Processes of recovery through routine or specialist treatment for Borderline Personality Disorder (BPD): a qualitative study

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Abstract

Background: Recovery processes in borderline personality disorder (BPD) are poorly understood.

Aims: This study explored how recovery in BPD occurs through routine or specialist treatment, as perceived by service users (SUs) and therapists.

Method: SUs were recruited from two specialist BPD services, three community mental health teams, and one psychological therapies service. Semi-structured interviews were conducted with 48 SUs and 15 therapists. The 'framework' approach (Ritchie et al., 2014) was used to analyse the data.

Results: The findings were organized into two domains of themes. The first domain described three parallel processes that constituted SUs' recovery journey: fighting ambivalence and committing to taking action; moving from shame to self-acceptance and compassion; and moving from distrust and defensiveness to opening up to others. The second domain described four therapeutic challenges that needed to be addressed to support this journey: balancing self-exploration and finding solutions; balancing structure and flexibility; confronting interpersonal difficulties and practicing new ways of relating; and balancing support and independence.

Conclusions: Therapies facilitating the identified processes may promote recovery. The recovery processes and therapeutic challenges identified in this study could provide a framework to guide future research.

Keywords: Borderline personality disorder; Recovery; Qualitative research; Psychological therapy

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Introduction

Individuals with a diagnosis of Borderline Personality Disorder (BPD) experience a wide range of difficulties, including rapid fluctuations in mood, unstable relationships and impulsive behaviour such as self-harm (NICE, 2009). Clinical trials have found specialist therapies for BPD, e.g., dialectical behavioural therapy (DBT) and mentalisation-based treatment (MBT), effective in reducing self-harming and use of crisis services and in improving mood (Stoffers et al., 2012). Epidemiological research also indicates that symptom severity among those using generic mental health services decreases over time (Zanarini et al., 2003). Thus, both specialist and generic treatments may bring about symptom improvement.

However, service users' (SUs) perceptions of recovery go beyond symptom improvement (Soundy et al., 2015) and their social and vocational functioning might remain impaired even after symptom remission is achieved (Zanarini et al., 2010). Recovery is understood as a way of building a meaningful and satisfying life, while integrating limitations caused by mental illness (Leamy et al. 2011). Qualitative studies exploring experiences of recovery in BPD indicate that SUs aspire to, and can make, meaningful changes in several areas (e.g., Castillo et al., 2013; Gillard et al., 2015; Katsakou et al., 2012; Lariviere et al., 2015). These include developing self-acceptance and self-confidence; learning new ways of relating to others; taking control of emotions and thoughts; and implementing practical changes (see review by Katsakou & Pistrang, 2017). However, most of these studies recruited participants from single specialist services and their findings may not generalise across a wider range of services. More importantly, although some studies point to helpful and unhelpful treatment characteristics, they focus on general experiences of recovery, rather than on *processes of recovery through treatment* – that is, how individuals make positive changes through routine or specialist treatment. Hence, our understanding of how treatment might

promote (or hinder) recovery remains limited (Barnicot et al., 2012; Katsakou & Pistrang, 2017).

The present study aimed to understand processes of recovery in BPD through routine or specialist treatment, as perceived mainly by SUs, but also by therapists. Understanding SUs' perspectives on how treatment leads to positive outcomes could aid the development of existing specialist psychotherapies as well as routine care. Therapists' views were explored in order to provide an additional perspective.

Method

Design

An exploratory, qualitative interview design was used to obtain rich descriptions of participants' experiences (Barker, Pistrang & Elliott, 2016).

Ethics

The study was approved by the local NHS Research Ethics Committee. All participants provided written informed consent.

Setting

SUs were recruited from two specialist BPD services (a DBT service and a therapeutic community using MBT), three community mental health teams, and one psychological therapies service offering mainly CBT. (The latter four services provided support to SUs with a range of diagnoses.)

Eligibility criteria

The inclusion criteria for participation were:

1. A diagnosis of BPD (as reported by the participating services) and a history of self-harming (including self-injurious behaviour, overdosing or suicide attempts).
2. Current or recent contact with the participating services.
3. Age above 18 years.

Exclusion criteria were: severe learning disabilities, insufficient English to participate in interviews and inability to give informed consent.

Sampling

Professionals from participating services identified eligible SUs. Purposive sampling was used to ensure a range of SUs were included (on clinical/demographic characteristics and stage of treatment, including those who had discontinued treatment). Recruitment of new participants stopped when the last five interviews did not introduce any new ideas and thus it was decided that saturation of the emerging themes was reached (Barker et al., 2016). A purposively selected subgroup of SUs (at different stages of treatment, using a range of services) was asked to name a therapist to be invited to participate in the study.

Participant characteristics

Of 54 eligible SUs, 48 (89%) were interviewed; four declined to participate and two did not attend their interview appointment. (This is an identical sample to Katsakou et al., 2012). Fifteen SUs gave consent for their therapist to be interviewed; all 15 therapists were interviewed. Participants' characteristics are presented in Table 1.

