experience... that can then lead to you, kind of, being more alone and then more loneliness

“Can't Seem to Find a Cure”: You spoke about struggling to find a fix for loneliness

it is that kind of lack of connection and part of that I guess is like you don't know how to say to somebody 'you know what, I feel lonely'. Because that has a lot of negative, you know you don't want to say that to people because that makes you sound like, oh, you've got no friends or you know which is not true because you can actually be surrounded by people and feel lonely.

Intensifies my Emotions: Some people spoke about loneliness intensifying their emotions – we didn't speak about this but please feel free to add comments below:

Enhancing Emptiness: Some people spoke about loneliness enhancing their experience of emptiness. Please feel free to add your comments about this below:

Theme 2: Fears about Connecting

Appendix K: Bracketing Interview Extract

I: Can you tell me a bit about your research?

SP: Yeah so mine is looking at the experience of loneliness in people with borderline personality disorder. So, we kind of know through research that people with borderline personality disorder have lots of interpersonal difficulties, umm, and one of them is, in recent years it's been shown that they have higher levels of loneliness than the general population, but we don't really know how that's experienced. And, one of the interesting things about it is, it's not thinking about social isolation, it's thinking about the kind of, discrepancy between perceived versus actual relationships. So what the person wants or expects from a relationship versus what they actual have. And that loneliness can be described as the gap in between that. And so for people with BPD that's particularly umm important, because they're a group that describes chronic dissatisfaction with their relationships. So, the idea is to kind of, be a qualitative piece of research to gain some understanding of their experience in their own words and what that's like. Because we don't really know that much about how they experience loneliness. Or what the differences are between how they might experience it and how the general population might experience it. So that's the kind of broad topic, and then, oh I should add that due to the current context, we're also thinking about it specifically during the pandemic, because it's quite hard to research loneliness without considering the pandemic, because obviously that's kind of affected everybody's experience of loneliness. So the idea is to think about how their experience of loneliness was before, but if anything has changed during the pandemic and during lockdown and social distancing.

I: And were you involved in deciding on the topic of the research or was already set up?

SP: Yeah so it was quite... No, so it was kind of one of those projects that's evolved and evolved and evolved until it's got to this point. So initially I was quite interested in doing a project on borderline personality disorder, umm, and I think clinically that's always been my interest. I've worked pre-training, in services with BPD and always enjoyed that work. And then, when thinking about developing a topic initially we were looking at the social relationships and the quality of social relationships for people with BPD and then it kind of developed into looking at where the gaps are in the literature and loneliness is something that's very recently being looked at in borderline personality disorder. And then Covid happened, which meant, initially we were going to recruit from NHS services, but unfortunately we made the decision not to, and it will be recruiting from online now, so that will change it in terms of people might not be using NHS services. So that will be quite interesting to find out who responds. And so yeah, I've been quite involved in it, and I think the topic of loneliness is something that interests me because I think there's a lot of conversation about whether it lies within the individual or within society. And yeah whether it's an individual problem or is it actually a result of society becoming more individualistic and less kind of community-based. So I've always been quite interested in that idea, and the idea of where the problem lies I guess in psychology anyway. So I think that was probably what drew me to it.