Personal Recovery and Borderline Personality Disorder

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Abstract

The overarching focus of this thesis is to better understand processes of positive change in Borderline Personality Disorder (BPD). The concept of personal recovery is of importance to this thesis because central to the theoretical basis of personal recovery is the view that it is possible to change in positive ways while living with mental illness. However, much of the existing literature on personal recovery is focused on mental state disorders such as schizophrenia rather than on personality disorder. The focus here is on personal recovery as the concept has been developed within consumer narratives and scholarship rather than on clinical recovery as used in outcome studies of mental illness because the personal recovery literature is focused primarily on process (rather than outcome). The meaning and experience of personal recovery are explored because the recovery paradigm has been widely adopted in health services as a way of supporting individuals who are affected by mental illness, yet it is unclear how well previously established recovery principles apply to BPD. To better understand the change processes associated with recovery from BPD and assess the utility of the recovery paradigm in supporting this population, interviews were conducted with consumers diagnosed with BPD and with clinicians working within individuals with BPD. Their perspectives on the disorder, personal understanding of recovery, and beliefs about how an individual might recover from BPD were explored using thematic analysis. The relationship between self-criticism, self-compassion and recovery was also explored as self-loathing has been identified as a common difficulty for individuals with BPD and may be a barrier to recovery.

Thesis including published works declaration

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes zero original papers published in peer reviewed journals and two unpublished publications. The core theme of the thesis is personal recovery and Borderline Personality Disorder (BPD). The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the student, working within the School of Psychological Sciences under the supervision of Dr Katherine Lawrence.

The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research.

In the case of Chapters 3 and 4 my contribution to the work involved the following:

Thesis Chapter	Publication Title	Status	Nature and % of student contribution	Co-author names Nature and % of Co-author's contribution*	Co-authors Monash student Y/N*
3	Consumer Perspectives on Recovery and Borderline Personality Disorder	Provisionally accepted for publication subject to revisions	80%. Concept and collecting data, data analysis and writing and refining drafts for submission	1) Dr Cameron Duff, input into analysis and manuscript 7.5% 2) Dr Jillian Broadbear, Input into manuscript 5% 3) Dr Sathya Rao, Input into manuscript, 2.5% 4) Dr Katherine Lawrence, Input into manuscript 5%	No

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4	Clinician Perspectives on Recovery and Borderline Personality Disorder	Accepted for publication	80%. Concept and collecting data, data analysis and writing and refining drafts for submission	2) Dr Jillian Broadbear, Input into manuscript 5% 3) Dr Katherine Lawrence, Input into manuscript 5% 4) Dr Sathya Rao, Input into manuscript, 2.5%	No

I have / have not renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

Student signature: **Date:** 07 September 2016

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author I have consulted with the responsible author to agree on the respective contributions of the authors.

Main Supervisor signature: **Date:** 07 September 2016

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Preface

This thesis is focused on the process of positive change from Borderline Personality Disorder (BPD). BPD is a complex, psychiatric condition characterized by significant psychosocial difficulties that often causes significant distress for individuals diagnosed with the condition. Given the complexity of the condition and the associated distress, it is perhaps not surprising that there has been, and still is, considerable clinical pessimism around the prospects of positive change (or progress) over time for individuals with BPD. BPD is still commonly characterised as a chronic condition that is unlikely to remit. We know now that this view is ill-founded. Two landmark outcome studies led by Mary Zanarini and John Gunderson suggest that change is possible. Individuals with BPD do remit albeit over fairly long periods of time. Outcome studies such as those led by Zanarini and Gunderson are important in that they provide a factual rather than impressionistic basis about prognosis. They also go some way in dispelling some of the considerable stigma that is commonly heard about individuals with BPD. However, outcome studies are not designed to focus on *how* change occurs and therefore are limited in terms of offering an understanding of the *process* of change.

The concept of personal recovery is particularly relevant to this broader enquiry into the *process* of positive change or progress in BPD. Proponents of personal recovery emphasize that quality of life can improve after an episode of mental ill-health and that it is possible to live a subjectively satisfying and meaningful life and also contribute to one's community while living with mental illness. Personal recovery as it has been described and developed within consumer narratives is focused on individual life 'journeys' with an emphasis on individual autonomy and agency. These emphases accord with the spirit of the current enquiry. An acknowledgement that progress in BPD is indeed possible as made clear by outcome studies is important here, but additional questions are of further interest beyond the insights offered within longitudinal studies of outcome. How do individuals with BPD make positive changes in their lives? In other words,

what factors contribute to progress being made? Or how might individuals with BPD experience improved quality of life and associated meaning or satisfaction in life? In attempting to better understand these processes, personal recovery offers a complex but important theoretical basis. A better understanding of the process of recovery may help individuals with BPD and may also be of interest to clinicians as well as carers in their support of the person diagnosed with BPD. Further, each of these questions is about *how* the *process* of change occurs and is ideally explored through qualitative methods. Qualitative methods are particularly well-suited to answering questions about *how* a particular phenomenon occurs. Accordingly, the first two papers presented here will report on a qualitative investigation of change in BPD specifically focused on the meaning and experience of recovery for consumers and clinicians.

Although the focus of this thesis is on how positive change occurs, we also know that there may be specific barriers to recovery for individuals with BPD. Self-loathing or intense and global self-criticism and an associated almost complete lack of self-compassion appear to be particularly important in this regard. Intuitively, it seems likely that self-loathing will be a significant barrier to recovery. The significance of self-loathing in relation to recovery is, however, largely a matter of clinical observation with some anecdotal rather than empirical evidence. Given the lack of empirical evidence in this regard, the final section of this thesis asks the question: What is the relationship between self-loathing and self-compassion and recovery from BPD? Is there indeed a relationship and if so how strong is that relationship? These questions are about the nature of a possible relationship and not about how the process of change occurs. Questions about what a relationship between variables are best answered using quantitative methods. Accordingly, the final part of this overall project will present an additional exploratory analysis and report on a statistical (correlational) investigation of the relationship between personal recovery and self-compassion and self-criticism. Clarifying the nature of the relationship between self-loathing and recovery from BPD may also inform clinicians about the place of treatment for self-loathing within the overall treatment of BPD.

1   Personal Recovery and Borderline Personality Disorder: An Overview

1.1   Introduction to Chapter 1

The first part of this introduction will briefly outline the nature of Borderline Personality Disorder (BPD) with a focus on aetiology, phenomenology and treatment. Two important outcome studies will then be reviewed in detail because the outcome literature suggests that positive change (remission and recovery) is possible. However, outcome studies are necessarily limited in how much they can reveal about the process of change. After consideration of the possibilities of remission and recovery as indicated within the clinical outcome literature, the contribution of literature focused on personal recovery to our understanding of change in mental illness and the conceptual basis of personal recovery will be explored. Consideration of the concept of personal recovery is a promising starting point for an understanding of the process of change in BPD because of the particular attention paid to the process of change in mental illness that has characterized the recovery literature. However, much of the existing recovery literature is focused on mental state disorders such as schizophrenia with limited consideration of personality disorder. As a starting point, a specific model of recovery - the CHIME model (Connectedness, Hope, Identity, Meaning, Empowerment) will be considered in relation to BPD. Specifically, each of the domains within the CHIME model will be reviewed in relation to BPD because the differences in the nature of personality disorder and mental state conditions have significant implications for how we understand personal recovery in BPD. The BPD-specific literature suggests significant insights into the role within recovery of changes in both how the individuals with BPD perceives himself or herself (self-representation) and within his or her relationships. Accordingly, a review of the BPD-specific literature will form the next section of this introduction. Self-loathing has been identified as a key impediment to recovery from BPD and the role of self-loathing within recovery from BPD will be considered next. Finally, implications for future scholarship in relation to recovery from BPD will be presented within the last section.

1.2 Borderline Personality Disorder: A Complex Condition

Personality disorder in general including BPD is a pervasive pattern of behaviour and personal experience that is not consistent with the expectations of the individual's culture (APA, 2015). Approximately 10% of the general population are affected by a personality disorder of some type (Samuel, 2011). BPD is the most commonly diagnosed of the personality disorder and affects approximately 0.7% to 2.7% of the adult population: with estimates of occurrence ranging from 1.6% to 2.7% within the United States (Lenzenweger et al. 2007; Tomko et al., 2013); 0.7% in Norway (Torgenson, Kringlor & Cramer, 2001) and 1.1% in The Netherlands (ten Have et al., 2016). Within an Australia context, BPD affects approximately 1% of the general population (Jackson & Burgess, 2000).

BPD is a complex condition that is characterised by vulnerabilities in relation to emotional regulation and also instability of both self-image and interpersonal relationships (Lieb et al., 2004). Diagnostic criteria reflect these core difficulties along with the behavioural manifestations of the disorder including self-harm, marked impulsivity, chronic suicidal thinking or behaviour and intense fear of abandonment with associated frantic efforts to avoid real or perceived abandonment (APA, 2015). Since only five of these nine criteria are needed for the diagnosis of BPD, the ways in which BPD is experienced by different individuals may be markedly different. The heterogeneity of how individuals experience BPD is mirrored within the diverse phenomenological and aetiological theories of the disorder (Leichsenring et al., 2011). Some theories focus on the biological basis of the disorder with, for instance, an emphasis on differences in brain anatomy and functioning in individuals with BPD compared to healthy controls and impulsivity as a temperamental trait (e.g., Gabbard, 2005; Livesley, 2008; Skodol et al., 2003). Others have suggested that adverse experience particularly in early childhood within the context of attachment relationships may be at the core of difficulties that vulnerable children

then face in later life (e.g. Fonagy & Lutyen, 2009; Levy, Beeney & Temes, 2011). Theorists who emphasize disturbed attachment relationships in early childhood also tend to focus on deficits in the ability to mentalize or with the representation of the self and with self-other relationships within adulthood (e.g. Fonagy & Bateman, 2016; Holmes, 2004; Levy et al., 2015). Neither of these perspectives is absolute, with theorists from a primarily biological perspective acknowledging the importance of supportive, nurturing relationships for vulnerable children. Conversely, theorists who emphasize difficulties within attachment relationships also acknowledge that biological vulnerability is important to the aetiology of the condition. The differences here seem to be a matter of emphasis rather than of absolute disagreement.

Linehan (1993) has suggests that a child's emotional vulnerability interacts with an 'invalidating environment' to create the conditions necessary for the future development of BPD. Linehan has described this etiological theory as the 'transactional model' and emphasizes that neither vulnerability within the child or caregiving deficits are in themselves sufficient aetiological explanation for BPD: it is the transaction between a vulnerable child and an invalidating environment rather than one of these factors alone that is needed for the individual to develop BPD.

Fonagy and Bateman (2008) offer more complex insights into the nature of an inadequate environment from within a psychodynamic framework. Their work has been influenced by psychodynamic thinkers such as Bowlby and Winnicott and rests on core understanding of the role of attachment as the key process within early development. Fonagy and Bateman theorize that mentalization deficits develop as a result of difficulties within the relationship between a vulnerable child and caregiver. Within Fonagy and Bateman's account, attachment processes connect biologically based vulnerabilities within the child with environmental influences. From within this attachment-informed perspective, the caregiver may not adequately or congruently mirror the child's affect or may not mirror the child's affect in ways that are sufficiently 'marked'. Marked mirroring involves an 'as if' quality by which the child is able to distinguish

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between the caregiver's own affect and the 'display' of the child's affect by the caregiver. Where mirroring is not congruent or is insufficiently 'marked' the child may not develop the ability to represent or purposely regulate their own affect. In other words, the individual under these conditions may have difficulties with mentalization. Mentalization involves the ability to understand and represent one's own mental states (thoughts, feelings, memories, desires intentions, aims and so forth) and also those of other people. Individuals with BPD particularly under conditions of emotional arousal may lose the ability to use conscious mentalizing capacities and rather rely on ways of perceiving reality that predate the development of mentalizing capacities. Fonagy and Bateman's aetiological account offers substantially greater detail about how an abusive or neglectful environment in early childhood may affect a constitutionally vulnerable individual's ability to mentalize in adulthood While there are substantial differences in the detail of this model, Fonagy and Bateman's account is not inconsistent with Linehan's transactional model. Without overemphasizing the similarities between these models, both suggest that the development of BPD is a complex process and further suggests that there is a complex interaction between a number of biological and social factors within the development of BPD.

In relation to the biological bases of the condition, individuals with BPD are more likely to have altered brain anatomy and functioning compared to healthy controls (Boutros, Torello & McGlashan, 2003; Nunes et al., 2009). Individuals with BPD may also have a biologically based propensity to experience emotion, particularly negative emotion, more intensely compared to other people without psychiatric difficulties (Kuo & Linehan, 2009). Alongside biological vulnerabilities, psychological factors such as abuse or neglect may also play a part. For instance, children with a court documented history of abuse were at increased risk of developing BPD when followed up 30 years later (Widom, Czaja, & Paris, 2009). Neglect or abuse is also commonly reported by individuals diagnosed with BPD (Zanarini et al., 1997). Sociocultural factors such a familial breakdown or marked stressors with in the family related to societal

breakdown may also predispose individuals to develop BPD (Bateman and Kravitz, 2013). BPD is clearly a complex condition with a diverse range of aetiologies, phenomenology and prognoses for individuals within the diagnosis.

The phenomenology and prognoses for individuals diagnosed with BPD is further complicated by the co-occurrence of other psychiatric disorders. While co-occurrence of other disorders with BPD is common, it should be acknowledged that the issue of co-occurrence remains a controversial one. Limitations with diagnostic systems such as the DMS-5 may lead to an over-diagnosis of disorders because of a late of clarity in relation to the boundaries of one disorder and others. Tomko and colleagues (2014) assessed co-occurrence in BPD within a national representative community sample of 34,481adults in the United States, the National Epidemiologic Survey on Alcohol and Related Conditions. A standardized, structured clinical interview was used to assess for DSM-IV diagnoses. As an indicator of overall co-morbidity, 84.8% of their sample assessed with BPD was also assessed with a lifetime occurrence of anxiety disorder; 82.7% with a lifetime occurrence of a mood disorder or an episode of depression or mania 78.2% with lifetime occurrence of a substance misuse disorder. BPD is also commonly co-occurring with other personality disorders (PD). For instance, Lenzenweger and colleagues (2007) reported the findings of a larger national, representative survey of personality disorder in the United States (the National Co-morbidity Survey Replication) in relation to PD with a total of 5692 adults. A two-part process was used for assessment of PD. Initial screening questions that formed the International Personality Disorder Examination were used and were then followed up with assessment using the full instrument when responses to the screening questions suggested the possibility of personality disorder. Within this study, tetrachoric correlations were used to estimate the co-occurrence of PD. Co-occurrence was common with, for example, a tetrachoric correlation of .82 with Dependent PD, .76 with Paranoid PD, .67 with Obsessive Compulsive PD, and .64 with Anti-social PD. Overall, these results suggest that co-occurrence of other PD is

common in the context of BPD as is co-occurrence of anxiety depressive and substance misuse disorders.

Personality disorder by diagnostic definition involves disruptions in psychosocial functioning (APA, 2015) with other assessments of psychosocial functioning reported in the literature adding detail to the picture provided by general diagnostic criterion. For instance, Tomko and colleagues (2014) reported that a diagnosis of BPD was significantly associated with indicators of interpersonal conflict such as trouble with an employer or manager at work, serious conflict with neighbours or relatives, and divorce or separation over the preceding 12 months. In relation to emotional functioning, individuals with BPD were also significantly more likely to report suicidal ideation or behaviour or a suicide attempt over the previous 12 months. These conclusions were based on odd ratios comparing the individuals with BPD to the study cohort overall. Individuals with BPD also appear to experience more functional impairment compared to both healthy controls and individuals diagnosed with mood or anxiety disorders. For instance, Ansell and colleagues (2007) assessed psychosocial functioning using the Longitudinal Interval Follow-up Evaluation (LIFE) at baseline and 6 month follow up. Individuals with BPD in this study showed significant more employment impairment compared to the healthy control group and were further impaired compared to both the mood and anxiety group on household functioning. Finally, the BPD group showed impairments in relation to functioning with children, partners and other relatives such as siblings compared to the control group without psychiatric disorder and the mood and anxiety group. The picture that emerges is one of significant difficulties across multiple functional domains with generally greater functional impairment in individuals with BPD compared to individuals with mood or anxiety disorders. Given the complexity of the presenting symptoms of many individuals diagnosed with BPD and the significant psychosocial impairment associated with the condition, it is perhaps not surprising that historically BPD has been considered a chronic, intractable condition (Sanislow, Marcus & Regan, 2012). The view that BPD is a chronic condition with limited prospects of remission or

recovery has been significantly challenged in recent times particularly in light of the efficacy of a range of treatments. This will be the focus in the next section.

1.3   Positive Change in BPD is Possible: Longitudinal Outcome Studies

Recent research has challenged the clinical pessimism that at times still surrounds a diagnosis of BPD, particularly in relation to remission of symptoms and also to a lesser extent to recovery of psychosocial functioning. Two large-scale, prospective, longitudinal studies of individuals with BPD demonstrate the remission of symptoms over time. The McLean Study of Adult Development assessed 220 adults as inpatients at index admission and then every 2 years for over 16 years (Zanarini et al., 2010;Zanarini et al., 2012). Over a ten year period Zanarini and her colleagues (2010) found that 86% of individuals with BPD no longer met diagnostic criteria for the condition. Recurrence of 36% after a 2 year remission and 10% after an eight year remission were also reported. Over a 16 year period, the remission rate was 99% over a two year period, with a relapse rate of 16% as subsequently reported by Zanarini and colleagues (2012). These findings are mirrored in the Collaborative Longitudinal Personality Disorders Study that assessed 175 adults diagnosed with BPD at 6 months, 12 months, and 2, 4, 6, 8, and 10 years (Gunderson et al, 2011). Eighty five percent of individuals remitted for at least 12 months over a ten year period, with a 12% recurrence rate. Clearly, these data challenge the view that BPD is a chronic, unremitting condition. However, difficulties with psychosocial functioning are a hallmark of the condition and recovery appears to be more difficult for individuals with BPD than a simple remission of symptoms.