(Insert Table 1 here)

Interviews

In-depth, semi-structured interviews were conducted. Initial drafts of topic guides were produced by CK. The topic guide for SUs was then discussed with two SUs with a diagnosis of BPD, who had used routine and specialist services; similarly, the topic guide for therapists was discussed with two therapists with a DBT and MBT background respectively. These discussions led to minor modifications in wording and focus.

For SUs, the main areas covered were: experiences of treatment, specific aspects that had been helpful or unhelpful, other factors that promoted or hindered recovery, and significant points and difficulties in the recovery journey. For therapists, similar areas were

covered, referring specifically to their work with the SU-participant who had been interviewed. The topic guides were used flexibly, allowing exploration of areas raised spontaneously by interviewees; follow-up questions were used to obtain detailed accounts.

SUs who were currently engaged with services were interviewed after they had used these services for a minimum of four months, so that they had some time to reflect on their experiences. CK conducted 45 interviews; three other researchers conducted the remaining 18 interviews. All interviews were audio-recorded.

Data analysis

The audio-recordings were transcribed by professional transcribers. The transcripts were verbatim records of the content of what was said; paralinguistic elements of speech were not included, as they are not essential for thematic analysis (Barker et al., 2016).

The transcripts were analysed thematically using the National Centre for Social Research 'framework' approach (Ritchie at al., 2014). This is a structured method that facilitates systematic analysis of large data sets (Gale et al., 2013). First, initial codes were developed inductively by examining each transcript; these codes were then inspected across the data set and synthesised to form a coding framework. Next, this framework was used to systematically code all transcripts, with the aid of the MAXqda software for qualitative analysis. A thematic chart was then produced for each transcript, documenting the supporting data for each code. Finally, these charts were used to identify patterns in the data and produce a set of themes that provided a parsimonious account. SU and therapist transcripts were initially examined separately; however, both groups expressed similar ideas and the coding framework and final set of themes therefore integrated both perspectives.

Several steps were taken to maximise the validity of the analysis. A consensus approach was used at each stage of the analysis (Barker & Pistrang, 2005). The coding framework was initially developed by CK and was refined through discussion with NP.

Following this, CK coded 13 interviews (21% of all interviews) with KB to consider coding issues and further refine the framework. Once all transcripts were coded, the generation of the final set of themes was arrived at through discussion with the research team.

Researchers' background

The research team comprised researchers with clinical and academic backgrounds in psychology and psychiatry, and a service user. The lead researcher (CK) is a clinical psychologist, with experience of using both DBT and MBT. She held several preconceptions about these therapies. For example, she valued structure and goal-setting in therapy, but felt that an in-depth exploration of relational patterns was equally important. Through self-reflection and regular discussion with the research team, she attempted to gain greater awareness of, and 'bracket', her assumptions (Fischer, 2009). Bracketing was a continuous process occurring throughout data collection and analysis.

Results

The themes were organised into two domains (Table 2). The first domain, "Processes of recovery", comprises three themes describing central processes that constituted SUs' recovery journey through therapy. The second domain, "Challenges in therapy", comprises four themes reflecting therapeutic challenges that needed to be addressed to support this journey. The term "therapy" in this context includes both psychological therapies and treatment in generic mental health services

(Insert Table 2 here)

Domain 1: Processes of recovery

This domain reflects mainly SUs' accounts, as it focuses on personal experiences of recovery. However, therapists' reports contributed to the themes.

The trajectories of SUs' recovery journeys suggested that the three recovery processes developed simultaneously. Each process reflected movement from long-standing difficulties

to better adjustment. Recovery was experienced as a series of achievements and setbacks, as SUs moved back and forth between these two poles of each recovery process. During this movement, they usually maintained an overall sense of moving forward, despite setbacks.

(Insert Box 1 here)

Process 1: Fighting ambivalence and committing to taking action

SUs experienced a constant battle between being motivated to change and giving up. Some described feeling scared of change. They found it hard to let go of their ways of blocking difficult emotions, such as self-harming or drinking, as these provided an instant sense of relief.

"Through a lot of stuff, it [drinking] was my way of blocking it out, so I'm scared of all them feelings, if I don't have that. I don't know if I would be able to deal with that pain". (SU26, DBT)

Initial motivation to change was linked to not wanting to let significant others down. Over time, however, SUs started taking responsibility for their recovery. They described reminding themselves of their long-term goals and the consequences of their actions.

As therapy progressed, participants started implementing changes in their lives. They became more aware of, and challenged, unhelpful ways of thinking. They started actively addressing their problems and developed specific strategies to deal with crises, such as keeping busy and considering their options before acting impulsively.

"Before, if anything that I found overwhelming [happened], the easiest way for me was to self-harm… with DBT… I would try to distract myself, just 5 minutes, it wouldn't seem so overwhelming after that... it gave me some time to think before I acted". (SU12, DBT)

SUs described how noticing their progress made them feel more confident that change was possible. This helped them maintain faith in therapy and remain committed to moving forward.

Process 2: Moving* from *shame to self-acceptance and compassion

SUs described a journey from feeling ashamed to developing self-compassion. Initially experiencing strong negative emotions, including shame, hate and anger towards themselves, they believed they did not deserve to receive help and should be able to cope with their difficulties.

"I didn't think that I deserved any help. From a very young age I was the one who dealt with things. I wasn't the one who got helped". (SU22, MBT)

Over time, SUs began to acknowledge that they had substantial difficulties and became more open to receiving professional help. They described gradually developing in therapy a better understanding of their emotions, thoughts and life experiences. Making sense of their difficulties led to increased levels of self-acceptance, self-compassion and confidence.

"I'm a lot more tolerant with myself… I've tried to be nice with myself, like 'that's actually very good, what you've done already, you don't need to kill yourself". (SU8, DBT)

Process 3: Moving* from *distrust and defensiveness to opening up to others

SUs described distrusting others and finding it hard to open up and establish intimate relationships; this often reflected problems in early attachments or a history of abusive relationships. Consequently, they were reluctant to talk about difficult issues and emotions, for fear of being rejected by significant others.

While in therapy, participants started developing a better understanding of relationships. They described becoming more aware of how other people's behaviour affected them and how their own behaviour affected others; they developed an understanding of other people as beings with their own thoughts and feelings, leading to less self-centred interpretations of others' behaviour.

"You can understand why you did this, you can understand why people did that to you… it opens your eyes… You get differences of opinions". (SU27, DBT)

Furthermore, participants described developing more effective ways of communicating: managing their anger and becoming more able to listen to others and contribute in

relationships. Therapists also noticed SUs' increased ability to participate in two-way conversations rather than appearing solely preoccupied with their own worries.

"By the last session… she was actually listening. She was taking some of the things that we were saying in. The beginning was just like letting it all out.... It was hard to even get a word in edgeways". (T33, generic services)

As therapy progressed, SUs felt supported to open up. This process started within the therapeutic relationship, but often generalized outside therapy. As participants became more engaged in relationships, they also became more able to confront others and express their needs more assertively. They negotiated different boundaries in existing relationships or ended relationships that they found unhelpful.

"My mum doing most things, my daughter doing the shopping, my boyfriend doing jobs… it was like I've got suffocated. So now I have the guts to turn around and say no, I can do this, back up!". (SU27, DBT)

Domain 2: Challenges in therapy

This domain describes four challenges that SUs and therapists perceived as important for therapies to address in order to promote recovery.

Challenge 1: Balancing self-exploration and finding solutions

Therapy was described as facilitating a process of self-exploration, which was invaluable in helping SUs understand their difficulties.

"It was repeated behavioural analyses that made me go 'when I have contact with that person I self-harm as a result'… it was a light bulb going on". (SU8, DBT)

However, for some SUs, therapy that focused on understanding the past, without providing solutions to current problems, was experienced as unhelpful: it brought up difficult issues that they felt unable to manage in the present.

"The reason it didn't help was because they'd dig into sensitive subjects that you keep locked away for your own protection, and when someone unlocks that door, it comes flying out… And you're sitting in the middle of this tornado…". (SU34, generic services)

SUs and therapists pointed out that therapies that emphasised finding solutions to present problems and offered guidance on dealing with crises were particularly beneficial.

Therapies that struck a balance between facilitating self-discovery and offering practical help were described as ideal.

"Someone just sitting there listening to her was not enough… she found it helpful when someone listened, but also gave her some advice and guidance". (T33, generic services)

Challenge 2: Balancing structure and flexibility

SUs valued therapies that offered a clear structure and a treatment rationale that was shared with them. They also appreciated working towards specific goals. When these characteristics were missing, therapy was experienced as too open-ended and confusing.

"I believed that having goals and understanding the order in which we work on things… that made sense and was quite comforting". (SU3, DBT)

On the other hand, SUs valued elements of flexibility. They stressed the importance of therapists allowing them to follow their own pace. Both SUs and therapists reported that SUs felt coerced and disrespected when they experienced therapists as rigid in following therapeutic agendas. They also described disagreements in treatment goals or challenging times when therapists lost sight of SUs' needs.

"When she was in a mode where she wanted to be thin and I was trying to ... go back to the goal of helping her eat more regularly, there would be conflict. Sometimes it was me needing to step back from the goal and work more with what was going on for her…". (T42, other psychological therapy)

Challenge 3: Confronting interpersonal difficulties and practicing new ways of relating

SUs who received group therapy described it as initially daunting. They felt exposed when sharing personal information, and sometimes experienced other SUs as dismissive or even bullying. They struggled to manage such challenging situations.