Recovery within the McLean Study of Adult Development study was defined as "good social and vocational functioning" and was operationalised as remission of symptoms and a Global Assessment of Functioning (GAF) score of 61 or greater. Using this definition, approximately 60% of individuals with BPD recovered for two years over a 16 year follow-up period and about 40% of participants achieved an eight year recovery over the same period

(Zanarini et al., 2012). Within the Collaborative Longitudinal Personality Disorders Study, a GAF score of 71 was used to assess psychosocial functioning and approximately 20% of individuals diagnosed with BPD attained a GAF score of 71 or higher for 2 months or longer. Together, these figures suggest that recovery of psychosocial functioning appears to be more difficult for people diagnosed with BPD as well as less common.

Further complexity is added to the overall picture of remission and recovery suggested by the studies cited above by the study of the different rates of remission of acute and temperamental symptoms. In relation to difference in rates of remission and recurrence of acute and temperamental symptoms, Zanarini and colleagues (2016) described twenty-four symptoms of BPD as either acute or temperamental symptoms. Acute symptoms included affective instability, significant identity disturbance, quasi-psychotic thought patterns, self-harm and suicide attempts. Temperamental symptoms included chronic depression or anxiety or anger, general impulsivity and intolerance of aloneness. As Zanarini and colleagues (2016) note the acute symptoms are more life threatening and more specific to BPD, particularly in combination compared to the temperamental symptoms that are common across a range of psychiatric conditions. The acute symptoms as defined in this study appear to remit and recur more frequently than the temperamental symptoms. One possible explanation for this difference is that the acute symptoms are the focus of interventions within the empirically supported treatments for BPD and are thereby more likely to remit. However, and as the authors note, the majority of study participants were no receiving empirically supported therapy specifically designed for BPD but were rather receiving supportive, non-intensive counselling provided by generalist clinicians. An alternate explanation is that the temperamental symptoms of BPD are less amenable to change and more likely to recur than the acute symptoms. Overall the picture that emerges is one of considerable variability in the remissions and recurrence rates for BPD with temperamental symptoms less likely to resolve over time than the more acute symptoms. This may also further explain why individuals with BPD are less likely experience recovery compared to remission of symptoms.

Recovery of vocational functioning or in relation to building satisfying relationships (clinical recovery) may require temperamentally based change in addition to the remission of acute symptoms. In turn, change of temperamentally based symptoms may be both less common and more subject to recurrence when compared to acute symptoms with an associated negative impact on the possibility of recovery of psychosocial functioning as defined by clinical measures of recovery.

Measures of clinical recovery are necessarily normative in that they set a common standard for what a functional life involves for all individuals (Davidson, Lawless & Leary, 2005; Slade et al., 2012). This leaves no possibility for the individual with mental illness (such as BPD) to determine for him or herself what a functional life might be. Moreover, clinical measures of recovery cannot capture what quality of life might be for the individual in the sense of what is satisfying or meaningful for him or her. Outcome studies must necessarily use an objective measure of psychosocial functioning and this precludes individual standards of life success. Outcome studies also necessarily offer limited insights into the individual process of change: they are simply not designed to study the process of recovery. Understanding more about the process of positive change rather than to focus on recovery as an outcome ought to help clinicians and others such as carers to support individuals with BPD. In examining the possibilities of positive change (or progress) a wide lens needs to be applied with an interest in broad possibilities for a life with BPD rather than a narrower focus on remission of symptoms. The concept of personal recovery is highly relevant to this exploration of progress as determined by each individual because it is particularly focused on the 'journey' of living with a mental illness and progressing towards a more satisfying and meaningful life (Anthony, 1993). Given the significance of the concept of personal recovery to this thesis, the theory behind the concept of personal recovery will be discussed, before the historical basis of the concept is considered.

1.4   Positive Change in Mental Illness: The Concept of Personal Recovery

Positive change or progress in BPD can be understood as an ongoing process by which an individual with BPD moves towards an increasingly meaningful and satisfying life. Progress within BPD as it is understood within this thesis has been strongly influenced by the concept of personal recovery from mental illness more generally. Anthony (1993, p.527) provides a widely accepted definition of personal recovery and suggests that personal recovery is "a deeply personal, unique process of changing one's attitudes, values, feelings and goals, skills and or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness". There is a fundamental understanding of recovery as a process (rather than an outcome) here and also an emphasis on individual self-determination in understanding what a meaningful, satisfying life is. There is also an important recognition that change within the context of living with a mental illness is not straightforward and may involve the individual living with some symptoms. Finally, Anthony's definition highlights that it is possible to contribute socially in diverse ways within a mental illness. This understanding of the possibilities of living well with a mental illness is highly compatible with the central aim of this thesis: to better understand the process of positive change within BPD.

1.5   Personal Recovery: Conceptual Basis and Implications for Mental Health Policy

Personal recovery as a construct is now well established within the scientific literature. The concept of personal recovery originated in consumer-led initiatives intended to reform services from an emphasis on disability, symptoms or chronicity towards mental health systems that emphasized living well even with ongoing symptoms of mental illness (for instance, Chadwick, 1995 & 1997; Deegan, 1997; Read & Reynold, 1996). It is this emphasis on living well within the community that marked out the concept of recovery as contesting conventional healthcare practices in the late eighties and earlynineties. Psychiatric practices were considered to be at best iatrogenic or even dehumanizing. In relation to these practices, Chadwick (1997, p.

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577) suggested that individuals recovering from psychosis should not be regarded as "organic entities on the receiving end of the ministrations of 'experts'". Chadwick implies here that it is in fact routine practice to regard individuals diagnosed with psychosis in this manner. Other first-person accounts of diagnostic conversations with mental health professionals reinforce Chadwick's point. Deegan (1997) described her personal experience of a diagnosis that emphasised limited life prospects without hope for a satisfying or meaningful life. Further, the theme of loss of control over one's life was a common one in a British anthology of first person accounts of experiences with the mental healthcare system (Read & Reynold, 1996). Individuals living with mental illness commonly reported that they felt that they had recovered from an episode of mental ill-health in spite of the healthcare system rather than through the care offered by mental healthcare professionals (for instance, Campbell, 1996). Within an American context, it was not usual for consumers to refer to themselves as 'psychiatric survivors' to highlight that they had survived aspects of mental healthcare such as involuntary treatment rather than being helped by the 'care' offered by psychiatry and associated disciplines (Davidson, 2003). The consumer literature not only contested everyday practices within mental healthcare as encountered and described by consumers, the experience of living with mental illness was also contested. An emphasis on chronicity by clinicians as reported by individuals diagnosed with mental illness was contrasted with accounts of 'ordinary' lives in the community and the everyday success of those lives (for instance, Read & Reynolds, 1997). The concept of recovery progressively became associated with an alternate view of living with mental health difficulties and a set of claims for alternate mental healthcare practices.

At the heart of this alternate concept was the ideal of empowerment for individuals diagnosed with mental health difficulties. Empowerment involved autonomy on the part of each individual within his or her life. If then current healthcare practices were found to be profoundly disempowering, change towards a recovery-oriented system was to be focused on empowering the individual diagnosed with mental illness to manage their own symptoms (in collaboration

with clinicians and others) and to choose for themselves how they pursued a satisfying, meaningful and contributing life (see Davidson, 2003 for an overview). Deegan (1997) highlights that individuals who have had the "traumatic" even "catastrophic" effects of mental illness understand the processes of disempowerment that accompany that experience. Indeed, Deegan (1997) situated the experience of mental illness within a group of associated forces all of which are disempowering: institutionalized stigma, low expectations on the part of others for the possibilities of the person's life and the "dehumanizing" effects of clinical treatments. In contrast, personal recovery for Deegan (1997, p.11) involves empowerment or, "the right to make choices and to have access to resources to improve the quality of our lives". Davidson, Rakfedt and Strauss (2010) have further emphasized the role of autonomy and consumer choice within personal recovery as one of the lessons learnt from the recovery movement. Autonomy in this context refers to the right of all individuals including those diagnosed with mental illness to "decide what they want based on their own values, preferences, interests and life histories" (Davidson, Rakfedt & Strauss, 2010, p. 248). If treatment systems were considered by consumers or psychiatric survivors to be iatrogenic at best or even dehumanizing, the answer was a new focus on personal recovery that involved the empowerment of the individual to pursue their life goals based on individual preferences. Personal recovery originated within consumer narratives about the experience of living with mental illness and the privations often associated with treatment systems. However, personal recovery has also been taken up within the mental health policy including in Australia.

The concept of personal recovery has been widely incorporated into mental healthcare policy and practice guidelines particularly within the English speaking world (Le Boutilllier et al., 2011). Within an Australian context, national policy aims to "enable recovery" with recovery defined as involving "the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability" (Commonwealth of Australia, 2009, p. 31). The emphasis here is on the adjustment made by each

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individual as he or she moves ('grows') beyond mental illness. The language of this definition of recovery mirrors the language used in Anthony's widely used definition from within the consumer literature. This suggests that national policy within Australia requires that clinicians uphold the principles of personal recovery within their work. Further, the Australian National Health and Medical Research Council (NHMRC) has published guidelines for clinicians who work with consumers with BPD (NHMRC, 2012). It is suggested that clinicians are respectful and non-judgmental and that they communicate clearly. Further, the guidelines recognise the sensitivity to abandonment that consumers with BPD may display and suggest that the changes within the treatment such as changes in the clinician are planned in advance. The NMHRC guidelines also recommend that the first-line treatment for BPD is structured psychotherapy rather than pharmacological treatment and further evaluate the evidence for a range of psychotherapies. The need for treatment designed (structured) particularly for BPD is highlighted within the guidelines. There are now a number of structured BPD-specific treatments which are efficacious in the treatment of the symptoms of BPD including Dialectical Behavior Therapy (Linehan, 1993), Mentalization Based Therapy (Bateman and Fonagy, 2004), Cognitive Analytical Therapy (Ryle, 1997) and Transference Based Therapy (Clarkin, Yeomans and Kernberg, 2007). Interestingly, it appears that predictors of greater gains in therapy do not relate to modality but rather to symptom severity at the beginning of treatment and the strength of the therapeutic alliance (Barnicott et al., 2012). The NMHRC guidelines also highlight the stance taken by the clinician rather than the particular therapeutic modality provided that modality is specifically designed for the treatment of BPD and is evidence-informed. .

Personal recovery has been taken up by researchers in ways that are highly sympathetic to a consumer agenda to reform mental healthcare. Researchers in this regard have focused on three key themes: (1.) the experience of living with mental illness with a particular focus on daily activities; (2.) experiences of mental healthcare and of associated relationships with healthcare professionals and (3.) examinations of the meaning and experience of recovery for individuals

diagnosed with mental illness. The scope and ambitions within the recovery literature mean that it

is dense and complex. The recovery movement has since its inception in the late 1980s been

centrally concerned with restoring the rights of individuals with mental illness. In turn, the view

that individuals diagnosed with mental illness should have the same rights as other citizens can be

traced back at least to the 1960s when the view that individuals should live in the general

community was expressed in the policy by the Eisenhower administration in the United States

(Davidson, Rakfedt & Strass, 2010). In Britain, reform followed a similar trajectory from asylum-

based systems to the closing of institutions and community living (Rogers & Pilgirm, 2001).

Reform within Australia was influenced by changes in Britain with the timing of reform

somewhat later than in Britain (Happell, 2007). A complete review of this complex literature is

beyond the scope of this thesis. Despite the complex origins of the concept, there is now a

coherent model of the processes that support recovery: the CHIME model (Bird et al., 2014;

Leamy et al., 2011). The implications for this important model in relation to what is known about

the nature and experience of BPD will be considered below.

1.6   CHIME Reviewed: Implications for BPD

The CHIME model, representing five domains of Connectedness, Hope, Identity,

Meaning and Empowerment) is an empirically validated model of the processes that underpin

recovery from mental illness and is the only model that synthesises the considerable literature on

recovery that has developed since the nineties (Bird et al., 2014; Leamy et al., 2011). In order to

understand the nature of personal recovery CHIME includes three key parts: (1) analysis of the

recovery journey, (2) identification of five key processes summarized within the CHIME

acronym and (3) a five part model of the stages of recovery. Leamy and colleagues (2011)

reviewed ninety-seven papers to develop a narrative synthesis of the nature, processes and stages

of change associated with personal recovery. However, much of the existing literature on

personal recovery that formed the basis of analysis for the CHIME model is focused on mental

state conditions particularly schizophrenia. This focus on mental state disorders may be more an artefact of previous research than evidence that recovery is not relevant to the processes of change in BPD.

At the same time, the experience of living with personality disorder may be quite different to the experience of living with a mental state disorder such as schizophrenia. Conditions such as schizophrenia are widely recognized as episodic in nature (Liberman et al., 2002; Silverstein & Bellack, 2008). Recovery in the context of conditions such as schizophrenia or major depression may involve a new and more satisfying life after an episode (or series of episodes) of acute illness. In contrast, BPD is by definition a longstanding condition that is accordingly not episodic (APA, 2013). It is important then to understand how the concept of personal recovery as developed within CHIME is both relevant to recovery from BPD and also what the limitations of the current understanding of personal recovery might be in relation to BPD. Each of the CHIME processes will be consider in relation to BPD. Hope and then Identity and Connectedness and Empowerment and finally Meaning will be considered below.

1.6. 1 Hope, Recovery and Borderline Personality Disorder

'Hope' within CHIME is understood in multiple and quite complex ways. A single overarching definition was not provided, however, five key sub-themes were identified: 'Belief in the possibility to change'; 'motivation to change'; 'relationships that inspire hope'; 'positive thinking and valuing success'; and 'having dreams and aspirations' (Leamy et al., 2011). More generally, hope can be understood as expectations for the future for attaining personally meaningful goals. Those goals should also be subjectively regarded as realistic or possible and depend on personal effort or characteristics such as resilience (Schrank, Stanghellini & Slade, 2008). On the face of it, hope is likely to be central to recovery from any mental illness including BPD. Experiences of hopelessness are unlikely to be a constructive part of the process of working towards a meaningful, satisfying and contributing life and there is no reason to think that a lack of

hope would be compatible with recovery from BPD. The absence of any hope or a climate of hopelessness within treatment systems has also been identified within a range of different consumer narratives including first person accounts of recovery from BPD (for instance, Van Gilder, 2010). This sense of hopelessness has also been widely reported within first person accounts of receiving a diagnosis of schizophrenia. Indeed, early work aligned to the development of recovery as a paradigm highlighted the hopelessness around a diagnosis of schizophrenia at that time (for instance, Mead and Copeland, 2000). Hope in a general sense is likely to be important in recovery from BPD but hope as it has been considered within the empirical research is not just a general sense of optimism for the future. More specifically, hope has been described as an impetus at the start of the recovery process and also in terms of 'futurizing'.

Empirical studies of hope in recovery from mental illness in general have confirmed that hope is important both for maintaining the personal impetus for recovery and as an initial motivation to change. Noiseux and Ricard (2008) reported on a qualitative study of 41 caregivers, professionals and consumers and described the 'spark' of hope for a better future as an important first step towards recovery .This highlights the importance of hope as an impetus for change in the early stages of recovery. Another recent qualitative study examined recovery from a range of mental illnesses. For participants in this study, 'futurizing' or coming to terms with the past and focusing on a more positive future was a crucial aspect of recovery (Kartalova-O'Doherty, Stevenson & Higgins, 2012). Taken as a whole, the existing work suggests that hope is not simply a general aspect of recovery but rather functions more specifically as an initial motivator for change (the spark of hope) and also a factor that maintains individual empowerment (futurizing). Both these aspects of hope are likely to be important to recovery from BPD. However, futurizing may take on subtle but nonetheless significant differences in recovery from BPD.

There may be important differences in the experiences of individuals with BPD that impact on the ways in which hope can be maintained. Conditions such as schizophrenia are widely recognized as episodic in nature (Liberman et al., 2002; Silverstein & Bellack, 2008). Hope in the context of schizophrenia is hope for a new and more satisfying life after an episode (or series of episodes) of acute illness. In contrast, BPD is by definition a pervasive and longstanding condition that is accordingly not episodic in nature (APA, 2013). Hope in this context may take on a different meaning. As highlighted previously, recovery from schizophrenia is *conceptualized* as a process of identifying with the illness as an aspect of the self but not the whole self and pursuing personally meaningful goals rather than a return to premorbid functioning (Davidson & Roe, 2007). At a theoretical level recovery has been described as a process of self-development beyond the limiting effects of illness, but empirical work with consumers suggests a more complex picture with the conceptualization of recovery through the lived experience of schizophrenia-spectrum conditions a more variable one. Within Piat and colleagues' (2009) study with 54 consumers in Canada, recovery did mean the evolving of a new sense of self beyond the pre-illness self for many participants, but for other consumers, recovery involved a cure and a return to premorbid identity. In contrast to the possibility of a return to premorbid functioning, the experience of recovery from BPD may be best supported by an emphasis on a creative process of developing a new sense of self in the present: it may indeed make no sense to talk of premorbid functioning in a condition that is present from adolescence or early adulthood.

Childhood trauma may also mark the experience of individuals with BPD (Bierer et al., 2003). In this sense, there may be little sense in speaking of hope for a return to identity prior to illness particularly if early experience is associated with trauma. This further suggests that recovery may be most constructively conceived of as a process of inquiry about the self that emerges in the present. This may in turn impact how hope can be maintained for individuals with BPD. Hope in the context of BPD may then be more aligned to an evolving process of self-

inquiry or self-discovery than is necessarily the case in recovery from schizophrenia. Clearly, clinical practices that focus on a return to the past rather than exploring the sequelae of trauma are unlikely to maintain hope where that experience is associated with trauma or be otherwise constructive for individuals with BPD. Work on past trauma is important but it also needs to be balanced with creative efforts to explore dimensions of the self in the present.

1.6.2 Identity, Recovery and Borderline Personality Disorder

'Identity' within the CHIME model is also not directly defined rather three subthemes are identified: 'Exploring dimensions of one's identity'; 'Rebuilding or redefining a positive sense of identity'; and 'Overcoming stigma'. 'Identity' and the associated terms such as the 'self' or the 'self-concept' are notoriously difficult to define (Kerr et al., 2015). In the common use of the word, the 'self 'refers to 'about me'. In more psychologically-oriented terminology, the self refers both to the object to which reference is being made 'me' and the 'I' that is making this observation of 'me'. The self refers to both the reflective capacity to think, observe or have feelings about 'me' and also the content of the thoughts that 'I' reflect on. The 'self' then can be understood as the total of the thoughts and feelings that 'I' have about myself and the capacity to reflect on those same thoughts or feelings. The 'self-concept' is understood as the sum of the multiple identities with which 'I' identify. Finally, 'identity' is the more specific social roles, or group memberships or characteristics that 'I' understand to be a part of myself (Oyserman, Elmore & Smith, 2012). The complexity of these concepts makes a straightforward or simple definition difficult. Further the three terms (identity, self-concept and self) are commonly used in interchangeable ways. For instance, within CHIME identity is used, but within the literature on recovery from mental illness in general, identity and the self are used interchangeably. Within the current thesis, identity will be used to refer to specific roles or characteristics that the individual see as central to how he or she is and the self will refer more globally to the thoughts and feelings about 'me' and to the reflective functions associated with thinking about 'me'.