"You were the newbie, that was quite daunting… you've got no idea what's going on at the beginning, and the thought of saying anything in that group is horrendous". (SU13, DBT)

Other common experiences included feeling disheartened after listening to other people's difficulties and seeing oneself as belonging to a group of people with problems. For

most SUs these challenges were perceived as a necessary initial difficulty that improved over time. For some, however, they contributed to their discontinuing therapy.

Over time, those who stayed in therapy began to perceive the group as a nurturing environment, which helped them feel less isolated and more *"normal"* as they shared experiences with others.

"It is very comforting to be with a bunch of people who know where I'm coming from, so I don't feel like a weirdo… it's nurturing for me… like almost an adopted family…". (SU22, MBT)

SUs and therapists perceived the group as a stimulating, but protected, environment that offered opportunities to practice trusting others, opening up, tolerating people who they considered difficult, and coping with a degree of anxiety.

"We have some tricky group members, but that's part of group therapy … that is quite handy, cause if everyone was lovely in the group, it would be slightly false, cause not everyone is lovely in the world". (SU9, DBT)

In parallel to practicing relating to others in groups, SUs also appreciated the opportunity to openly discuss and repair conflicts in their relationship with their therapist(s). Addressing difficult issues without ending the relationship was experienced as a valuable new skill.

"We were able to negotiate, which I wouldn't have been able to do before… I was able to stay, and work through it, and hear what she was saying… that's been one of the biggest skills for me". (SU25, DBT)

Challenge 4: Balancing support and independence

SUs described needing intensive, regular therapy to address their complex difficulties. Therapy that was at least a year long and included group and individual work was seen as beneficial; less intensive therapies were seen as inadequate in supporting stable change.

"I had done CBT before... but only short-term. As soon as I stopped seeing the therapist… everything comes back crashing down on me again... [MBT], because it's three times a week...and I am going to be here for longer, I'm able to get into the ideas". (SU22, MBT)

SUs also valued feeling understood and accepted by therapists. For some, this was their first experience of a supportive relationship. In contrast, feeling disrespected by professionals was seen as a discouraging experience that delayed recovery.

However, support needed to be balanced with promoting independence in therapy, especially towards its ending. The shift from intensive therapy to having to cope on their own was often experienced as abrupt. Some SUs felt that therapies or therapists did not manage successfully the transition between encouraging a degree of dependence and attachment in the beginning with fostering more independence towards the end.

"I was doing well at DBT because I was getting the attention of three hours a week in therapy, crisis coaching, I was having somebody who I was relying on… DBT hadn't identified that I was over-reliant on my therapist". (SU3, DBT)

SUs stressed the importance of negotiating a gradual ending that took into account the personal meaning of separations and their sensitivity to rejection. When this did not occur, endings were experienced as sudden and overwhelming. Therapists echoed this view, noting that striking a good balance between providing adequate support and fostering independence was particularly challenging.

"She was still using me very actively right till the end, and I didn't want to be discharging someone until they're doing most of it a lot more independently… so I couldn't be confident that she won't relapse at some point". (T42, other psychological therapy)

Discussion

This study explored SUs' and therapists' perspectives on how recovery in BPD occurs through routine or specialist treatment. The first domain of themes described three parallel processes that constituted SUs' recovery journey: fighting ambivalence and committing to taking action; moving from shame to self-acceptance and compassion; and moving from distrust and defensiveness to opening up to others. The second domain described four therapeutic challenges that needed to be addressed to support this journey: balancing self-exploration and finding solutions; balancing structure and flexibility; encouraging SUs to

confront interpersonal difficulties and practice new ways of relating; and balancing support and independence.

The accounts of recovery in this study are consistent with previous qualitative research indicating that recovery in BPD is experienced as a fluctuating movement between achievements and setbacks (Katsakou & Pistrang, 2017). However, this study provides a more elaborated description of the main areas in which this movement occurs, i.e., developments in taking action, self-compassion, and relationships.

The three recovery processes occurred across a range of specialist and generic therapies. This finding is consistent with the view that common processes that are present across many psychological interventions (despite differences in specific strategies of each model) drive change in therapy (Wampold, 2010). Yet, it is worth considering to what extent the two specialist therapies received by study participants aim to support the identified recovery processes. DBT provides specific strategies to enhance SUs' commitment to change and support them in taking action (Linehan, 1993), while MBT emphasises understanding relationships and practicing relating to others (Bateman & Fonagy, 2006). Both therapies work on self-acceptance and compassion by facilitating processes such as mindfulness and mentalisation respectively, which aim to help SUs make sense of their emotions and actions. However, specific strategies to enhance taking action and developing a deeper understanding of relationships might be missing from MBT and DBT respectively.

The findings also point to how therapies might facilitate the identified recovery processes, by addressing specific therapeutic challenges. Two of the identified challenges reflect perhaps the central tasks that therapists undertook to directly support these processes: balancing self-exploration with problem-solving, and encouraging clients to practice relating to others in different ways. The first task involves ensuring that therapy focuses on assisting SUs in making sense of their experiences, while also supporting them in actively tackling

problems. The second challenge refers to encouraging individuals to work on developing new ways of relating to others, including opening up and trusting others and negotiating conflicts. Participants' accounts indicated that these new skills were first built in therapy and were subsequently applied to other relationships.

Our findings also highlight another challenge that therapies need to address to support SUs in maintaining their ability to self-manage in the long-term: balancing support and promoting independence. SUs' accounts suggest that therapists did not always adequately manage the transition between encouraging a degree of dependence and attachment in the beginning of therapy with fostering more independence towards its end. As professionals working with individuals with a diagnosis of BPD often feel overwhelmed by the intensity of the difficulties (Markham & Trower, 2003; Sulzer et al., 2016), working on longer-term goals, such as fostering independence, might not be seen as a priority during treatment. This might be an oversight of SUs' long-term needs and contribute to increased service use.

Limitations

Although the study aimed to explore processes of recovery across routine and specialist services, approximately two-thirds of the SU-participants had received a form of specialist therapy, and almost half had received DBT; the findings might therefore emphasise processes that occur in specialist BPD treatment. The perspectives of SUs who completed therapy might also be overrepresented, as only 24% of participants had discontinued treatment; however, the therapy completion rate is consistent with completion rates reported for this group (Barnicot et al., 2011). Finally, although the response rate for study participation was high, SUs who declined to participate may have had different views.

Implications

This study identified three processes that SUs experienced as central in their recovery journey. Treatments facilitating these processes may increase SUs' engagement with services

and promote recovery. However, specialist therapies for BPD often focus on limited areas of change (Farrell et al., 2009), which might hinder recovery and lead to continued dependence on services.

Our findings suggest that not striking a balance between offering support and fostering independence in therapy might also lead to poor outcomes. Although it can be difficult to focus on promoting independence when SUs present with a multitude of immediate problems and risks, strategies to address this challenge need to be developed.

The recovery processes and therapeutic challenges identified in this study could provide a framework to guide future research. Examining how these relate to recovery outcomes could inform the future delivery of routine and specialist treatment.

References

Barker, C. & Pistrang, N. (2005). Quality criteria under methodological pluralism: implications for doing and evaluating research. *American Journal of Community Psychology, 35*, 201-212.

Barker, C., Pistrang, N., & Elliott, R. (2016). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd ed.). Chichester, UK: Wiley.

Barnicot, K., Katsakou, C., Bhatti, N., Savill, M., Fearns, N. & Priebe, S. (2012). Factors predicting the outcome of psychotherapy for borderline personality disorder: a systematic review. *Clinical Psychology Review, 32*, 400-12.

Barnicot, K., Katsakou, C., Marougka, S. & Priebe, S. (2011). Treatment completion in psychotherapy for borderline personality disorder: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica, 123*, 327-338.

Bateman, A. & Fonagy, P. (2006) *Mentalisation-based treatment for borderline personality disorder: a practical guide*. New York: Oxford University Press

Castillo, H., Ramon, S. & Morant, N. (2013). A recovery journey for people with personality disorder. *International Journal of Social Psychiatry, 59*, 264-73.

Farrell, J.M., Shaw, I.A. & Webber, M.A. (2009). A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: a randomized controlled trial. *Journal of Behavior Therapy and Experimental Psychiatry, 40*, 317–28.

Fischer, C.T. (2009). Bracketing in qualitative research: Conceptual and practical matters. Psychotherapy Research Methods, 19, 583-590.

Gale, N.K., Heath, G., Cameron, E., Rashid, S. & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*, 117.

Gillard, S., Turner, K. & Neffgen, M. (2015). Understanding recovery in the context of lived experience of personality disorders: A collaborative, qualitative research study. *BMC Psychiatry, 15,* 183.

Katsakou, C., Marougka, S., Barnicot, K., Savill, M., White, H., Lockwood, K. & Priebe, S. (2012). Recovery in Borderline Personality Disorder (BPD): a qualitative study of service users' perspectives. *PLoS One, 7,* e36517.

Katsakou,C. & Pistrang, N. (2017). Clients' experiences of treatment and recovery in Borderline Personality Disorder: a meta-synthesis of qualitative studies. *Psychotherapy Research.* Advance online publication.

Larivière, N., Couture, É., Blackburn, C., Carbonneau, M., Lacombe, C., Schinck, S.A., … & St-Cyr-Tribble, D. (2015). Recovery, as Experienced by Women with Borderline Personality Disorder. *The Psychiatric Quarterly, 86,* 555–568.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445–452.

Linehan, M.M. (1993) *Cognitive-behavioral treatment of Borderline Personality Disorder*. New York: Guildford.