In the context of recovery from mental illness, the process of regaining a viable sense of personal identity after an episode of mental ill-health has also been described as remaking a "durable sense of self" (Sells, Stayner & Davidson, 2004, p.87). It is likely that the authors are referring more to identity rather than the self as defined above although the two terms are used interchangeably. Nevertheless, a durable identity in this context refers to an identity or identities that are distinct from mental illness and also that successfully resist stigma. Developing a durable sense of identity is likely to be an important recovery process for individuals with BPD in common with those with other types of mental health difficulties. However, this process may be complicated by the nature of BPD and the difficulties around a coherent sense of self that individuals with BPD may experience. The difficulties around a coherent sense of self associated with BPD have been described as a limited ability to commit to the "world, themselves or other people" (Jorgensen, 2006, p.627). Disturbance in relation to the self has been identified as a core feature of the difficulties associated with BPD by major treatment models (See Kerr et al., 2015 for a review). Recent qualitative work with consumers diagnosed with BPD further accords with the view that BPD can be viewed as involving disturbances in relation to the self. Gillard, Turner and Neffgen (2015) explored the subjective experience of BPD within a qualitative study with 6 service users interviewed on two occasions. The subjective experience of BPD was described as, "a tension within the self between the internal and external worlds". Theoretical accounts of BPD and qualitative research into the subjective experience of BPD both suggest difficulties with the self are central to the experience of living with BPD. These difficulties may further involve intensely negative appraisals of the self.

Empirical studies suggest that individuals with BPD have typically negative views of themselves. For instance, studies using card sorting approaches suggest that individuals with BPD have self-representations with greater self negative valences when compared to healthy controls (Beeney et al., 2016; Vater et al., 2015). Further, individuals with BPD typically rated most of their self-representations negatively, with few positive qualities attributed to the self (Vater et al.,

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2016). This tendency to overwhelmingly see the self negatively has further been described as intense self-loathing within literature that is based on clinical observation or single case studies (Bender & Skodol, 2007; Kravitz, 2012 a & b).Self-loathing can be understood as an attribute of one's personality which is pervasive (has been present in the past and is assumed to continue in the future) of self-hate that exceeds "situation-specific shame and having generally low self-esteem, feeling inferior, unlovable or incompetent to include deep experience of self-disgust, self-revulsion and global shame and feeling fundamentally flawed" across a range of contexts and situations. (Krawitz, 2012 b, p. 501). Although the tendency to see many aspects of the self negatively is a somewhat different and more precise concept than that of self-loathing, the two concepts have considerable overlap. Further, the empirical work generally supports the conclusions drawn from the literature drawing on clinical observation or case studies to the extent that card-sorting studies suggest significantly more negative appraisals of the self when compared to healthy controls.

Severe difficulties with self-representation may contribute to difficult or unstable interpersonal relationships in adulthood that may in turn be based in disrupted attachment relationships with caregivers in early childhood. The interpersonal style of individuals with BPD has been reported as more commonly being characterised by preoccupied / unresolved attachment when compared to individuals without a diagnosis of BPD (Choi-Kain et al., 2009). Preoccupied / unresolved attachment style in adulthood is often the outcome for individuals with a characteristically disorganized attachment to caregivers in childhood. Disorganized attachment is a pattern of relating whereby the child is faced with an approach / avoidance dilemma when the caregiver. rather than being a source of reassurance when the child is frightened, is actually the source of that fear. The child is faced with a 'double bind': the child seeks reassurance from the parent or caregiver but is also frightened by that same caregiver (Main, 1995). The sequelae in adulthood to disorganized attachment in childhood can be a preoccupied or unresolved style of relating to others particularly in intimate relationships. Staebler and colleagues (2011) conclude

that individuals diagnosed with BPD are typically highly ambivalent in their relationships with others. both seeking intimacy and avoiding it. This dilemma has been characterized as a desperate need for interpersonal connection that is also marked by intense fear of rejection (Clarkin & De Panfilis, 2013). Attachment theory not only suggests that difficulties with the self / other relationship is at the heart of the difficulties individuals with BPD experience, but further suggests that interpersonally individuals with BPD must resolve the approach / avoidance dilemma in their relationship with others.

The picture that emerges both from theoretical models of BPD including attachment theory, clinical observation about self-loathing and the more limited empirical work focused on the subjective experience of BPD is that difficulties in relation to the self are at the heart of the difficulties experienced by individuals with BPD more generally. Those difficulties are not only a matter of self-representation but also involve characteristically disorganized attachment styles with implications for interpersonal relationships. This makes the task of developing a "durable sense of self" difficult (Sells, Stayner & Davidson, 2004, p.87). In common with others recovering from mental health difficulties, individuals with BPD must incorporate the illness experience into their identity in ways that resist the stigma associated with mental illness. Alongside this difficult process, individuals with BPD may also need to develop ways to reconcile the tensions within the self and resolve the approach / avoidance dilemma in relation to relationships with others. This may in turn make the work on the self in recovery from BPD more complex than the 'identity work' as it has been conceptualized within the recovery literature.

1.6.3 Connectedness, Empowerment, Recovery and Borderline Personality Disorder

Although 'Connectedness' is not directly defined within Leamy and colleagues' (2011) work, four sub-themes are identified within CHIME: 'Peer support and support groups'; 'Relationships'; 'Support from others' and 'Being part of the community'. Connectedness can then be understood as the subjective sense of relationship with others with a particular emphasis

on supportive and trusting relationships. This is a somewhat different if not related concept to that of relatedness or relationality within the clinical literature. Relationality within the clinical literature is focused more specifically on the capacity to maintain viable relationships with others. Relationality within this context can be understood as the capacity to generate coherent and benign concepts of the self in relation to others (Bender and Skodol, 2007). The emphasis within the concept of 'relationality' is on capacity and can be compared to the emphasis on subjective perceptions within the concept of 'connectedness' Within the context of this thesis, 'connectedness' will be used to refer to the subjective perceptions of an individual's relationships whereas 'relationality' will be used to refer to the capacity for integrated and benign images of the self, of others or the self in relation to others.

'Empowerment' within CHIME encompasses three key themes: 'Personal responsibility', 'Control over life' and 'Focusing on strengths'. Overall, empowerment within the context of CHIME appears to refer more to the concept of autonomy rather than agency although the two concepts are closely related. Agency is understood here as the capacity to act within one's social world and autonomy is understood as the right to make decisions for oneself about one's life. Empowerment may then refer to the support offered by others to assume autonomy for oneself and to act as an agent within the social environment. The clinical literature has focused more on agency understood as the capacity for action within the social world rather than on autonomy. Empowerment might then be seen as encompassing both autonomy and agency. Connectedness and relationality may both impact on empowerment. In relation to relationality, a lack of capacity to see others as other than malevolent is unlikely to lead to a strong sense of agency: one is unlikely to act in the social world if others are seen as dangerous or as otherwise malevolent. In relation to connectedness, experiences of stigma may also impact on the individual's sense of agency and in more subtle ways on autonomy: one is unlikely to make free decisions about oneself or to act in the world if one feels constrained by the fact of a mental health diagnosis.

Connectedness and empowerment will be considered together here because of the close interrelation between these concepts.

Authors from a wide range of theoretical perspectives have suggested that disturbance in relatedness or relationality within the context of disturbances of the self characterises the difficulties which individuals with BPD experience (see Bender & Skodol, 2007 for a review). Empirical work within the BPD literature further supports the perspective that individuals with BPD experience difficulties in relatedness. The rejection sensitivity that appears to characterize the interpersonal style of individuals with BPD has significant implications for recovery particularly in relation to how individuals relate to others. Alder and colleagues (2012) suggest that individuals with BPD construct complex narratives about self, that differ from the narratives of controls on a number of dimensions including agency. Individuals with BPD described an impaired sense of agency when compared to controls. Difficulties in viewing oneself as an agent capable of acting in the world may make clinical interventions aimed at empowerment worthwhile but difficult.

The recovery literature also emphasizes the social nature of recovery with a broad interest in the kinds of relationships that support recovery (for instance, Ådnøy Eriksen et al. 2012; Ådnøy Eriksen et al., 2014; Topor et al., 2011). The task of redefining an individual sense of identity does not occur in a vacuum; rather the right to full citizenship occurs within the specifics of the social environment (Topor et al., 2011). Further, the opportunities (and restrictions) within a particular social environment offer specific resources for re-establishing a sense of connectedness and associated social agency (Mezzina et al., 2006). Individuals diagnosed with BPD may face difficulties in common with others with a mental health diagnosis. Stigma may play a part here as may limited financial and social resources. Sigma and limited means may limit possibilities for agency for both individuals with BPD and others with other types of mental illness (Tew et al., 2012). Beyond the difficulties associated with stigma, individuals with BPD may also face additional difficulties in gaining a sense of agency within their particular social

circumstances. Alongside others diagnosed with mental illness, respect, warmth and belief in capacities and abilities are critical to supporting recovery (Mancini, 2007). Indeed, "a sense of safety and building trust" has been identified within a hierarchical recovery from BPD model as the primary process that must be in place before further recovery work can occur (Castillo, Ramon & Morant, 2013, p.268). Individuals with BPD may face a double dilemma in recovery. Not only do individuals with BPD face the barriers to social agency that have been identified for individuals with schizophrenia, the nature of BPD may also create approach / avoidance difficulties. Clearly, the emphasis within a recovery paradigm on connectedness is highly relevant in relation to BPD, but difficulties with relationality may make connectedness more complex than had been suggested within the existing recovery literature.

1.6.4   Meaning, Recovery and Borderline Personality Disorder

'Meaning' within CHIME is understood in relation to six more specific themes: 'The meaning of mental illness experiences'; 'Meaning in relation to social roles'; 'Meaning in relation to social goals', 'Quality of life', 'Spirituality' and 'Rebuilding life'. The diversity of these themes is also apparent within the literature on meaning in life within the psychological literature. Despite this diversity, meaning in life can be understood as a sense of fulfilment that arises from awareness of order, coherence and purpose and of the ability to pursue goals that are perceived as worthwhile by the individual (Wong, 2012). There is then a cognitive component to meaning of life (subjective recognition of coherence or purpose) and a behavioural component (pursuit of subjectively worthwhile goals). The diversity of themes within CHIME that contribute to meaning as an overarching domain also suggests both a cognitive component (meaning in relation to the illness experience and in social roles) and a behavioural component (the pursuit of goals). Overall, meaning is also likely to be connected to subjective understandings of relationships and to a subjective sense of agency: meaning in relation to social roles is likely to rest on a prior understanding of the quality of relationships and the pursuit of goals implies an adequate sense of

agency. As highlighted above, relationality and a strong sense of agency are particular difficulties for individuals with BPD.

The self, relationality and meaning form a three-part cluster within BPD. Difficulties with the self may affect relationships with others, but in turn a sense of meaning within an individual's life may be limited where there is a lack of cohesion in relation to the self and where relationships with others are disturbed. Meaning in this sense is intrinsically tied to a sense of self and further refers to the 'language game' involved in intimacy with others (Holmes, 2003). As Holmes (2003, p. 525) observed, individuals with BPD "might be seen as unable or unwilling to play by the rules of a normal affective language game: feelings are enacted, ignored, and over-ridden rather than described, heard, understood, or reciprocated." Meaning from this attachment-based perspective is intrinsically involved in language and is also crucially intersubjective. It is within our relationships with others, and the language we use within these relationships, that a personal sense of meaning for the individual emerges. This sense of meaning is quite specific and also differs from how meaning is understood within the recovery literature or how meaning in life is understood within the general psychological literature. The complex and quite specific understanding of meaning within the BPD literature suggests that the two discourses are not compatible. The comparative lack of theoretical depth in relation to how meaning is understood within the recovery literature may also been seen as a current limitation of the recovery paradigm. Complex processes that involve the self and relationality may need to be reflected upon before a sense of meaning in life emerges for the individual with BPD. This suggests that while meaning in life is likely to be important to all individuals recovering from mental illness, the specific difficulties that individuals with BPD face complicate recovery in ways that go beyond the current understanding of meaning within the recovery literature.

1.6.5 Specificity of Personal Recovery in BPD: Relevance of and

Differences from CHIME Processes

Consideration of CHIME in the context of BPD suggests that each of the five processes is relevant to BPD to some extent. The picture that emerges from consideration of the CHIME recovery processes within the context of BPD is that the nature of the condition itself means that recovery from BPD may involve a complex set of processes that are phenomenologically different from other conditions such as schizophrenia. Understanding these differences is important in understanding the specific processes that support positive change in BPD. In relation to hope, a clinical focus on chronicity and the possibility of only a limited or impoverished life will of course be iatrogenic for all individuals living with a mental illness including BPD. However, the specificity of the BPD also matters here. Consideration of the phenomenology of BPD suggests that recovery involves complex processes that are different to the processes of recovery from mental state disorders such as schizophrenia. The developmental trauma that is commonly reported by individuals with BPD makes hope for the future a creative, unfolding process of self-inquiry into a new or evolving sense of self without the possibility of a return to a past sense of self. In relation to empowerment, issues around agency that particularly affect individuals with BPD may make empowerment complex.

The differences in the phenomenology of BPD and the implications for recovery are perhaps most apparent in relation to identity, commonality and meaning. Difficulties with a sense of self, including identity and relationality, are diagnostic criteria for BPD and there may be a blurring of the relationship between remission of symptoms and recovery in relation to BPD when compared with other conditions such as schizophrenia. Living with BPD involves core difficulties with the self and the self in relation to others (Gillard, Turner & Neffgen, 2015). Developing a coherent sense of self and forming healthy relationships may be particularly difficult for individuals with BPD with core implications for the process of recovery. It may not be enough only to develop a "durable sense of self" as it has been described in the recovery

literature. Rather individuals with BPD may need to avoid stigma and self-stigma and also resolve an inherent tension between the internal and external aspects of the self. Fostering self-compassion also appears to be central to working with the difficulties with the self that contribute to the wider difficulties individuals with BPD experience. There is also now an emerging literature on personal recovery and BPD more specifically. All of the BPD-specific literature has been published after the CHIME model was developed. This newer literature offers specific insights into the nature of BPD particularly from the perspective of individuals diagnosed with the condition and further exploring the meaning and experience of recovery from BPD. This comparatively limited literature (compared to the breadth of work that forms the basis of CHIME) will now be reviewed because although still fairly limited the BPD-specific literature offers initial insights into the specific nature of recovery in BPD.

1.7   Personal Recovery and Borderline Personality Disorder: Empirical Studies

Six key qualitative papers are relevant to our understanding of change in BPD. Three papers focused directly on recovery in outpatients with BPD within metropolitan clinical settings (Holm & Severinsson, 2011; Katsakou et al.,2012; Larivière et al., 2015); one paper focused on recovery for residents diagnosed with BPD within a therapeutic community (Castillo, Ramon & Morant, 2013); one paper focused on the lived experience of BPD (Gillard, Tuner & Neffgen, 2015) and one paper focused on the experiences of the self and identity in BPD (Agnew et al., 2016). These studies add perspectives on how positive change is experienced through consideration of the experience of living with BPD and also recovery in relation to the condition. The two studies with implications for an understanding of the lived experience of BPD will be considered first because an understanding of the experience of BPD grounds an understanding of the associated difficulties in recovery that individuals with BPD experience.

Before discussing the findings from these studies, a note on the language used in this literature is also important here. A number of terms are used somewhat interchangeably and this

can at times complicate the conclusions that can be drawn from the studies considered here and further complicates the process of comparing findings across studies. For instance, 'identity' and 'commonality' within the CHIME model is more commonly described in terms of the 'self' and 'relationships' within the BPD-specific qualitative literature with occasional use of the 'self' and 'self / other' or the individual's 'internal' and 'external world'. Exact definitions for these terms are often missing from the studies to be examined below, making definite statements about intended meaning difficult. Nevertheless, it appears that the self is usually used as a more global term to describe thoughts and feelings about 'me' and the reflective capacity to think about those same thoughts. Identity is more commonly used to describe more specific social roles that the individual identifies with. However, these observations are general in nature and it is at times difficult to know what exactly terms like the 'self' or the 'internal world' or 'external world' mean. In terms of the language used here a range of terms will be used that mirror the language of the source studies with the self and self/ other relationship used when the author is interpreting a particular study.

Turning to the first of the studies to be reviewed here, Gillard Turner and Neffgen (2015) argue that any account of personal recovery that is sensitive to the nature of BPD must rest on a prior account of the experience of living with BPD. Six participants recruited from a specialist, outpatient clinic were interviewed on two occasions to explore their understanding of living with BPD. Thematic analysis resulted in themes including "The internal world'; 'The external world'; 'Recovering or discovering the self – reconciling the internal and external worlds' and 'Thinking and feeling differently'. The internal world was described by participants as involving feelings of isolation including extreme self-criticism with associated putative feelings directed towards the self and at times almost total detachment from others. The external world was perceived as unpredictable and hostile and also participants reported feeling helpless in relation to others. Coping strategies included withdrawing from the external world and participants further highlighted that actual stigmatizing experiences added to their desire to withdraw. The associated

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need for change and also acceptance of oneself was described as the basis for recovering or discovering the self. Change in this context was reported to involve changes to self-care and also changes in relationships with others. In parallel with changes in relationships with others, participants also recognised the need for change in their responses to internal aspects of their experience, that is, to thoughts and feelings. Overall the authors understand living with BPD as a continual "tension within the self between the internal and external worlds" with associated complex, difficult and conflicting feelings (Gillard, Turner & Neffgen, 2015, p. 183). Recovery from within this account involves reconciliation between the internal and external aspects of the self. This process of reconciliation involves finding a way to feel safe in the external world and also appears to involve recognition of the need for change balanced with an acceptance of oneself as one is.