Markham, D. & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours. *British Journal of Clinical Psychology, 42*, 243-56.

National Institute for Health and Clinical Excellence (2009). *Borderline personality disorder: treatment and management*. United Kingdom: National Institute for Health and Clinical Excellence.

Perseius, K.I., Ekdahl, S., Asberg, M. & Samuelsson, M. (2005). To tame a volcano: patients with borderline personality disorder and their perceptions of suffering. *Archives of Psychiatric Nursing, 19*, 160–168.

Ritchie, J., Lewis, J., McNaughton Nicholls, C., & Ormston, R. (Eds). (2014). *Qualitative research practice: A guide for social science students and researchers* (2nd ed.). London, UK: Sage.

Soundy, A., Stubbs, B., Roskell, C., Williams, S.E., Fox, A., Vancampfort, D. (2015). Identifying the facilitators and processes which influence recovery in individuals with schizophrenia: a systematic review and thematic synthesis. *Journal of Mental Health, 24*, 103-110.

Stoffers, J.M., Völlm, B.A., Rücker, G., Timmer, A., Huband, N. & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. *The Cochrane Database of Systematic Reviews, 15*, CD005652.

Sulzer, S., Muenchow, E., Potvin, A., Harris, J., Gigot, G. (2016). Improving patient-centred communication of the broderline personality disorder diagnosis. *Journal of Mental Health, 25*, 5-9.

Wampold, B.E. (2010) The research evidence for common factors models: A historically situated perspective. In BL Duncan, SD Miller, BE Wampold & MA Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (pp.49-83). Washington DC: American Psychological Association.

Zanarini, M.C., Frankenburg, F.R., Hennen, J. & Silk, K.R. (2003). The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. *American Journal of Psychiatry, 160*, 274-283.

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2010). The 10- year course of psychosocial functioning among patients with borderline personality disorder and axis II comparison subjects. *Acta Psychiatrica Scandinavica, 122(2),* 103-109.

Table 1. *Socio-demographic and clinical characteristics of participants*

	Service users (N=48) N (%)	Therapists (N=15) N (%)
Gender		
Female	39 (81)	8 (53)
Male	9 (19)	7 (47)
Age		
Mean (range)	36.5 (18-58)	40.1 (28-58)
Ethnicity		
White	33 (69)	12 (80)
Black	5 (10)	1 (7)
Asian	10 (21)	2 (13)
Employment		
Unemployed	37 (77)	N/A
Voluntary work	3 (6)	N/A
Employed	8 (17)	N/A
Professional background		
Psychologist	N/A	6 (40)
Nurse	N/A	6 (40)
Social worker	N/A	2 (13)
Psychiatrist	N/A	1 (7)
Partnership		
Living alone	28 (58)	N/A
Living with partner/ family	20 (42)	N/A
Co-morbid Diagnoses		
Any other PD	33 (48)	N/A
Depression/ dysthymia	21 (44)	N/A
Bipolar disorder	4 (8)	N/A
Schizoaffective disorder	4 (8)	N/A
Eating disorder	6 (13)	N/A
Anxiety disorder (PTSD, OCD, phobia)	8 (17)	N/A
Substance misuse	8 (17)	N/A
Treatment received/delivered[a]		
DBT	23 (48)	5 (33)
MBT	8 (17)	3 (20)
Other psychological therapy	6 (13)	3 (20)
Generic services	11 (23)	4 (27)
Stage of treatment[b]		
Completed/ ongoing treatment	28 (76)	N/A
Dropped out	9 (24)	N/A
Received counselling/therapy in the past		
Yes	44 (92)	N/A
No	4 (8)	N/A

[a] Participants receiving DBT or MBT were recruited from two specialist BPD services; those receiving other psychological therapy were recruited from a psychological therapies service; those receiving generic services were recruited from three community mental health teams.
[b] Only applicable to those receiving psychological therapy (N=37)

Table 2. *Domains, themes and subthemes*

	Total sample (N=63) N (%)	Service users (N=48) N (%)	Therapists (N=15) N (%)
Domain 1: Processes of recovery			
Process 1: Fighting ambivalence and committing to taking action	**63 (100)**	**48 (100)**	**15 (100)**
Giving up, feeling held up by the past and scared of change	63 (100)	48 (100)	15 (100)
Not letting others down	35 (56)	30 (63)	5 (33)
Taking responsibility	53 (84)	40 (83)	13 (87)
Managing difficult thoughts	44 (70)	35 (73)	9 (60)
Taking practical steps to resolve problems and crises	49 (78)	40 (83)	9 (60)
Noticing progress and developing hope	32 (51)	22 (46)	10 (67)
Process 2: Moving from shame to self-acceptance and compassion	**61 (97)**	**46 (96)**	**15 (100)**
Feeling ashamed and blaming self for problems	36 (57)	29 (60)	7 (47)
Acknowledging problems and asking for help	23 (37)	19 (40)	4 (27)
Understanding self and difficulties	46 (73)	34 (71)	12 (80)
Self-acceptance, compassion and confidence	32 (51)	23 (48)	9 (60)
Process 3: Moving from distrust and defensiveness to opening up to others	**58 (92)**	**44 (92)**	**14 (93)**
Fear of being open and exposing oneself	35 (56)	29 (60)	6 (38)
Understanding relationships	26 (41)	18 (38)	8 (53)
Listening to others and communicating in a less angry way	22 (35)	16 (33)	6 (38)
Opening up and trusting others	38 (60)	25 (52)	13 (87)
Being assertive and negotiating boundaries	18 (29)	14 (29)	4 (27)
Domain 2: Challenges in therapy			
Challenge 1: Balancing self-exploration and finding solutions	**57 (90)**	**42 (88)**	**15 (100)**
Self-exploration is helpful	44 (70)	32 (67)	12 (80)
Focusing only on understanding the past is unhelpful	16 (25)	12 (25)	4 (27)
Problem-solving is valuable	45 (71)	34 (71)	11 (73)
Challenge 2: Balancing structure and flexibility	**54 (86)**	**39 (81)**	**15 (100)**
Structured, goal-oriented therapy with a clear rationale	24 (38)	16 (33)	8 (53)
Flexibility and choice	47 (75)	35 (73)	12 (80)
Challenge 3: Confronting interpersonal difficulties and practicing new ways of relating [a]	**44 (70)**	**31 (65)**	**13 (87)**
Feeling overwhelmed and exposed in group[b]	26 (62)	21 (62)	5 (63)
Practicing relating to others in group[b]	29 (69)	22 (65)	7 (88)
Addressing conflicts and negotiating boundaries in the therapeutic relationship	21 (33)	12 (25)	9 (60)
Challenge 4: Balancing support and independence	**61 (97)**	**48 (100)**	**13 (87)**
Regular/ intensive therapy	35 (56)	25 (52)	10 (67)
Supportive therapist	48 (76)	40 (83)	8 (53)
Managing ending/ continuity of care	37 (59)	28 (58)	9 (60)

[a]Percentages for this domain are calculated for the whole sample and therefore might appear lower than in reality, as two of the three subthemes are only applicable to approximately two thirds of the sample (see footnote b).

[b]Subthemes applicable to 34 service users with some experience of group therapy and 8 therapists with service users currently in group therapy, a total of 42 participants. Percentages for these subthemes are calculated for these subgroups only.

Box 1. Additional quotations for all domains, themes and subthemes

Domains, themes, subthemes	Quotations
Domain 1: Processes of recovery	
Process 1: Fighting ambivalence and committing to taking action	
Giving up, feeling held up by the past and scared of change	*"Half of me of course wants to get better but the other half, it's got to the point that I really don't care anymore… I'm losing motivation… I've got a wall between me and the rest of the world and you are very protective of that wall, and when you go into therapy…you are on the defensive… and you are saying to yourself 'no-one is going to knock that, you'll be blown if anyone's going to knock that wall down', so half the battle is lost because you are not giving it your 100%".* (SU34, generic services)
Not letting others down	*"If anything goes wrong, I immediately think that [self-harming]'s what I want to do … But I don't cut because I don't want to let [therapist] down, I don't want to let [sister] down".* (SU4, DBT)
Managing difficult thoughts	*"I am challenging my own thoughts a lot more… for example, like with the self-harming, it was like 'no, I don't have to do this because I am worth more than this, people do like me'. I didn't feel like that before… but when I come here [group therapy]… I feel liked and accepted".* (SU22, MBT)
Taking responsibility	*"It only works if you're going to put the work into it: all the homework, all the writing… There were times when I didn't want to do that at all… But I did it religiously because I wanted to sort myself out. Because if you're expecting someone to fix you, it's not going to happen".* (SU13, DBT)
Taking practical steps to resolve problems and crises	*"I'd let things build up in me, whereas now I deal with things… like say I've got to pay a bill, I'd say I'll pay it next week. I'd leave it until the red letter, but now I don't leave it. As soon as I get the bill, I pay it".* (SU29, DBT)
Noticing progress and developing hope	*"I have gained some knowledge, confidence… I think I've got this far and I want to move on into the next step".* (SU14, MBT)
Process 2: Moving from shame to self-acceptance and compassion	
Feeling ashamed and blaming self for problems	*"I can't be bothered to do this… and then I get guilt, because I think I'm letting people down, I'm letting myself down, so I'm beating myself up constantly".* (SU26, DBT)
Acknowledging problems and asking for help	*"I felt as if I had to do everything on my own… Still that happens every now and then, but I do give in and go, ok, I do need a bit of help… really I 've got to admit that I do need to come in [to therapy] and see someone".* (SU20, MBT)
Understanding self and difficulties	*"When they said I had Borderline Personality, it all made sense… How I've been with relationships, how I've been with my children, how I was as a person".* (SU29, DBT)
Self-acceptance, compassion and confidence	*"I feel more confident and I do approach problems. I keep on doing something and then thinking, I wouldn't have done that last year… I'm stronger in myself".* (SU4, DBT)
Process 3: Moving from distrust and defensiveness to opening up to others	
Fear of being open and exposing oneself	*"I started getting uptight, I didn't want to talk to no-one, no-one to know what had happened to me… That's why I stopped going [to therapy]… I find it hard to trust*