Agnew and colleagues (2016) explored the complexity of the self and identity within the context of living with BPD by eliciting the life stories of women living with BPD. The authors interviewed five female participants in order to elicit an understanding of their life story. These life stories were described in response to a single initial question asking participants to talk about their life. Follow up interviews were conducted to allow for reflection on the part of participants. Their study is grounded in theoretical accounts of the self which suggest that optimally the individual has a self-understanding that is complex, multiple and relational and also flexible in response to the demands of different contexts. This understanding of the self is contrasted with a conception of the self as unified or singular with associated difficulties in responding to different contexts or contradictory aspects of experience. Optimally, there is complexity or multiplicity within the self that allows for flexibility in response to different contexts but there is also a sense of continuity within the self between different contexts or situations.

Thematic analysis resulted in major themes of 'Connecting to myself', 'Distance between us' and 'Hurt and healing'. In relation to the first of these themes, participants were able to describe different aspects of themselves: their sense of self was complex in this sense. However,

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participants also described experiences of extreme disjunctions with abrupt changes between positive and negative understanding of the self. This sense of disjunction led to an overall sense of disconnection between different experiences of the self and of discontinuity between situations. In relation to the second theme, others were frequently experienced as hostile or alienating although participants also described positive experiences of compassion and intimacy. This suggests that individuals' perception of others is not always a matter of alienation but involved complex, mixed experiences. However, participants further described difficulties at times in how they perceived themselves in relation to others. Notably some participants reported experiences of a blurring of the boundary between oneself and the other person. In relation to the third theme, participants again described a mix of experience in relation to others with experiences of being profoundly hurt particularly by childhood trauma but also other different experiences of being cared for and nurtured. Trauma in childhood and the associated difficulties in adult life in relation to the self and relationships with others were highlighted. Participants articulated in an insightful way the impact of trauma on their sense of self, but recognition of traumatic experience and associated impacts on the self were not accompanied by a sense of agency in changing relationship patterns that were perceived as detrimental to the self. Although recovery is not directly addressed, this study does imply that positive change may involve work on the self and on relationships.

Overall, Agnew and colleagues' (2016) study has parallels with Gillard, Tuner and Neffgen's (2015) findings particularly in relation to the overarching difficulties with the self and with relationships. Gillard, Turner and Neffgen highlight both internal difficulties with the representation of the self and also difficulties in relation to other people who are often seen as dangerous or hostile. Recovery is then understood as the reconciliation of these tensions between internal experience of the self and the self in relation to others. Although the authors do not directly address personal recovery, Agnew and colleagues' study adds insights into the nature of the work on the self that may be needed to foster recovery. Specifically, work on the self may

involve consideration of the abrupt shifts within the individual's experience of him- or herself and the associated sense of discontinuity between different contexts or even different times. Further, this work on the self may also address change in relationship dynamics with the fostering of the individual's sense of agency within relationships when those relationships are viewed as detrimental to the self. Taken together these two studies suggest that recovery involves work on the self and self/other relationships.

The remaining four studies of interest focused on a different set of questions in relation to recovery and considered recovery directly, from the consumer point of view and within a range of contexts including outpatient clinics and a therapeutic community. In relation to the meaning of recovery for consumers, Katsakou and colleagues (2012) explored attitudes to recovery amongst 48 consumers from metropolitan based outpatient services. Half of their participants felt that the concept of recovery was relevant to their experiences with the other half reporting that recovery did not adequately describe their experiences of making progress with BPD. Those participants who felt that 'recovery' was not a faithful descriptor of their experiences reported that 'recovery' implies a binary set of possibilities in progressing with BPD: one either still has difficulties or one had 'recovered' and this implied living without difficulties. These participants suggested that this was not the case with BPD and that there were many other possibilities between severe or chronic difficulties and being 'fully recovered'. Some participants in this study also felt that this binary set of possibilities was particularly inappropriate given that all-or-nothing thinking is a hallmark of BPD as a condition. Interestingly, while the possibility of a complete recovery was rejected by some participants, most of the participants felt that it was possible to make progress in the context of living with BPD: positive change was a part of their experience.

Concerns about the appropriateness of the word 'recovery' for their experiences were similarly expressed by participants in another more recent study (Larivière et al., 2015). Twelve women diagnosed with BPD who had completed a 2 year outpatient program participated in the study. About 60% of participants reported that 'recovery' was an adequate descriptor of their

experiences in progressing with BPD. The remaining 40% associated recovery with the cure of a physical illness and suggested that a complete cure from BPD was not possible and also noted that they had lived with BPD for a long time and felt that they would always live with BPD making recovery an inadequate choice of word to describe their experience. In common with participants in Katsakou and colleagues' study, participants in this study reported that while 'recovery' may not be the best term to describe their experiences, progress with BPD was possible.

In addition to the meaning of 'recovery', the experience of recovery has also been considered within four studies. Three of these studies focus on recovery in general (Castillo, Ramon & Morant, 2013, Katsakou et al., 2012 & Larivière et al., 2015) and one focused more specifically on suicidality in relation to recovery from BPD (Holm & Severinsson, 2011). Katsakou and colleagues' study will be reviewed first in conjunction with Holm and Severinsson's work on recovery in BPD in relation to suicidality. Castillo and colleagues' study will be considered next because it also speaks to issues in relation to the self and relationships but can further be interpreted as suggesting a complex interplay between change in the self and changes within relationships with others. The final study focused on recovery from BPD is of a more minor nature but can nevertheless suggest that the recovery involves a complex interplay of the individual and his or her perception of the self and the changes between the 'person' and the 'social environment', or in other words, relationships with others.

Katsakou and colleagues' (2012) findings directly address the self and relationships along with a range of more specific themes. The authors report five themes related to the experience of recovery: 'Accepting self and building self-confidence', 'Taking control of emotions, mood and negative thinking', 'Reducing suicidality, self-harming and other symptoms', 'Improving Relationships; and 'Practical Achievements and Employment'. Clearly, only two of these themes speak directly to importance of change in the individual's self-concept and relationships. However, other themes also relate to the need for change in relation to the self and within

relationships. Taking responsibility for oneself is apparent in the theme related to managing

emotions and negative thinking and also in relation to reducing suicidality and self-harm.

Practical achievements such as managing a household or finding employment were also related to

how individuals saw themselves, for instance, as more 'competent'. Although the authors do not

make this specific observation, it appears that practical changes are not wholly an expression of

changes in how the individuals perceive themselves but rather a means through which changes in

the self can be actualized. For instance, in being more self- accepting by feeling more positive

about oneself through practical achievements.

Holm and Severinsson (2011) explore recovery from suicidality within the context of

BPD. In-depth interviews were conducted with 13 women living in the community who were

recruited via mental health clinicians in both private and public settings and a community-based

mental health organization. Thematic analysis of the interview data suggested two major themes:

'Struggling to assume responsibility for self and others' and 'Struggling to stay alive by

enhancing self-development'. Clearly, both of these themes speak to the need for therapeutic

work on the self for individuals in recovery from suicidality. Struggling to take responsibility for

oneself involved no longer blaming oneself for past trauma and also negotiating the extremely

difficult question of how one relates to family and intimate others. The authors further suggest

that suicidal behaviour is an extreme form of identity confusion and that survival involves being

able to move from an unstable or incoherent identity or sense of self to a more stable and

coherent one. Enhancing self-development as a means of staying alive starts by taking up the

possibility of a 'new self' and of changed relationships with others. Holm and Severinsson's

study not only highlights the vital importance of reflection on the self and relationships and the

need for the development of a new self within the context of surviving chronic suicidality, but

further makes clear the intense levels of emotional distress associated with this process. The

authors conclude that when the individual with BPD feels safe, trusted and their own sense of self

is confirmed they are able to move beyond suicidality. In this sense, recovery could be seen as

essentially relational: only through supportive relationships is the development of a new self possible.

Castillo and colleagues interviewed 66 consumers within a residential, therapeutic community in Britain. Eight themes are reported: 'A sense of safety and building trust', 'Feeling cared for and creating a culture of warmth', 'A sense of belonging and community' 'Learning the boundaries – love is not enough', 'Containing Experiences and Learning Skills', 'Hopes, dreams and goals and their relationship to recovery', 'Achievement, identity and roles' and 'Transitional recovery and how to maintain healthy attachment'. These eight themes are further presented within a hierarchical model of 'transitional recovery' with 'Safety and building trust' at the base of this model and 'Transitional recovery' at the apex. The authors make reference to Maslow's hierarchy of needs and suggest that while recovery is not a linear process each of the higher processes builds on the lower ones. 'Transitional recovery' is also used to highlight that recovery is not an outcome or end state but rather an ongoing process. The focus of this model is the self in relation to others. For instance, each of the four lower themes suggests the need for a renegotiation of the self in relation to others and the highest level of transitional recovery is associated with the maintenance of healthy attachments to others. This focus on the self/other or relationships as essential to change in BPD is not unexpected in the context of a study conducted within a therapeutic community: the veracity of the therapeutic community as a vehicle for change rests on the view that improving relationships with others has positive benefits for the individual's sense of self (Jones, 1968). Nevertheless, this study suggests that there is a complex interplay between the self and the self in relation to others in recovery from BPD. For instance, 'Learning the boundaries' suggests, as the authors highlight, the need not only for respect for oneself but also respect for the 'reality' of others and for difference in order for the individuals to take responsibility for themselves. Overall, Castillo and colleagues' study can be read as extending the focus on the self and the self / other relationship by suggesting that there is a complex interplay between the individual's understanding of the self and that self-concept in

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relation to others. This understanding of the interplay of the self and self / other relationships is focused on the renegotiation of these aspects of the individual's experience internally. However, the interplay of the self and others echoes the conclusions of Holm and Serinsson's study in that this internal process may also be best supported relationally. In other words, the internal changes that are necessary in recovery from BPD (in relation to the self and relationships) must also be best supported by a trusted relationship with another person such as a therapist or carer. In this sense, change is also relational.

The final study to be reviewed here is of a more minor nature with less clearly articulated themes compared to the other three studies considered above. Larivière and colleagues (2015) interviewed 12 women on two occasions recruited from two specialist services for BPD in a metropolitan context. Three themes were developed through thematic analysis: 'Dimensions Related to the Person', 'Dimensions Related to the Environment' and 'Dimensions Related to Occupation'. Although the language used in this study is markedly different from the others, some similar conclusions can be drawn about the nature of recovery in BPD. Each of the themes described in this study is presented as a somewhat undifferentiated list of positive opportunities for change with little theoretical integration. For instance, change in relation to the person involving thirteen specific subthemes is described, but these aspects of change are simply listed by the authors without further integration. Nevertheless, one of these themes involves work on identity and others involve both changes to self-acceptance and in relation to self-responsibility, for instance, in relation to managing one's own emotions. One subtheme is described in relation to the theme of the environment: 'Improving relationships'. However, there is limited discussion of how individuals with BPD may achieve improvements in their relationships. The final theme related to occupation again largely lists changes that allow for a renegotiation of the self within the context of intimate relationships or the wider community for instance, by having and maintaining a job or carrying out a personal project. Overall, the limitations of this study in relation to the conceptualization of recovery in BPD make the findings difficult to interpret.

This is an emerging literature and the cohesiveness of the each study's conclusions when compared with other studies could be easily overstated: the findings of these studies are not unified and appear to suggest quite varied conclusions about recovery in BPD when compared. This lack of cohesiveness may reflect the diversity of contexts within which the studies were conducted (outpatient clinics and a therapeutic community). Further, there were methodological differences in how the studies were conducted. Finally, there may be considerable diversity in how individuals with BPD experience recovery. Further, work on how consumers experience recovery will be fruitful in clarifying the questions that the literature to date suggest. In addition, clinicians are in a strong position to observe recovery and their insights may add to the existing literature.

Despite the diversity within this literature, there are some common themes. Together, this literature highlights the importance of a changed understanding of the self and changed relationships with others. Alongside these overarching themes there is also a third set of concerns that focus more on practical matters such as reducing symptoms and managing self-harm and gaols and achievements such as obtaining employment. These more concrete concerns appear to be important in allowing the individual to develop some sense of agency in relation to the social environment or to heal disrupted patterns of relating to the self and others. In other words, these more concrete concerns speak to strategies individuals with BPD use to reconcile the tension between difficult internal representations of the self and the self in relationship with others (Gillard, Turner & Neffgen, 2015). However, the process of developing a changed sense of self and of oneself in relation to others does not appear to be two separate processes. For instance, the complex interplay of the self and the relationship between the self and others is also implied within Castillo and colleagues' study. Further, the healing of suicidal behaviour and development of a 'new self' necessary to that process of healing within Holm and Severinsonn's study was intensely relational in nature. Overall, the existing literature suggests a complex set of processes support change or recovery for individuals with BPD. Despite this complexity, the self and

relationships are key themes. Interestingly, it has been further suggested that self-loathing is a specific barrier to recovery for individuals with BPD (Kravitz, 2012 a & b). Self-loathing, self-criticism and self-compassion will be considered in the following section because while it has been suggested that there is a relationship between self-loathing and recovery this had not been examined empirically.

1.8   Barriers to Personal Recovery: Self-loathing and Intense Self-Criticism

Self-loathing or excessive self-criticism has been identified as a common barrier to recovery in BPD (Kravitz, 2012a & b). Further, self-loathing has been identified specifically as a barrier to recovery within BPD rather than within recovery from mental illness more generally. This thesis is centrally concerned with recovery from BPD and will focus on self-loathing rather than other barriers to recovery such as hopelessness because self-loathing is particularly relevant to recovery from BPD rather than mental illness more generally. Self-loathing can be understood as more than shame in a specific situation or typically low self-esteem. Rather self-loathing is the pervasive experience in the present, past and likely in the future of "severe chronic self-hating, self-disgust and self-contempt" (Krawitz, 2012a, p.409). Self-loathing may also be associated with the subjective belief that one is entirely unworthy and deserving of punishment. The belief that one deserves to be punished may lead to self-harming or suicidal behaviours. Severe self-criticism has been similarly described as more than situationally specific shame or global low self-esteem. Rather, self-criticism can be understood as a pervasive pattern of negative emotion directed at oneself that includes anger, disgust and contempt for the self (Gilbert et al., 2004). Although not identical constructs, self-loathing and self-criticism share many common features, for instance, pervasive contempt for the self and an association with shame that extends beyond specific situations to be a significant aspect of self-judgments.

Self-compassion is another closely related construct although not the exact opposite of self-criticism. Self-compassion has been described as having three inter-related parts that are

apparent when experiencing a subjective sense of failure or pain. The first is developing a kind

and understanding stance towards oneself. The second is an understanding of one's failures as

part of the human condition rather than a unique personal fallibility and the third involves

acceptance without avoidance or over-identification of painful thoughts or emotions (Neff,

2003a). Self-compassion has been associated with greater well-being within general community

samples. Within a meta-analysis, Zessin, Dickhauser and Gardbade (2015) found a large effect

size $r = 0.47$) between self-compassion and well-being. Self compassion has also been associated

with psychopathology with a large effect size reported within a meta-analysis of depression,

anxiety and stress ($r = - 0.54$). While other forms of psychopathology have not been examined the

previously cited studies suggest that there may be a relationship between some forms of

psychopathology and self-compassion.

Fonagy and Bateman (2004) have contributed to an understanding of self-loathing within

BPD within a psychodynamic framework with their concept of the 'alien self'. The concept of

the 'alien self' connects difficulties within early attachment relationships with the development of

self-hatred as an intrinsic aspect of the self-structure. As previously noted, mentalization

describes the broad capacity to understand and represent mental states within the self (or others)

in terms of intentions. The development of a sufficiently stable sense of self and of self agency

rests on the primary ability to mentalize. Where the mirroring of the child's affect by the

caregiver is not contingent or where the caregiver's mirroring is insufficiently 'marked' the child

may not be able to develop the ability to connect his or her own affect with constitutionally based

(real) experiences. In this case, the child will look externally to the caregiver for an understanding

of internal states rather than internally for a viable version of his or her own experience. This

internalization of the other's experience will lead to self representation which is either dissociated

or otherwise alien to the child's own experience. Without an adequate experience of one's own

mental states to explain experience an agentic self of self will not develop. Rather the child and

the adult with BPD is left with the non-responsiveness of the caregiver as an alien part of his or

her self. The self under these conditions may be experienced as coherent but also as intrinsically bad. From within Fonagy and Bateman's model, the experience of the alien self leads to the intense self-hatred or self-loathing commonly observed in individuals with BPD. From this theoretical perspective, difficulties within the self are at the heart of the difficulties that individuals with BPD experience. Following Fonagy and Bateman's model, the self-hatred which is at the heart of the self-structure for individuals with BPD is a key difficulty. Given the central place of self-loathing within BPD psychopathology, this thesis will also consider self-loathing as a central barrier to recovery.

However, to date, the role of self-loathing as a barrier to personal recovery has been a matter of anecdotal evidence based on clinical observation rather than empirical investigation (Kravitz 2012 a & b). Accordingly, empirical testing of the association between personal recovery and self-compassion and self-criticism may be fruitful to clarify the nature of the relationships between these constructs. Nevertheless, two preliminary trials of interventions designed to increase self-compassion in individuals diagnosed with BPD have been reported (Lucre & Corten, 2012; Felieu-Soler et al., 2015). Implicit in the studies is the view that self-loathing is a barrier to recovery in BPD to the extent that increasing self-compassion was hypothesized to lead to a decrease in symptoms, although the relationship between recovery and self-compassion was not directly examined. In the first of these studies participants received 16 weeks of compassion focused therapy within a group format. This pilot study examined within-subject difference in self-criticism with a reduction in hatred towards oneself and an increase in the ability to reassure oneself but with no reduction in self-criticism of oneself as inadequate. Participants in the intervention group within the second study received three sessions weekly over three weeks of loving-kindness / compassion meditation training whereas the control group received mindfulness meditation practice. Both groups received 10 weeks of mindfulness training and practice immediately before the loving-kindness / compassion intervention because mindfulness was regarded as an important prior skill to cultivating loving-kindness / compassion.

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No between groups differences were found for self-criticism or self-kindness. However, the intervention group did show greater acceptance of all experience including negative experience compared to the control group (Feliu-Soler et al., 2015). The authors suggest that acceptance may be a first step towards less self-criticism and greater self-compassion. Self-compassion has been associated with greater acceptance of one's experiences particularly negative experiences and the consequences of these experiences may be a foundation for greater self-compassion (Neff, 2011).

The results of these preliminary trials have been mixed and suggest that directly focusing on cultivating compassionate and kind attitudes towards the self with individuals with BPD may not be effective. Rather, as suggested by clinical observations, it may be more effective to approach diminishing excessively harsh self-criticism and promoting self-compassion somewhat indirectly (Kravitz, 2012b). In exploring the possibility that speaking directly about being compassionate to oneself is not effective in this group, personal recovery in relation to the component parts of the concept of self-compassion and self-criticism may be fruitfully explored.

Establishing whether or not greater self-compassion is associated with the process of recovery is important because as a strong relationship between the two would suggest that self-loathing is an important treatment target for individuals with BPD. Further, existing treatments may be refined to incorporate a greater emphasis on self-compassion. At the same time, exploring the relationships between personal recovery and self-compassion and self-criticism may suggest other approaches to cultivating self-compassion that do not directly speak to being compassionate or kind to oneself but rather incorporate more specific approaches. However, to date there is no instrument developed to measure self-loathing directly. As noted above self-criticism is a closely related construct to self-loathing and will be used in this thesis as proxy construct to self-loathing because no measure of self-loathing is available. However, it is acknowledged that low levels of self-compassion and high levels of self-criticism may not necessarily indicate self-loathing Despite these limitations, high levels of self-criticism and low levels of self-compassion in relation to recovery from BPD may suggest the utility of further investigation of self-loathing

within BPD. For instance, development within future research of a measure of self-loathing may be worthwhile as may the development of interventions designed to address self-loathing. The exploration of self-compassion and self-criticism in relation to recovery from BPD is presented as a preliminary investigation that may indicate the validity of further research into self-loathing.

1.9   Extending our Current Understanding of Change in BPD: Current Research Directions

Much has been written about the difficulties that individuals with BPD experience, but much less is known about the process of change within BPD. In other words, there has been a focus on dysfunction rather than recovery and much more needs to be learnt about progress or recovery in BPD. Although there is some initial work around consumers' experience of recovery in BPD there remains a lack of cohesion within the existing literature and further understanding particularly of the specifics of the process of recovery from consumers' perspectives is needed. Further, clinicians' perspectives may add to our understanding of recovery because clinicians are in a strong position to observe recovery. The central purpose of this thesis is to better understand the process of positive change in BPD. The concept of personal recovery is highly relevant to this wider enquiry into change in BPD. However, personal recovery has been largely developed in relation to mental illness in general rather than personality disorder or BPD more specifically. As highlighted above, CHIME appears relevant in this regard but CHIME is also a general model. As the authors of CHIME acknowledge personal recovery will be a more robust and clinically useful concept the more it is understood in relation to specific populations and contexts (Bird et al., 2014). The BPD-specific literature focused on personal recovery is emerging in nature and, as is often the case with an emerging literature, both the substance and language of studies in this area are not always consistent. Nevertheless, overcoming difficulties with the self and within relationships appears to be particularly relevant to recovery from BPD. However, much is still unclear about personal recovery in BPD. For instance, there has been an appropriate focus on

consumer experience within the recovery literature: consumers are best placed to speak about their own experiences. Nevertheless, clinicians have experiences of supporting and observing the 'journey' of change and may have interesting observations to make about the process of recovery. Recovery is also an important policy goal and how clinicians have interpreted recovery and use the concept within their work is likely to impact on how consumers experience recovery as a goal for their treatment within everyday clinical interactions. How clinicians understand the importance of recovery for their work in support of progress with BPD is not clear.

More specifically, the word 'recovery' is not always seen by consumers as relevant to their lived experience, but further exploration of the meaning of recovery for consumers is needed. Without a better understanding of the meaning of the words for consumers it is unclear how or when its use is appropriate in practice. The experience of recovery is also beginning to be better understood particularly in relation to difficulties with representations of the self and within relationships. However, the exact processes that support recovery are still not clear: the existing literature is varied and not always consistent and further clarification of key processes may inform consumers with BPD about the experiences of others with the condition and this may in turn assist with their recovery. If recovery is to be the goal of mental healthcare systems (as it should be) then a more complex and nuanced language around recovery may also assist consumers in their understanding of the concept and may also help clinicians to support the processes of recovery. A more complex understanding of the processes of recovery, and language around recovery, may be based in a better understanding of the experiences of change from consumers with the experience of living with BPD. Central to this thesis is an interest in the process of change in BPD from both a consumer and clinician perspective. In relation to specific processes that may support recovery in BPD, amelioration of intense self-loathing may be one specific aspect of positive change. But much of the work around self-loathing is based on clinical observation rather than empirical investigation. Accordingly, the relationship between self-

loathing and personal recovery will also be investigated along with the relationship between personal recovery and the component parts of self-compassion and self-criticism.

Overall, this thesis asked two related sets of questions that are nevertheless different in nature. The first two studies presented within this thesis aims to better understand the process of recovery from BPD. Both consumer and clinician perspectives will be considered to broaden the basis of our current understanding of recovery and BPD. This first set of questions is focused on process, that is, on how change occurs or more specifically on how recovery is understood by consumers and clinicians and experienced by consumers. The second questions relate to a quite different kind of inquiry: is there a relationship between self-criticism, self-compassion and personal recovery? Questions about process or *how* a particular phenomenon unfolds are best answered by qualitative methods (Creswell, 2007). Accordingly, this thesis involved collecting interview-based data and thematic analysis was used to explore the first set of questions. The first aim of the final component of the thesis is to examine the relationship between personal recovery and self-compassion and self-criticism. The second aim is to explore the relationship between the component parts of personal recovery and the component parts of self-compassion and self-criticism in order to establish is a more specific approach to cultivating self-compassion may be most constructive with this group. The second question is about *what* the relationship between two variables might be. This is a question much more suited to investigation by quantitative methods. Accordingly, the second part of this thesis involved statistical analysis of questionnaire data to determine if there is a relationship between self-compassion, self-criticism and personal recovery and if so how strong this relationship is.

2 Overview of Current Research Methodology

2.1 Research Aims

The central aim of this thesis is to better understand what 'recovery' means to consumers diagnosed with BPD and the clinicians who provide psychological services to such consumers to further understand the specific processes that support recovery from BPD and to examine the relationship between personal recovery and self-compassion and self-criticism.

2.1.1 Research Questions & Hypotheses

The qualitative component of the thesis aims to better understand the meaning of 'recovery' and the experience of recovery from both a consumer and clinician perspective within an overarching interest in processes of change. More specifically, the following questions were examined within the qualitative component of the thesis:

1. How do individuals diagnosed with BPD understand 'recovery'?

2. How do clinicians experienced in working with individuals diagnosed with BPD understand 'recovery'?

3. How do individuals diagnosed with BPD experience the process of recovery?

4. What do clinicians understand to be involved in the process of recovery from BPD?

5. How do clinicians facilitate recovery from BPD?

6. What does recovery in practice mean within everyday clinical practices?

There are no specific hypotheses for the qualitative component of the thesis as a grounded theory methodology rests on the premise that there are no assumptions about the content of analysis prior to the investigation being conducted (Cresswell, 2007).

The quantitative component of the thesis specifically examined the relationships between self-criticism and self-compassion and recovery from BPD. It was hypothesized that higher levels of self-reported recovery from BPD will be associated with higher levels of self-rated self-compassion and that higher levels of self-rated recovery would be associated with lower levels of

self-criticism. The quantitative component of the thesis also examined the relationships between the component parts of personal recovery and the component parts of self-compassion and self-criticism. Given the exploratory nature of the investigation of the relationships between the component parts of personal recovery and the component parts of self-compassion and self-criticism there are no hypotheses for this part of the investigation.

2.2- Research Process

Recruitment for all components of this project was initially planned at the Monash Health DBT Clinic In Melbourne Australia and at Spectrum, the state-wide personality disorder service for Victoria, Australia. Spectrum is a part of Eastern Health in Melbourne. An ethics application was made to Eastern Health on 27 August.2013. Additional information was requested and supplied on 19 September 2013 and final approval was granted on the 2 December 2013. An ethics application was made to Monash Health on 15 June 2016. Subsequently, the DBT clinic at Monash Health closed and the application for ethics approval was withdrawn. Ethics approval from Monash University based on the recommendations of the Eastern Health HREC was granted on 7 January 2014. Closure of the DBT clinic at Monash Health meant that the programs at Spectrum were the only publically funded clinic for BPD in Melbourne. Both consumers and clinicians were recruited from Spectrum and clinicians were also recruited from another adult mental health service within Eastern Health. Spectrum consumers completed both the (consumer) interview and questionnaire part of the project and Spectrum and other Eastern Health clinicians completed the interview component.

Given the closure of the DBT clinic at Monash Health, it was decided to make an application to recruit consumers for the interview and questionnaire components of the project at a private hospital, The Melbourne Clinic. This was to ensure adequate recruitment was achieved. Application to the HREC at The Melbourne Clinic was made on 26 March 2014 and subsequently granted on the 9 April 2014. The Melbourne Clinic consumers were not asked to participate in the

qualitative part of the project because this part of the recruitment was completed prior to recruitment commencing at The Melbourne Clinic. Consumers at The Melbourne Clinic only completed the questionnaire component of the project. The ethics application was consequently amended to reflect this change and that amendment was granted on 30 August 2014. . Difficulties arising from the process of gaining the treating psychiatrist's approval prior to data collection at The Melbourne Clinic limited the number of participants that it was possible to recruit from that site.

Permission to use a professional transcription services for transcription of nine interviews of the interviews was granted on 30 December 2014 from Eastern Health.

2.3   Setting

Consumers were recruited from Spectrum, the specialist state-wide personality disorder service for the state of Victoria in Australia. Clinician participants were recruited from Spectrum and the Chandler House Adult Mental Health Service (AMHS) Continuing Care team, a more generalist adult mental health services. Offices for Spectrum are located in Ringwood East and Fitzroy and Chandler House is located in Upper Ferntree Gully, Melbourne, Victoria. Spectrum works with, and provides secondary consultation, to local Area Mental Health services for treatment of people with personality disorder. Spectrum provides individual and group-based therapy for individuals who are at risk of serious self-harm or suicide and have particularly complex needs. Spectrum treats individuals diagnosed with severe or borderline personality disorder who are also in treatment with other area mental health services such as Adult Mental Health Services (AMHS) or child and adolescent mental health services (CAMHS). Typically, Spectrum's clients have a case manager within an area mental health services, an individual therapist at Spectrum and may also participate in group-based therapy. Spectrum provides individual and group therapy informed by Dialectical Behaviour Therapy (DBT), Mentalization Based Therapy (MBT), and Acceptance and Commitment Therapy (ACT) with all staff

supervised and involved in regular peer consultation. Chandler House Continuing Care team is part of the Outer East Adult Mental Health Service (AMHS) and provides non-urgent assessment, treatment and case management to individuals with a range of mental state disorders including schizophrenia, bipolar disorder, severe anxiety or depression and severe personality disorder. Both Spectrum and adult mental health services such as Chandler House are funded by the Victoria State Government. Consumers were also recruited from the DBT clinic at the Melbourne Clinic. The Melbourne Clinic is a private psychiatric hospital in Melbourne. The DBT program offers both individual therapy on a weekly basis with skills training group therapy with all staff involved supervised and involved in peer consultation.

2.4   Participants

Seventeen consumers and sixteen clinicians from Eastern Health services and two consumers from The Melbourne Clinic participated in the project. All consumers in the qualitative part of the project were clients of Spectrum; this was a convenience sample. All Spectrum consumers completed both the interviews and the questionnaire components of the project. Fourteen of the seventeen clinicians were employees of Spectrum and two clinicians were employees of Chandler House Continuing Care team. Client participants were sixteen females and two males with an age range of 19 to 59 years (average age 33.9 years). Clinician participants were three males and fourteen females with an age range of 30 years to 73 years (44.5 average age). Five social workers, 4 nurses, 5 psychologists, 1 psychiatric registrar and 1 consultant psychiatrist participated in the study. Participation of both clinicians and service users was recognised with a $25 shopping voucher for each interview which the participant took part in. Two female consumers from the Melbourne Clinic participated in the questionnaire component of the project. The age range was 25 to 32 years.

2.4.1   Participant Recruitment

Spectrum clinicians were asked (by email letter) to identify clients who were not in crisis and were capable of consenting to participate in the project. The treating clinician then approached the potential participant and asked if he / she would be willing to receive a letter and follow up telephone call from the researcher (FD). Consumers were then recruited via invitation letter from research supervisor (SR) in his capacity as clinical director of Spectrum and follow-up telephone call by the researcher (FD). Advertising flyers were also displayed at Spectrum. Consumers who verbally consented to being involved in the project were then invited to participate in the face-to-face interview and to complete the recovery / self-compassion questionnaire. Each consumer interview was conducted in the offices of Spectrum and the clinician interviews were either conducted at Spectrum or in the offices of Chandler House. Formal consent to participate was obtained prior to any interviews beginning via the signing of the Participant Information and Consent Form (PICF). In the case of the consumer interviews, the treating clinician was available at the time of the interview for clinical support in cases where the participant became distressed. Two clinicians were involved in this regard during the consumer interviews. On one occasion the consumer became tearful and the treating clinician was consulted and subsequently spoke with the consumer in the absence of the researcher and it was mutually decided by the consumer and the clinician that the interview would continue. On the second occasion the consumer had questions about the research protocol and wished to speak to the treating clinician before clarifying with the researcher. The consumer spoke to the treating clinician in the absence of the researcher. Subsequently, the consumer, clinician and researcher spoke together and the researcher clarified that data would be stored at Monash University and not Monash Health which was the consumer's previous understanding. The consumer noted that this was a satisfactory arrangement from her perspective.

Clinicians at The Melbourne Clinic were asked (by email letter) to identify clients who were not in crisis and were capable of consenting to participate in the project. Potential participants at the Melbourne Clinic were identified by their DBT clinician. Consumers' capacity

to consent was determined by the treating psychiatrist. The DBT clinician then asked the consumer if he / she wished to participate. Where the consumer indicated that he / she would like to participate consent was sought for the researcher to telephone the consumer to seek verbal consent to participate and to organize a time to meet to complete the questionnaire. All questionnaires were completed within the offices of the Melbourne Clinic with the researcher available to answer questions. Formal consent to participate was obtained prior to the completion of any questionnaires by signing of the Participant Information and Consent Form.

Potential clinician participants from Eastern Health and Spectrum were invited to participate in the clinician interviews by email letter and follow up telephone call(s) by the researcher (FD). Formal consent to participate was obtained prior to the commencement of any interviews by signing of the Participant Information and Consent Form.

2.5   Ethics Approval

Prior to commencement of the research, ethics approval was sought from the Eastern Health, Monash University and The Melbourne Clinic Human Research Ethics Committees (HREC) in Melbourne Australia. Ethics approval for the project was granted on 2 December 2013 from Eastern Health HREC and 7 January 2014 from Monash University HREC. The approval number for the Eastern Health HREC approval is E09- 1314 and the approval number for the Monash University HREC is CF14/22 – 2013002005. The Melbourne Clinic approval was granted on 9 April 2014 and the approval number was 240. Ethics approval was granted before participant recruitment commenced.

Amendments to the original Eastern Health application were made to allow for professional transcription of some interviews. This amendment was approved on 30 December 2014. Amendments were also made to the Melbourne Clinic application to reduce the scope of the project from both the interview and questionnaire components to the questionnaire component only. This amendment was approved on 13 August 2014.

2.6   Procedure

At the time of the consumer interviews at Spectrum but prior to commencing the interview itself, the researcher discussed the Participant Information and Consent Form (PICF), see Appendix B.1 for copy of the PICF. The researcher then answered any questions and then invited the consumer to give written consent by signing the consent form. The treating clinician was contacted prior to the interview to ensure that he / she was available at the time of the interview to support their client in the event that they became distressed during the interview. Demographic information was collected including age, gender, employment status and relationship status. Diagnosis of BPD was determined by completion of the Borderline Personality Disorder component of the Structured Clinical Interview for DSM-IV-II before commencement of the interview or completion of the questionnaire. All Spectrum consumers completed the Recovery Assessment Scale (RAS) (Corrigan et al., 1999) and the Neff Self-Compassion Scale (NSCS) (Neff 2003b) and the Forms of the Self-Criticizing/ Attacking and Self-Reassuring Scale (FSCRS) (Gilbert et al., 2004).

In the case of clinician participants at Spectrum and Eastern Health, at the time of the interviews but prior to commencing the interview itself, the researcher discussed the Participant Information and Consent Form (PICF), see Appendix B.2 for a copy of the clinician PICF. The researcher then answered any questions and then invited the participant to give written consent by signing the consent form. Clinicians also provided demographic information was collected including age, gender, highest academic qualification and professional designation.

All interviews were digitally recorded and participants were identified by first name only on the audio recording. Interviews were transcribed by the researcher and by an external transcription service in accordance with the amendment to the Eastern Health ethics approval dated 30 December 2014. Where a first name appeared on the audio file the name was transcribed as '[Participant's name]'. Where an organization such as Spectrum was identified on the audio

recording the organization was transcribed as '[agency]'. Where a third person such as a clinician was identified the person's name was transcribed as '[clinician]'. Transcripts of the interviews were stored in digital form on a password protected computer at Monash University. No identifying information appeared on the transcripts. Transcripts were available only to the research team associated with this project.

All digital research information was stored on a Monash University computer and was pass word protected. Paper copies of the PICFs, demographic and diagnostic information and the original questionnaires were stored in a locked filing cabinet at Monash University. All digital and paper-based information will be retained for seven years. After seven years, computer files will be deleted and paper copy data will be shredded.

Prior to the consumer completing the questionnaire at The Melbourne Clinic, the researcher discussed the Participant Information and Consent Form (PICF), see Appendix B.3 for copy of the PICF. The researcher then answered any questions and then invited the participant to give written consent by signing the consent form. The treating clinician was available at the time the consumer completed the questionnaire to support the consumer should the he or she become distressed. Demographic information was collected including age, gender, employment status and relationship status. Diagnosis of BPD was determined by prior completion of Borderline Personality Disorder component of the Structured Clinical Interview for DSM-IV-II as this is a standard part of the diagnostic process at The Melbourne Clinic and all participants been diagnosed using the Borderline Personality Disorder component of the Structured Clinical Interview for DSM-IV-II. All consumers at The Melbourne Clinic completed the Recovery Assessment Scale (RAS) (Corrigan et al., 1999) and the Neff Self-Compassion Scale (NSCS) (Neff 2003b) and the Forms of the Self-Criticizing/ Attacking and Self-Reassuring Scale (FSCRS) (Gilbert et al., 2004). Paper copiers of the PICFs, demographic and diagnostic information and the original questionnaires were stored in a locked filing cabinet at Monash

University. All information will be retained for seven years. After seven years, computer files will be deleted and paper copy data will be shredded.