	people because of what happened to me when I was a kid. I had over 21 years of abuse". (SU16, DBT)
Understanding relationships	*"Trying to think about other people for a change, I'm really trying to do that... I find it difficult to listen to, even my friends… I've started to think more about how other people see me. I've stopped being so selfish… I actually leave my house to go see people now, rather than expect people to come to me all the time".* (SU17, MBT)
Listening to others and communicating in a less angry way	*"It made me… say what I had to say without the anger. Now I plan what I'm gonna say and I say it in a quiet manner".* (SU1, DBT)
Opening up and trusting others	*"She vented her anger at what had happened to her and how unfair it had been… she continued to feel angry with the abuser but not in a way that got in her way of feeling OK about herself and her other relationships. She started to trust a bit other relationships, as she could distinguish them from the abuser, cause the anger got directed there".* (T42, other psychological therapy)
Being assertive and negotiating boundaries	*"[My friend] was winding me up, the way she was talking to me… 'I am not dirt, I am you friend, recognise it… I don't care if you are my close friend and if you've known me for however long, it doesn't matter'... I ve told her to sort out her attitude… I said to her 'I am telling you nicely now'... I didn't swear once, I was talking to her in that respectful manner".* (SU33, generic services)

Domain 2: Challenges in therapy

Challenge 1: Balancing self-exploration and finding solutions

Self-exploration is helpful	*"I think having more of an understanding of what state of mind might leads her to take an overdose - getting a sense of what the triggers are - that piece of work has begun here… and I think because of more frequently reflecting on her state of mind, she's at a less of a risk of that, because of ... understanding how she is doing on an emotional level".* (T22, MBT)
Focusing only on understanding the past is unhelpful	*"When I've seen a psychologist before… I kept bringing up my past… but I wasn't going anywhere with it, in some cases it would make me feel worse… it was coming up to the surface and then throughout the week it would be playing on my mind… that was getting me more frustrated, because I wasn't moving on".* (SU9, DBT)
Problem-solving is valuable	*"You can really talk through your problems and what is important… it's like having a personal coach, if anything is hard for you, you set goals how to achieve it with my therapist; I found that really helpful".* (SU12, DBT)

Challenge 2: Balancing structure and flexibility

Structured, goal-oriented therapy with a clear rationale	*"The therapy has been excellent, very goal-driven, very specific and very oriented in achieving things and making sure one understands things… achieving a small goal and then moving on to the next one has been brilliant"* (SU9, DBT).
Flexibility and choice	*"Because the treatment is so structured, which is in some ways a positive thing, I feel I don't really know what my client thinks sometimes… or how they feel about working on self-harming. So, sometimes I just want to have some free time to explore what they think and their personal goals a bit more… some free space where I don't have to be adherent and do something according to the book…".* (T4, DBT)

Challenge 3: Confronting interpersonal difficulties and practicing new ways of relating

Feeling overwhelmed and exposed in group	*"I've got this fear that people are laughing about what I'm gonna say and I close up… I didn't give it my best shot, I only went to group therapy once".* (SU26, DBT)
Practicing relating to others in group	*"It gave me confidence in myself that I 'm able to challenge people and maybe open up a bit more and just interact with people… all the dynamics in the group does give you something to think about, about how you respond and how you deal with what's going on"* (SU14, MBT).
Addressing conflicts and negotiating boundaries in the therapeutic relationship	*"It was about being really transparent about what was going on. I suppose we reached an understanding where I would tell what I thought the conflict was, the difficulty, and made it very clear that it was ok for her to disagree, to be angry with me if I suggested a wrong thing and then we negotiated it together".* (T41, other psychological therapy)
Challenge 4: Balancing support and independence	
Regular/ intensive therapy	*The fact that it [therapy] was set out the way it was, the skills training a couple of hours, it was so regular, if you decided you wanted to sort things out, then you had a good chance to do that.* (SU13, DBT)
Supportive therapist	*"The therapists really took an interest in me as a person even though I gave them a hard time… I feel they didn't give up on me, even though the things I said were very hurtful… I have a lot of admiration and respect for them".* (SU38, other psychological therapy)
Managing ending/ continuity of care	*"The ending of DBT is like a cord being cut… I was devastated, I thought 'why didn't he prepare me for this?' We got borderline personality, rejection is very hard… it didn't end the way I anticipated and I think I don't feel 100%".* (SU1, DBT)