2.6.1 Materials

2.6.2 Materials: Qualitative Studies

A semi-structured interview guide was developed for both the consumer and clinician interviews based on the existing recovery literature. The interview guide was principally developed by the candidate (FD) with input from one supervisor (CD). Interview questions were not viewed or discussed with consumer or clinician participants prior to the interviews.

The key questions asked during the consumer interviews included:

- Could you describe the experience of living with BPD?
- Could you describe any changes you have experienced with BPD?
- Do you think that it is possible to change in positive ways with BPD?
- What has change been like for you?
- How would you describe the process of change for you?
- What does recovery from mental illness mean to you?
- Does the concept of recovery make sense for you in relation to BPD?
- What would recovery be like for you?
- How was the diagnosis of BPD explained to you?
- How did you understand that explanation?
- Have you experienced stigma around the diagnosis of BPD?
- What has your experience of clinicians been in relation to your recovery?
- How have clinicians helped (or not helped) in your recovery?

Follow up questions were then asked depending on the participant's responses. These follow-up questions or responses by the interviewer varied from interview to interview and were intended to elicit further information or clarify the meaning of an answer or to maintain a conversational tone

throughout the interview. Additional questions were developed as the interviews / analysis progressed in accord with the iterative nature of a grounded theory methodology. Additional questions were added to the interview schedule about the factors that affect recovery after the fourth consumer interview. These additions were made in accordance with the emerging analysis of themes. More specifically, the first four participants talked about specific conditions of recovery and these emerging themes suggested more targeting questions in the subsequent interviews.

The following questions formed the basis of the clinician interview guide:

- What does the concept of recovery from mental illness mean to you?

- Does the concept of recovery make sense to you in relation to BPD?

- How would you describe the process of recovery?

- How do you think clinicians can assist with recovery?

- Does the concept of self-compassion inform your work?

The inclusion of a question specifically focused on self-compassion was included because self-loathing and self-compassion were particular foci for investigation within this thesis. Additional questions or probes were asked depending on the nature of the participant's responses. For instance, questions about stages of recovery were asked where the participant had talked about stages as a part of the process of recovery.

2.6.6 Materials: Quantitative Studies

Structured Clinical Interview for DSM-IV Part II BPD Scale (SCID-IV-II-BPD)

The SCID-IV-II BPD scale is a structured clinical interview with 9 items. The participant is asked a question or series of questions about each item and responses are rated from 1 to 3. One indicates the absence of the criterion, two indicates the presence but subthreshold of the criterion and three indicates a threshold presence of the criterion. The SCID-II is regarded as the gold standard of diagnosis tools with recent studies finding good to excellent inter-rater reliability

on the BPD scale with reported Kappa values of 0.74 (Huprich, Paggeot & Samuel, 2015) and 0.91 (Loobestael, Lerugans and Arntz, 2011).

Recovery Assessment Scale (RAS)

The RAS is a 41 item self-report instrument designed to assess personal recovery. Participants rate themselves on a 5-point Likert scale with 5 = strongly agree and 1 = strongly disagree. Sample items include "I can handle it if I get sick again" and "I have a desire to succeed". The RAS has good reliability and validity with acceptable test-retest reliability (r = 0.88) and good internal consistency (*alpha* = 0.93) (Corrigan et al., 1999). The RAS has also been shown to have a five-factor structure (Corrigan et al., 2004). The five factors are (1.) Personal confidence and hope, (2.) Willingness to seek help, (3.) Goal and success orientation, (4.) Reliance on others and (5.) No dominance of symptoms. Cronbach's alphas for the five factors range from acceptable to good (*alpha* = 0.74 to 0.87) (Corrigan et al., 2004).

The items on the RAS were initially developed based on the recovery stories of four consumers and was subsequently assessed with 35 consumers in the United States (Corrigan et al., 1999). The RAS was selected from a range of other available measures of personal recovery because it has strong psychometric properties compared to other measures of personal recovery and examines the key dimensions of recovery and has been assessed as appropriate for use within an Australian context (Burgess et al., 2011). See Appendix C.1 for copy of the RAS.

The RAS has not been used previously with individuals diagnosed with BPD making comparison of progress with other BPD samples not possible. However, the RAS has been widely used with other samples with mental illness more generally making some comparison with other samples possible. The mean score can be compared to an analysis of 28 studies of recovery from mental illness in general that utilized the RAS. The mean score from these 28 studies was *M*= 3.78 *SD* = 0.19 with a range of *M* = 3.14 to 4.12 (Salzer & Brusilovskiy, 2014).

A potential limitation of the RAS is that it was developed prior to the current models of recovery such as CHIME (Connectedness, Hope, Identity, Meaning and Empowerment).

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Nevertheless, each of the subscales of the RAS with the possible exception of 'Meaning' related conceptually to the key concepts of the CHIME model. For instance:

- Connectedness : Healthy Reliance on Others on the RAS;

- Hope : Personal Confidence and Hope;

- Identity : Personal Confidence;

- Empowerment : Goals and Orientation to Success.

Further, many of the statements on the RAS directly tap constructs similar to those summarized by the CHIME model. For instance:

- Connectedness: "I ask for help when I need it"

- Hope: " I am hopeful about my future?"

- Identity: "I like myself".

- Meaning: I have purpose in my life".

- Empowerment: I am the person most responsible for my own improvement".

Neff Self Compassion Scale (NSCS)

The NSCS is a 26 item self report instrument designed to assess how individuals show acceptance of themselves and a kind attitude towards themselves. Participants describe themselves on a 5-point Likert scale (1 = Almost never and 5 = Almost always). Sample items include 'I try to be loving towards myself when I am feeling emotional pain' and negatively scored items such as 'When times are really difficult, I tend to be tough on myself'. The NSCS has good internal consistency (*alpha* = 0.92) and good test –retest reliability (alpha = 0.93) (Neff, 2003b). The NSCS has been shown to have a six factor structure: self-kindness, self-judgment, common humanity, isolation, mindfulness and over-identification. Cronbach's alphas for the six factors range from good to excellent (*alpha* = 0.85 to 0.92) (Castilho, Pinto-Gouveia & Duarte, 2015). See Appendix C.2 for copy of the NSCS.

Forms of Self-criticism / Self-attacking and Self-reassurance Scale (FSCRS)

The FSCRS is a 22 item self-report instrument designed to assess how individuals think about things when they encounter difficulties in their lives. Participants respond on a 5-point Likert scale (0 = not at all like me and 4 = extremely like me). Sample items include 'I remember and dwell on my failings' and 'I have a sense of disgust with myself'. The FSRS has been shown to have a three factor structure: Inadequate self, hated self and reassure self. Cronbach's alphas for the three factors range from good to excellent ($alpha = 0.85$ to 0.90) (Gilbert et al., 2004).

2.7   Data Analysis

2.6.1 Thematic Analysis of Qualitative Data

Thematic analysis was used to identify key themes within the interview data. Each transcript was read independently by the researcher (FD) and research supervisor (CD) and a coding book was maintained. As each new interview was completed the transcript for the new interview was compared with the existing transcripts and new themes were noted in a coding book. Emerging themes were then identified and a coding tree developed. The researcher (FD) and the research supervisor (CD) discussed the preliminary codes and developed categories that reflected themes (axial coding) (Auerbach and Silverstein, 2003). Similarities across codes were used to identify themes, with all themes reviewed to ensure that they remained representative of the codes until thematic saturation occurred. In this way, repeated patterns in the data were identified and also conflicting opinions were identified. Any discrepancies in the codes identified were resolved by discussion at regular meetings. Transcription of each interview took approximately a day and occurred prior to the next research interview. Meetings at this stage of the research occurred on a regular basis from January 2014 to June 2015.

2.6.2 Analysis of Quantitative Data

The questionnaire data was analysed using SPSS statistics package. Negatively worded items on the Neff Self-Compassion Scale (NSCS) (items 1,2,4,6,8,11,13,16,18,21,24,25) were reverse scored with 1 rescored as 5, 2 as 4, 3 as 3, 4 as 2 and 5 as 1. Negatively scored items on

the Self-Criticizing/ Attacking and Self-Reassuring Scale (FSCRS) (items 3,5,8,11,13,16,19,21) were also reverse scored with 0 rescored as 4, 1 as 3, 2 as 2, 3 as 1 and 4 as 0. There are no negatively scored items on the Recovery Assessment Scale (RAS). Violations of assumptions were tested. A Kolmogorov-Smirnov test was performed and it was determined that the data did not meet assumptions of normality. Scores on the RAS and NSCS did not violate assumptions of normality but the distribution of scores on the FSCRS did violate assumptions of normality. Pearson's *r* values were calculated for the RAS scores and NSCS scores and Spearman's *rho* values were calculated for RAS scores and FSCRS scores. Pearson's *r* values were also calculated for each of the subscales of the RAS and the NSCS and Spearman's *rho* values were calculated for each of the subscales of the RAS and the FSCRS.

3. Consumer Perspectives on Recovery and Borderline Personality Disorder

3.1 Introduction to First Paper

This chapter presents a manuscript submitted to the Journal of Mental Health Training, Education and Practice. The aim of the manuscript is to understand what consumers understand to be the meaning of 'personal recovery' and also to understand consumers' perception of how positive change occurs in BPD. Consumers have a lived experience of that process which may be informative because it is part of a first-person experience. This manuscript focused on consumers' experience of recovery because insights derived from first-person, lived experience are highly valuable in understand the nature of a social construct such as personal recovery. The manuscript presented here reports on the data collected about experiences of personal recovery corresponding to the first eight questions asked as part of the consumer interviews. Data related to the later questions around diagnosis and experiences of clinicians was not included in the writing up of this manuscript as it was decided that experiences of recovery was the more important information given the emerging nature of the literature. Data related to experiences of diagnosis and clinicians was analysed and a coding tree reflecting this process is presented below in Section 3.3.

The format of this chapter is consistent with the Journal of Mental Health Training, Education and Practice requirements, however, for ease of reading the manuscript pagination has been replaced with thesis pagination.

3.2 Manuscript of Paper 1

Consumer perspectives on personal recovery and Borderline Personality Disorder

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Consumer Perspectives on Recovery and Borderline Personality Disorder

Abstract

Purpose - Borderline Personality Disorder (BPD) is a complex condition characterized by a number of psychosocial difficulties that typically involve considerable suffering for individuals with the condition. Recovery from BPD may involve specific processes such as work on how the self is perceived by the individual with BPD and his or her relationships which differ from those common to recovery from other mental health conditions. The details of the processes that may best promote changes within the self and relationships are yet to be established.

Design / methodology / approach - Seventeen consumers from a specialist BPD service were interviewed to identify factors they have experienced that contribute to recovery from BPD. Thematic analysis within a Grounded Theory framework was used to understand key themes within the interview data.

Results – Key themes identified included five conditions of change: Support from others; Accepting the need for change; Working on trauma without blaming oneself; Curiosity about oneself and Reflecting on one's behaviour. The emphasis was on specific conditions of change rather than the more global goals for recovery suggested by recent models.

Findings - To apply these condition of change more broadly, clinicians working in the BPD field need to support processes that promote BPD-specific recovery identified by consumers rather than focusing exclusively on the more general recovery principles previously identified within the literature.

Originality / value – The specific factors identified by consumers as supporting recovery in BPD are significant because they involve specific skills or attitudes rather than

aspirations or goals. These specific skills may be constructively supported in clinical practice.

Keywords: Borderline Personality Disorder, recovery, self, relationships

Paper type – Research paper

Introduction

The concept of personal recovery is well established in the literature; however its relevance to personality disorders including Borderline Personality Disorder (BPD) is just beginning to be explored. To date, the majority of the recovery literature has focused on mental state disorders such as schizophrenia. Recent models of recovery such as CHIME (Connectedness, Hope, Identity, Meaning, Empowerment) are based on this existing literature, but their relevance to the experiences of individuals in recovery from BPD is yet to be established (Bird et al., 2014). CHIME may fit well with the experiences of individuals with personality disorder but this has not yet been empirically established. There is broad agreement that exploration of the experiences of diverse groups, including individuals with personality disorder, will enhance our understanding of recovery and improve the utility of recovery models (Leamy et al., 2010). In addition to focusing on the experiences of individuals with mental state disorders other than personality disorder, models such as CHIME offer limited insight into the specific processes that support personal recovery. CHIME may provide important aspirational goals for recovery across diverse groups but further exploration of the experiences of individuals from diverse groups may add to the specificity of models of recovery for different individuals. Therefore there is a pressing need to elucidate the experiences of individuals with BPD, particularly in light of establishing whether there are specific processes that may support recovery from BPD.

Although the study of personal recovery in relation to BPD is a recent phenomenon, earlier outcome studies suggest that recovery (based on a clinical definition of recovery) is possible for individuals with BPD. In their landmark longitudinal study, Zanarini and colleagues (2010) reported that over a 10 year period, 86% of participants with a diagnosis of BPD experienced remission of symptoms, with a typical duration of at least 4 years and a 15% relapse rate. In contrast, recovery, defined as remission of symptoms and "good social and vocational functioning", was reported for only 50% of individuals during the 10 year follow up, with approximately 30% unable to maintain recovery beyond 2 years (Zanarini, 2012, p.477). Achieving *recovery* in BPD appears to be much more difficult compared to achieving *remission of symptoms*, although the evidence that both remission and recovery do occur highlights the reality of positive change. However, little is known about the process of change in BPD or the situational variables that may support it.

Several important longitudinal studies demonstrate that improvement in BPD symptoms and psychosocial functioning is possible (Zanarini et al, 2010; Gunderson et al, 2012, however they do not shed light on what underlies the process of change for individuals living with BPD. The concept of 'personal recovery' is an instructive starting point for any such investigation, because the focus of personal recovery is on the *journey* or *process* of positive change. Understanding the specific, practical conditions that support recovery may require a focus on process rather than outcome.

The limited literature on recovery from BPD suggests that maintaining a therapeutic focus on self-representation and understanding the self in relation to others is a key challenge. Katsakou and colleagues (2012) reported that while promoting self-acceptance was a key aspect of recovery, it was a neglected aspect of the treatment.

Notably, only about half of the study participants endorsed 'recovery' as adequately describing their experiences of positive change within BPD. Castillo, Ramon and Morant (2013) developed an eight-part hierarchical model of recovery in BPD within the context of a therapeutic community. At the lower levels of the model were processes leading to improved relationships, which the authors describe as essential 'building blocks' to higher order processes such as recovery. Lower order or foundational processes included 'A sense of safety and building trust' and 'Feeling cared for'. Holm and Severinsson (2011), in a study of recovery from suicidal behaviour amongst women diagnosed with BPD, also emphasize the importance of the relationship with self and others to recovery. Positive change within the experience of BPD is enhanced by relationships that engender trust, promote safety, and involve acceptance of the individual as they are. Overall, the picture that emerges from the BPD recovery literature is that work on the self within the context of strong, supportive relationships is central to recovery.

Recent scholarship that focuses on the lived experience of BPD (rather than on recovery from BPD per se) supports the premise that recovery from BPD crucially involves change within self representations and within interpersonal relationships. This literature is not focused on personal recovery directly, nevertheless exploration of recovery may best rest on an understanding of lived experience. Accordingly, the lived experience literature is highly relevant to an exploration of personal recovery in BPD. Living with BPD has been described as a constant tension between internal and external experiences of the self (Gillard, Turner & Neffgen, 2015); recovery from BPD may be understood to involve a reconciliation of this tension. Agnew et al (2016) suggested that this tension may be subjectively experienced as a series of disjunctions or abrupt shifts between positive or negative representations of the self, leading to difficulties in

relationships due to a blurring of the boundary between how internal experience and external experiences of other people are understood. Taken together, the work of Gillard, Turner and Neffgen (2015) and Agnew and colleagues (2016) suggest that difficulties with self-representation and the impact that this has on relationships may be at the heart of the lived experience of BPD. This is likely compounded by self-concepts with largely negative attributes held by people with BPD compared to people without the condition (Beeney et al., 2016; Vater et al., 2016). Accordingly, the focus of recovery may best be directed to processes involving change in self representation and in one's relationships with others. Although representations of the self and relationships may be central, the specific factors that support recovery from BPD remain unclear. CHIME offers some guidance in relation to mental illness more generally, but if clinicians and carers are to more fully support recovery, clarification is needed about specific conditions that promote recovery in BPD.

This paper is the first in a two part project with the other part of the project focused on clinician perspectives on recovery. The aim of this paper is to explore how recovery occurs from the perspective of consumers. This exploratory, qualitative, interview-based study was designed to inductively develop an understanding of the meaning of, and conditions for, recovery from the perspective of consumers with a BPD diagnosis. Despite the emphasis of existing literature on the significance of work on the self and within relationships, far less is known about how these processes unfold in the context of recovery from BPD, and how they actually contribute to recovery. We further note that the term 'consumer' has been used in accordance with common practice in Australia where the study was conducted.

Method

Setting

Participants were recruited from a specialist BPD outpatient service where they were receiving treatment while supported concurrently by a case manager from an adult mental health service. The specialist outpatient service provides weekly hour long individual therapy and a minimum of an hour of group therapy with telephone support typically available at other times. The specialist service provides treatment for personality disorder via a range of modalities including Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), and Mentalization Based Therapy (MBT) in weekly individual and group formats. Treatment admission is typically two years, overseen by psychiatrists who also provide primary care.

Participants

Seventeen outpatients participated in the study. Participants were aged from 19 to 59 years (average 33.9 years); 15 were female. Participants' time in treatment, including treatment prior to admission to the specialist service, is presented in Table 1. Fourteen participants were not currently working or studying, two participants were studying part-time, and one participant was studying full-time.

Duration of Treatment (Lifetime)	Number of Participants
0 – 6 months	2
6 – 12 months	3
12 – 18 months	3
18 – 24 months	4
25 months or longer	5

Table 1: Participants' Duration of Treatment (Lifetime)

Procedure

All 17 participants were diagnosed with BPD using the Structured Clinical Interview for DSM Disorders (SCID-II). All interviews were conducted by the lead author. Questions were based on a semi-structured interview, with three initial interview questions: "What does the idea of recovery mean to you?" and; "Does the concept of recovery make sense to you in relation to BPD?" and; "What would recovery be like for you?" Additional questions were then asked about their personal experience, such as: "Could you tell me a little about the process of recovery for you?" Additional questions depended on how the participant responded: "Could you describe the stages of recovery that you have talked about?" or, "You spoke about the start of the recovery process for you. Could you elaborate a little on what that was like?" The interview was split into two parts with a brief break in the middle. The duration of the interviews ranged from 22 to 79 minutes and audio recordings of each interview were transcribed in full. Participants were given a (AUD) $25 shopping voucher for each interview in appreciation of their participation.

Study Design

The study design drew on Grounded Theory, which offers a well-developed methodology for exploring the nature of a social phenomenon by an iterative process of comparison and evolving refinement of emerging themes (Strauss & Corbin, 1994). Accordingly, Grounded Theory is well suited to the study aims of exploring the meaning of recovery in BPD. A process of constant comparison of emerging codes was used to develop higher order themes (Glaser, 1992; Glaser & Strauss, 1967). Thematic analysis was also employed to identify the themes that best summarize the data overall (Henwood, 2006). The study design was approved by the Eastern Health Human Research Ethics Committee: E09 1314.

Analysis

Each transcript was read several times to achieve familiarization with the content. Ideas that were repeated across transcripts were grouped together and coded, and a codebook was maintained. Twenty-five higher order categories were developed from the initial line by line open coding. Seven themes were developed according to similarities across categories, with all themes continuously reviewed to ensure that they were representative of the categories and codes. The first and second authors conducted coding and the identification of themes independently; any difference in opinion was resolved through discussion.

Results

Two themes were developed from the results of this study with two subthemes developed for the first theme and five subthemes for the second and are presented in Table 2.

Themes	Subthemes
Understanding	'Positive change is 'Risky' but Possible'
Recovery	'Positive Change is Difficult but Possible through Constant Hard Work'
Conditions of Change	'Support from Others'
	'Acceptance of the Need for Change'
	'Work on Past Trauma without Blaming Oneself'
	'Curiosity about Oneself'
	'Reflection on One's Behaviour

Table 2 Summary of Study Themes and Subthemes

The number of participants who contributed to a particular theme or subtheme are indicated throughout the reporting of the themes / subthemes below.

Understanding Recovery

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Positive Change as 'Risky' but Possible

Many participants (9 / 17) were ambivalent about recovery, seeing it as unrealistic, particularly when understood in terms of a cure. The responses given by all participants (17 / 17) contributed to this theme.

Participant 7 commented, "I don't know if the word recovery is realistic. It might be for some people". Ambivalence was also expressed about the impossibility of knowing what recovery might be. For instance, Participant 17 said, "I really do want to recover because of all the rubbish that I go through because of it [BPD]. But, at the same time, recovery is detracted a bit by the fact that I don't really know what it looks like." Many participants preferred to speak instead about management of their condition. Despite this emphasis on the difficulty of recovery, the possibility of positive change was widely endorsed, with some participants preferring to talk about 'change' rather than 'recovery'. For instance, Participant 12 commented "I think ... yeah, I think it's possible. For myself anyway … and for a lot of others, I'm sure they can… change, yeah." Looking back on the therapy that they had received, Participant 14 said,

> "And when . . . before like I started to get well, I would've gone, no way, there's no recovery from BPD. Like I didn't feel there was like any light at the end of the tunnel or anything. And I would just go 'whatever' kind of thing. But now I'm like, yeah, I honestly do feel like there's a huge hope for me."

Ambivalence about recovery was also reflected in the perception that using the term 'recovery' was possibly invalidating. Indeed 4 / 17 participants called recovery a "scary" word. This attitude was more likely to be expressed by participants who were at the start of treatment. Some participants highlighted the sense of danger they felt around the use of the word 'recovery'. Recovery for them evoked concerns about the risks of change or of a different, new and difficult experience. This was particularly the case for participants

looking back on their treatment for BPD. For example, Participant 7 reflected that, "When I first started treatment I couldn't even discuss leaving here. I couldn't even discuss the word recovery, for me . . . it was just so scary." Participant 7 expanded on this, adding "I don't use the word recovery per se … [recovery is] one of the things I am trying to come to terms with." For other participants it was the idea of change within the concept of recovery that was "risky" or "scary", with Participant 17 commenting that recovery,

> "scares the living daylights out of me because I've never been anyone without mental illness … I've had mental illness since I was seven, so I don't know what I'm going to do once I've recovered. I don't even know who I would be."

The risk articulated here is a fear that change involving a renegotiation or rethinking of the self will also destabilize one's existing sense of self. Change that involves work on the self is "risky' because of the possibility of losing one's sense of self.

Positive Change is Difficult but Possible through Constant Hard Work

Our participants wholly endorsed the possibility of positive change (17 / 17 participants). However, the possibility of a cure from BPD was clearly and universally rejected, with an emphasis on how hard the work of change was, along with quite modest expectations for a more satisfying life. Such was the modesty of expectations surrounding the concept of recovery that many of our participants cautioned against having expectations that life would be "fantastic". Participant 4 commented that,

> "…recovery to me is not going to be fantastic, life is [not] going to be awesome, you know, I have accepted that recovery, again I need to take small steps, but recovery would be just to have some inner peace."

Participant 8 echoed these comments when she said, "I think it is still hard work, you know, every day is not cruisey." Participant 9 appeared to be cautioning against the assumption that the road to recovery was easy when she said,

"In general, I think that people who are seeking recovery need to be aware that in reality they are probably going to have to go through a lot of stuff in order to get it. Umm, there are a lot of barriers there that they need to get through and they are probably going to get treated like shit before they get anywhere good."

An emphasis on how hard change is and the constant, hard work involved was expressed by Participant 4 when she described recovery as "Constant work, daily, hourly, just continual, continual struggles, continual battles, continual hard work." A number of participants spoke about "small" or "baby steps" and emphasized that recovery was not a straightforward process of continual improvement. Participant 5 added that "it's a bit like forward, backwards, forward and backwards". Participant 8 emphasized the struggle involved in her recovery when she said that it "felt overwhelming and almost huge" at times. There was also recognition that recovery is "different for everyone" or as Participant 9 suggested, "different things work for different people."

Conditions of Change

Participants consistently emphasised the complex and not necessarily linear nature of change. These personal or situational shifts are summarized as the 'conditions of change'. Five conditions of change were identified and are outlined below. A majority of participants (15 / 17) contributed to this theme.

Support from Others

For many participants (14 / 15), change was said to be relational inasmuch as it was achieved with the assistance and support of others. For instance, our participants

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commented on how important their relationships with others were in their recovery journey and also noted that hearing different ideas and opinions expressed in therapy was revelational for them. Participant 4 noted that, "until you actually hear things spoken or even with other clients not just the [names agency] staff but listening to others, it sort of reinforces or you come to a realization." The relationships that supported recovery were with friends, family or intimate partners or with clinicians or peers in therapy. Participant 7 commented that "a lot of it has been to do with a very supportive and understanding husband" adding that for her "the change started even though I probably started much earlier; it was more people around me started to see." Similarly, Participant 14 noted that,

> "My relationship with my ex-partner and my kids were the biggest thing for this. Like I don't think I would've cared half as much about myself or the outcome of my life if I didn't have them in my life, if you know what I mean."

For others it was peers in therapy who inspired confidence in their own ability to change. Participant 13 noted that "we are so deeply connected" and that they "make me feel like I'm not alone, there's more people in there, in this world with my same feelings, and we can, we can get better."

Acceptance of the Need for Change

For some participants (10 / 15), the first step towards change was acceptance of the need for it, along with developing a belief that change was possible. For instance, Participant 2 emphasized "…not accepting my illness and things like that. So obviously the other way around, not accepting of the illness and then accepting it and traumatic experiences that have happened." Participant 8 echoed these insights when she said,

> "I know initially early on I was probably in denial; that was probably a big hurdle that I had to get over and get through. Umm, yeah I don't know aside

accepting the diagnosis."

Willingness to change was also a common 'first step' to recovery as Participant 6 commented: "Umm, I think that people just need to be willing to change. I think that is the biggest thing that people come up against."

Work on Past Trauma without Blaming Oneself

Some participants (5 / 15) emphasized the effects of trauma and their need to work through it with the aim of no longer blaming themselves for this trauma or its psychological and behavioural consequences. For instance, describing the process of therapy for her, Participant 7 said: "I realized that it wasn't just me being oversensitive or stupid, that these symptoms that I was having were actually part of a disorder". This participant added,

> "One of the positive changes that I have already seen is that I have stopped blaming myself. For so many years I had thought that it was just me being silly or clingy or difficult to deal with, but the positive changes that I can now see it is not me, like I am separate from BPD and those were just the symptoms showing up at the time, it wasn't about me particularly."

Participant 6 expressed similar thoughts about learning to trust herself more through the therapeutic process: "And I guess one of the things that I am learning to do is to trust myself a bit more and I guess again it is not one of those things where you go 'oh look what happened here' but it is all over time."

Curiosity about Oneself

Some of our participants (9 / 15) suggested that thinking about oneself or having curiosity about oneself was a key step towards positive change. This enquiry into the self was variously expressed as curiosity about the self or as self-discovery or increased

self-awareness. For instance, some participants associated the benefits of therapy specifically with a focus on the self and understanding the self better. Participant 4 said:

> "Through the start of my recovery I found myself being curious and it was doing [names group] that what I was learning and what was being taught …. umm, yeah it was more curiosity."

Participant 4 added: "It's been a big learning curve so my self-awareness has improved massively, umm so it's been really, really good." Reflecting about one's thinking was also an important part of increased self-awareness as Participant 14 noted: "Yeah, yeah, like me thinking about like the way that I think, I think it's yeah, changed as well."

Reflection on One's Behaviour

Reflection on their role in past difficulties and the impact of past behaviour on other people were also key parts of change for a number of our participants (6 / 15). For instance, Participant 12 said that "And I guess also you do have to sit back and look at your own behaviour to a certain extent and go, 'That didn't work, and that wasn't a good idea, I'm going to have to take on what other people are suggesting'." Participant 12 added:

> "I grew up and I'm like, 'Things are hard for me, why is that?' And I'd slowly go, 'Yeah, when I do that, it doesn't work out.' So I sort of had to re-learn some things… It's not, you know, not about the world molding to you."

The need to reflect on one's behaviour was also described in terms of how it impacts on other people and the need to understand this and change one's behaviour, as Participant 15 described it: "I mean, I was… drinking, and overdosing, and doing all that sort of thing in front of my kids, and they were the ones putting me to bed, or ringing the ambulance, or… And I'd never--'cause I was so caught up in… what I was feeling, and all that sort of stuff, I didn't really look at it as to what they were going through."

Discussion

Our principal aim was to explore the meaning of the word 'recovery' and identify processes of personal recovery from BPD that are important to consumers. This paper focused on consumer concepts of personal recovery and the factors that were important to them during any process of positive change they may have experienced. Seven key subthemes were identified, two of which encapsulate how consumers understand 'recovery' in the context of their BPD diagnosis, and five of which identify factors describing 'conditions of change'.

Each of the five conditions of change identified in this paper reflects exploration of new ways to relate to oneself or to others. However, the 'conditions of change' each involve a *skill* or specific *process* rather than a more aspirational goal. For instance, support from others can be seen as an overarching requirement of recovery in BPD because, as our participants highlight, recovery is not an individual process but is rather highly social in nature. Accepting the need for change also suggests that a key skill for individuals with BPD is not only recognizing current difficulties but also marshalling resources to support change. The change process may involve consideration of past trauma. Our participants also suggest that a non-blaming therapeutic environment is important. A key recovery attitude that individuals with BPD may need to cultivate is acceptance of the impact that past trauma has had on their lives without taking on a sense of self blame. Our analysis also suggests that cultivating curiosity about oneself may be another specific skill that supports work on the self and that may lead to greater self-acceptance. The goal of greater self-acceptance may require the specific skill of having curiosity about oneself. It is notable that the conditions of change that our participants identified as important to their recovery were actually concrete or specific skills rather than more general goals.

The 'conditions of change' identified in this study confirm and extend the existing literature on recovery and BPD. For instance, CHIME describes key aspects of recovery and also identifies aspirational goals for recovery (Bird et al., 2014, Leamy et al., 2011). However, one of the limitations of the existing literature on personal recovery is the lack of clarity regarding how these goals will be translated into everyday clinical practices. The change processes identified within our study extend the existing literature by suggesting specific skills in relation to recovery and BPD. Support for these specific skills, as opposed to adhering to a more general set of aspirations, may help to extend the work of personal recovery. Each of the identified conditions of change involves a change in self-representation or relationships with others, previously identified as central to recovery (Agnew et al., 2016; Gillard, Turner and Neffgen, 2015). This emphasis on the self and relationships shares similarities with established models such as CHIME. For instance, Connectedness and Identity are related concepts to the emphasis on the self and relationships within our data. However, the literature is unclear about specific processes that support change in self-representation or relationships. For instance, greater self-acceptance has been identified as a key but neglected goal for consumers (Katsakou et al., 2012), but how greater self-acceptance may be achieved is not described. However our data suggest that processes of self-inquiry including the specific skill of curiosity about the self may be the key. Curiosity about the self, particularly if guided by a supportive other, may lend itself to a more balanced appraisal of the self (which is often problematic for individuals with BPD), and accordingly lead to greater self-awareness and self-acceptance.

The data presented here also have a number of implications for clinical practice. Although all participants endorsed the possibility of progress or positive change, recovery was also described as 'risky' or 'scary'. The personal costs associated with

change for individuals with BPD have not been widely recognized in the literature. However the reality of these risks was clearly expressed with many of our participants regarding change as a risk or threat to their established sense of self. The fear of incoherence or even absence of a stable sense of self, and the personal crisis this implies, highlights the need for clinicians to be particularly sensitive to this risk, particularly in the early stages of change where anxieties may be especially elevated. The risk for some individuals living with BPD is that change may imply 'not knowing who I am at all' with debilitating, even terrifying consequences. This also illustrates how the language of recovery may not always be constructive.

Clinicians may also need to support help-seeking from others to support recovery, by working with carers for example. Clinicians may also have a role to play in assisting consumers to understand the treatment options available to them. Clinicians may need to support clients are they develop greater curiosity about the self in order to support greater self-acceptance. Processes of self-inquiry that balance positive and negative aspects of the self are crucial here; clinicians may need to be quite creative in finding ways to support balanced self-inquiry. Furthermore, participants suggest that it is not enough to aspire to better relationships, but rather to recognize and acknowledge past behaviour that may have negatively impacted on relationships. Clinicians will need great sensitivity while supporting the difficult process of acknowledging past behaviors that have negatively impacted on relationships. This suggests that clinicians need to be mindful not only of the sequelae for trauma but also of their clients' experiences of stigma associated with blame and the re-traumatization this may create. As consumers highlighted, the key to recovery appears to be maintaining a balance in a non-blaming environment, for instance, in acknowledging the impacts of one's own behaviour, with acceptance of the complexities of one's self. Overall, the dual framework of acceptance

and change needs to be carefully balanced within any intervention that fosters positive change or recovery from BPD (Linehan, 1993).

The picture that emerges from our participants' observations is that recovery from BPD is a complex set of processes revolving around the self, which are supported and reinforced though dialogue or relationships with other(s). Each of the five conditions of change identified in this study (support of others; acceptance of the need for change; work on trauma; curiosity about oneself; and reflection about one's behaviour) may need to be present simultaneously for recovery from BPD to be optimized. The question of how to optimize recovery in terms of the timing of interventions would be a worthwhile focus for future research.

Limitations and Future Directions

The current study is exploratory and preliminary in nature and participants were all recruited from a single specialist service. Further qualitative explorations of progress or change in BPD are needed to determine if the conditions of change identified here are relevant to consumers in different settings. Future exploration of the roles of others, including carers, peers, and clinicians, may also help to clarify the relational nature of change in BPD. Future work may usefully investigate whether existing evidence-based treatments support recovery or are mainly efficacious in relation to remission of symptoms. Moreover, longitudinal work may reveal which components of existing treatments are, or are not, supportive of recovery. The interplay between the factors identified in this study may also be constructively explored within future, longitudinal research.

Conclusions

Five conditions appear to be central to the process of change in the context of BPD: (i) Support from others (ii) Acceptance of the need for change, (iii) Work on past trauma

without blaming oneself, (iv) Curiosity about oneself, and (v) Reflection on one's behaviour. A complex interplay between these conditions is likely in each individual experience of recovery given the nonlinear and 'risky' nature of change described by participants. These conditions of change may only be realized within a trusted relationship with a helping other, professional or otherwise. For clinicians working with individuals with BPD, operating from a conventional recovery-oriented viewpoint may not be sufficient or even desirable; rather it may be necessary to find ways to explicitly incorporate each of the conditions of change identified by consumers in this study.

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3.3 Additional Results: Consumer Qualitative Data

Change as working on past trauma / not blaming oneself anymore

Change as gradual, constant & hard work and non-linear process (and believing that I am capable of change)

Change as accepting past trauma

Change as relational

Positive Change is Possible

Accepting responsibility for own behaviour

Conditions of Change

Curiosity about myself / Self-discovery/ Learning to trust yourself

Change as risky and 'fragile'

Recovery is a good idea but hard to believe in

Change as Increased Self-awareness and self-worth

Being willing to change / believing

Stigma: The diagnosis was never explained to me

Diagnosis

Recovery: is it possible for me?

'Recovery' as potentially invalidating – a 'scary word'

Experiencing BPD: Personal Difficulties and Public Stigma:

Recovery as an individual process of moving towards a satisfying life (peace from my own mind)

Living well with BPD but not recovering

Emotional Dysregulation and Relationship Instability

Difficulties getting appropriate treatment

Recovery as being 'normal'

Clinicians who help

Clinicians who understand the complexity of BPD and attend to the

Therapy as an ongoing collaboration / clinicians who are genuinely caring

Stigma: 'Being Fitted into a Box'

Another perspective or a 'sounding board'

Clinicians who ask questions and don't make assumptions and set goals that are important to the client not the clinician

Clinicians who emphasis responsibility / having goals to work towards

Being told you are manipulative and attention-seeking (manipulation as a fear response)

Figure 1: Coding Tree: Consumer Qualitative Data

4. Clinician Perspectives on Recovery and Borderline Personality Disorder

4.1 Introduction to Second Paper

This chapter is the manuscript submitted to Journal of Mental Health Training, Education and Practice. The aim of the manuscript is to understand what clinicians understand to be the meaning of 'personal recovery' and also to understand clinicians' perception of how positive change occurs in BPD. Consumers may be in the best position to speak to the experience of recovery because they have first-hand experience of the process of recovery. However, clinicians may observe recovery in their work and are also in a position to observe and understand the process of personal recovery. Consideration of clinician perspectives also adds a degree of triangulation to the wider investigation of the meaning and process of personal recovery. The manuscript presented here reports on the data collected about experiences of personal recovery corresponding to the four questions asked as part of the clinician interviews. Data related to working with self-loathing / self-compassion was analysed and a coding tree reflecting this process is presented blow in Section4.3.

The format of this chapter is consistent with Journal of Mental Health Training, Education and Practice requirements, however, for ease of reading the manuscript pagination has been replaced with thesis pagination.

4.2   Manuscript of Paper 2

Clinician perspectives on personal recovery and Borderline Personality Disorder

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Clinician Perspectives on Recovery and Borderline Personality Disorder

Abstract

Purpose - Recovery is an important concept within mental healthcare policy. There is a growing expectation that clinicians adopt approaches that align with recovery principles, despite significant disagreements about what recovery-oriented interventions might look like in practice. It is also unclear how recovery may be relevant to personality disorder.

Design / methodology / approach – Sixteen clinicians were interviewed at two mental health services in Melbourne, Australia. These clinicians had specialist training and experience in the treatment of borderline personality disorder (BPD) and provided insight regarding the meaning and relevance of the recovery paradigm in the context of BPD. Thematic analysis within a Grounded Theory approach was used to understand key themes identified from the interview data.

Results - Thematic analysis suggested that clinicians understand recovery in three distinct ways: as moving towards a satisfying and meaningful life; as different ways of relating to oneself, and as remission of symptoms and improved psychosocial functioning. Clinicians also identified ways in which recovery-related interventions in current use were problematic for individuals diagnosed with BPD. Different approaches that may better support recovery were discussed.

Findings – This study suggests that practices supporting recovery in BPD may need to be tailored to individuals with BPD, with a focus on cultivating agency while acknowledging the creative nature of recovery.

Originality / Value – Clinicians are in a strong position to observe recovery. Their insights suggest key refinements that will enhance the ways in which recovery in BPD is conceptualised and can be promoted.

Borderline personality disorder, clinician, recovery, qualitative methods, thematic analysis

Paper Type Research paper

Introduction

The concept of personal recovery has grown in importance within mental healthcare policy for all consumers, including individuals diagnosed with personality disorder (Le Boutilllier et al., 2011). The concept of personal recovery originated during the early nineties within consumer narratives that contested the nature and quality of psychiatric care at that time (Davidson, Rakfedt & Strauss, 2012). Subsequently, what was originally an 'outsider' concept has been widely endorsed within national healthcare policy. Within the Australian context of the current study, the stated aim of national policy is to "enable recovery", with recovery defined as involving "the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability" (Commonwealth of Australia, 2010, p. 31). The language of this definition of recovery mirrors the definitions from the consumer literature (for instance, Anthony, 1993) Furthermore, there is an emphasis on the individual nature of recovery and on care that is centred on the consumer's needs, highlighting the positive influence of consumer definitions of recovery on national policy.

The adoption of recovery concepts within public policy and in the language and practices of professional treatment services remains controversial in Australia and elsewhere. The concept of recovery arose in the context of the social justice claims of the survivor / consumer movement (For instance Anthony, 1993; Deegan, 1997). The activism associated with these claims asserts that mental health consumers / survivors have different and at times conflicting interests to those of professionals working within mainstream mental health services. Indeed, it has been suggested that the concept of recovery has been "stolen" by policy makers and mental health professionals, denying consumers opportunities for on-going activism or associated reform of the mental health

system (Resnick and Hunt, 2015). Furthermore, it has been argued that the mainstreaming of recovery has "manufactured" a smoke screen that obscures the lack of substantive reform (Braslow, 2013).

There is indeed the risk that 'recovery' is little more than a hollow policy imperative that lacks impact on everyday clinical practice. It is arguable, for example, that existing recovery oriented practice and policy neglects the role of the social environment in either supporting or limiting recovery outcomes for individuals. While the evidence linking recovery with the social environment is currently limited, emerging evidence indicates that family and friends, the community and the wider social context are all important (Ådnøy Eriksen et al, 2012; Topor, Borg & Davidson, 2011; Williams & Tufford, 2012). Clinicians comprise part of an individual's social environment and along with others may either positively or negatively influence an individual's recovery. In keeping with discussions of the role of the social environment in supporting recovery, we argue that unless recovery is taken up within clinicians' work, it will remain a 'vision' rather than a viable process able to influence outcomes for consumers (Williams et al., 2016). We acknowledge the complex politics underlying the use of the term recovery by clinicians, particularly the concern that the adoption of particular interpretations of recovery by policy makers and mental health services may undermine the important role of consumers as activists within mental healthcare systems. However, if it is to move beyond a policy imperative and positively impact clinical practice, there needs to be a better understanding of how recovery has been taken up within clinical work so far.

Although consumers are in the best position to offer first-person perspectives on recovery, clinicians commonly observe recovery in their work. Accordingly, clinicians may constructively add to our understanding of personal recovery. Understanding how

clinicians support recovery of consumers diagnosed with Borderline Personality Disorder (BPD) is important because this will have a significant impact on quality of care, and the ways in which consumers experience mental healthcare. Existing models of recovery such as CHIME (Connectedness, Hope, Identity, Meaning, Empowerment) identify important goals for the conduct of mental healthcare services (Bird et al, 2014; Leamy, 2011). However, it is unclear how recovery has been interpreted and implemented in practice, particularly with consumers with BPD. It is important that we understand how personal recovery is being interpreted in clinical practice as well as whether the use of recovery-focused practices are in accord with policy requirements. The approaches taken by clinicians to implement recovery-based care may also reveal specific strategies that constructively add to the overarching goals that have been identified in models such as CHIME. It is also possible that clinicians may identify limitations to the practical implementation of recovery-focused care. Understanding the limitations of current recovery-based practices may be particularly important in relation to BPD. Much of the existing literature is focused on schizophrenia and other mental state disorders, with little reflection on recovery in the context of personality disorder. Improving our understanding of recovery from BPD, from both consumer and clinician perspectives, will ensure that recovery-based care for consumers with BPD is better tailored to their needs.

The current paper describes the second part of a two part project. The first part of the project focused on consumer perspectives on personal recovery. Consumers and clinicians bring different perspectives to the questions this project explores. The power differential between clinicians and consumers clearly informs the perspectives each group has on the value of 'recovery' as a concept and practice. The two parts of this project are reported separately to avoid obscuring these differences in perspectives, experiences and judgements of clinicians and consumers. Similarities and differences

between consumer and clinician perspectives will be discussed within this paper. The present study was exploratory, qualitative, and interview-based. It was designed to inductively develop an understanding of the meaning of recovery from a clinician perspective, reflecting on their practical experience with the concept of recovery and how they support recovery in practice. The aims of this component of the project are (1) To explore the meaning of 'recovery' as it is understood by clinicians; (2) To ask clinicians to identify key processes that they believe underlie recovery from BPD; (3) To better understand how clinicians perceive their role in supporting recovery; (4) To better understand what recovery means in practice to clinicians.

Method

Setting

The sixteen clinicians who participated in this study were recruited from two community-based mental health services in Melbourne, Australia, both of which provide adult, outpatient services. One was a specialist BPD service and the other a generalist service, broadening the range of clinician perspectives on recovery and BPD. The specialist service treats personality disorder using various approaches including Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), and Mentalization Based Therapy (MBT) in weekly individual and group formats. Admission for treatment is typically two years, overseen by psychiatrists who also provide primary care. The generalist service provides treatment for a range of mental illnesses including BPD on an individual basis, focusing on case management rather than in-depth or trauma-related therapy, with outpatient psychiatric care as needed.

Participants

Clinical staff took part in interviews about recovery and BPD. Participants received a (AUD) $25 shopping voucher in appreciation of their participation. Five social workers, 4 nurses, 5 psychologists, 1 psychiatry registrar and 1 consultant psychiatrist were

interviewed. Fourteen of the sixteen interviewees were employed by the specialist personality service with the remaining two employed by the generalist mental health service. The focus of this study was on clinicians with specialist experience of working with individuals with BPD, although clinicians from a more general service were also included as they may offer different insights into recovery in BPD. Participants were aged from 30 to 73 years (average 44.5 years) and 13 were female.

Procedure

All interviews were conducted by the lead author. Written consent was obtained from all participants before the interview commenced. Interview questions were based on a prepared semi-structured interview guide, although follow-up questions were individually tailored according to the particular insights interviewees offered. All interviewees were asked about (i) their understanding of the meaning of recovery from mental illness generally; (ii) their views regarding the appropriateness of the concept of recovery in relation to BPD; (iii) the nature of recovery (or 'positive change') in BPD including stages of and preconditions for recovery; and (iv) the qualities or approaches that clinicians can bring to the therapeutic relationship in order to facilitate recovery. The duration of the interviews ranged from 28 to 65 minutes. Some participants offered detailed examples related to their experiences whereas others answered in more general terms.

Study Design

The definition and implications of recovery from the clinician perspective have received little attention within the existing literature. Accordingly, the design of this study was inductive and exploratory in nature. This study was guided by Grounded Theory, which offers a well-developed methodology for exploring the nature of a social phenomenon such as clinicians' perspectives on recovery, using an iterative process of comparison and evolving refinement of emerging themes (Glaser, 1992; Glaser & Strauss, 1967). Thematic analysis was used with the aim of identifying a small number of themes that

summarize the overall data (Henwood, 2006). Thematic analysis enables understanding of how meaning is given to psychosocial phenomena and is widely used in qualitative health research. It is particularly appropriate for exploration of novel research questions such as questions around recovery from BPD (Strauss & Corbin, 1994). The study design was approved by the Eastern Health Human Research Ethics

Analysis

Thematic analysis was used to evaluate the interview data. Each transcript was read several times to achieve familiarization with the content. Ideas that were repeated across transcripts were grouped and coded and a codebook was maintained. Initially, hand-written line by line, open coding was used on the transcripts. Themes were developed according to similarities across codes, with continuous review of all themes to ensure that they remained representative of the codes until thematic saturation occurred, that is, no new themes could be identified. Higher order themes (reported below) were subsequently developed using analysis of related themes. The first and second authors conducted coding and the identification of themes independently, and any disagreement was resolved through discussion within the research team.

Results

Four themes were developed from the results of this study, each of which contained two or three related subthemes (Table 1). These are presented below according to the themes.

Themes	*Subthemes*
Understanding Recovery	'Recovery: a complex individual process of moving towards a more satisfying life'
	'Recovery; Different Ways of Relating to Oneself' and

	'Recovery; Symptom Relief and Psychosocial Improvement'
Recovery and BPD	'Cultivating Curiosity about Oneself' 'Fostering Agency' and 'Recovery as a Creative Process'
Recovery in Practice	"When Recovery Goes Wrong: Seeing the Model not the Individual' and "Recovery as Potentially Invalidating when not in Tune with Clients' Experience'
Supporting Recovery	Change is Relational' and 'Aligned', 'Attuned' and 'Alongside'

Table 1 Themes and Subthemes

The number of participants who contributed to a particular theme or subtheme is indicated below as each theme or subtheme is reported.

Understanding Recovery

Recovery, as understood by clinician participants, was about moving towards a satisfying and meaningful life. A small number of participants understood recovery specifically in relation to the work that they did with clients on the client's self. On the other hand, some participants understood recovery in more clinical terms, as remission of symptoms and improved psychosocial functioning. This suggests that there were substantial differences in the ways that clinicians articulated recovery.

Recovery: a complex individual process of moving towards a more satisfying life

A majority of clinicians (9/16) described recovery in ways that were compatible with the literature on 'personal recovery' noted above, emphasizing that it was a process that is

highly individual involving finding meaning or a satisfying life. Participant 2 described recovery as, "Getting a life you want in a way. It is a bit fanciful but that is what people strive for. They want to achieve the things that they want, and I guess to be the person that they want to be." Participant 1 had a similar view, commenting that recovery involved "the client feeling a little bit more able to do what they want to do in their lives". For Participant 16, recovery was about finding meaning, describing recovery as having, "some source of meaning in their lives that allows them to feel that they've led a life with meaning and some sense of fulfilment for themselves. That's my concept of recovery."

Recovery: Different Ways of Relating to Oneself

A few participants (3/16) defined recovery for their clients in terms of ways of relating to oneself or to one's 'symptoms' differently. For instance, Participant 8 commented that recovery, "means to me the person finding a way of making sense of their experience, ways of accepting what has happened to them, … because for me avoidance and non-acceptance of illness sometimes seems to get in the way". Participant 5 expressed a similar perception of recovery in terms of a changed relationship with goals and desires: "So it doesn't necessarily mean achieving particular goals that one sets oneself, but I suppose it is to have a relationship with one's desires or goals where they are integrated in some way into one's life". A related but slightly different perception of a changed relationship to one's symptoms was expressed by Participant 6, "I would see that as the recovery, that one is no longer subjected to the symptoms but to be able to recognize the history of them and, ahh, being able to put them to work for them rather than against them".

Recovery: Symptom Relief and Improved Psychosocial Functioning

The remaining participants (3/16) understood recovery in ways that are consistent with clinical notions of recovery, but not necessarily models of personal recovery. Participant 7 understood recovery "is something that might go in stages. So obviously if someone is having [a] mental health diagnosis then it [is] recovering from the symptoms of a particular disorder and then more from a psychosocial perspective, recovery in terms of vocational recovery and social kind of recovery". A similar clinical perception of recovery was expressed by Participant 9 who suggested that recovery meant " improving of symptoms related to mental illness. So perhaps . . . the degree or severity of those symptoms reducing . . . Or potentially kind of going away completely ... and improvement in terms of functioning . . . in areas of life. ... improvement in kind of psychosocial type of factors."

Recovery and BPD

The majority of participants (10/16) suggested that recovery from BPD may be different not only for each individual but from recovery from other conditions. More specifically, a number of processes important to recovery from BPD were identified. Although none of these processes are incompatible with recovery as it has been described in models like CHIME, the emphasis was at times different. Our participants placed particular emphasis on the creative nature of the process of recovery from BPD with respect to the practices of self-care, curiosity and self-inquiry, and the concurrent development of strong interpersonal relationships in order to reshape identity in the present. Curiosity about the self was identified by clinicians as the specific skill needed to promote changes within the individual's perception of himself or herself. Self-discovery has been identified as important to recovery from BPD elsewhere (see Gillard et al., 2015) but is not typically emphasized within the more general recovery literature.

Cultivating Curiosity about Oneself

Some participants (6/17) emphasized the client's need for work on the self that involves a process of self-inquiry or curiosity. For instance, Participant 1 emphasized that "Certainly in the work that we do, we encourage clients to be curious about the way that they think, about themselves". Participant 13 understood curiosity about oneself as a "shift" within the process of recovery: "I'm curious about the shift that happens for people that's not necessarily just BPD, just in general…But, say someone who's wanting a solution…and they have therapy for a while and then they actually get curious, they get interested in themselves. I think that is the start of something really important."

Fostering Agency

Alongside an emphasis on the creative nature of recovery, participants also emphasized that fostering agency on the part of the individual with BPD was central to their work in promoting recovery. The important of agency was highlighted by some participants (5/16) in ways that are compatible with CHIME, but with a difference in emphasis. For instance, Participant 3 suggested that "I think it is really important to see the person as a self-functioning agent somehow, despite whatever they throw at you that might tell you otherwise". For participant 6, agency is at the heart of recovery, with the first step towards recovery involving being allowed or encouraged to speak for oneself: "…through the process of speaking in a talking treatment, [the client] is able to speak for themselves and to put something forward of themselves, and for their experience to come to the fore rather than is often the case that they are spoken for". This participant added that clients are categorized diagnostically which "… is problematic when it becomes the person's entirety, their whole, it becomes who they are."

Recovery as a Creative Process

Some of our participants (7/16) emphasised that recovery is not a simple or straightforward process, but demands a great deal of creativity on the part of the recovering individual. This is highlighted by participant 6: "I think certainly the patients I have worked with in my experience with BPD … that really the process of treatment is something more creative and they can actually come to be something that they never were. So it is not about recovering or going back to something prior to this disturbed state, but actually for some people they have never had the capacity to say speak for themselves or recognize who they are or what they are or where they have come from, so really I see it as something more creative." Participant 5 emphasized that recovery may be creative in the sense that someone arrives at a different place than they intended, "I don't have a particular template for what recovery might look like because of course it is going to be different from individual to individual, but I also need to stress that the individual may also be surprised … they might have a sense of recovery without actually achieving the things that they set out to do in the first place."

Recovery in Practice

A majority of participants (11/16) asserted that conceptualisations of recovery can be problematic in clinical practice. This is evident in situations involving inflexibility around what recovery work is. This inflexibility is likely to affect individuals with BPD, as some of the commonly used recovery models have been developed for conditions such as schizophrenia. This problem is highlighted by one participant's recollection of individuals with BPD being discharged from a service because their needs didn't match the models of recovery established in that service.

When Recovery Goes Wrong: Seeing the Model not the Individual

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Some participants (4/16) expressed concern that in their experience the notion of recovery lends itself to use within mental health systems in ways that are inflexible or "template" like. For instance, Participant 13 commented that, "... but I do think anything, say within case management, that's picking up a model and are trying to apply a model to a person is just kind of the same old problem." This participant added, "I can imagine recovery being used, serving just the same function, you know, 'The client can't identify their recovery goals so we'll discharge them.'". Participant 13 then went on to contrast this with other more flexible approaches, "I've spoken to workers at [names agency] I think, and they had kind of taken up recovery ideas but had. . . I think a lot of social justice stuff in for those people, and so they seemed to be applying it a little bit flexibly, and what they were talking about was kind of, 'Where do you want your life to go?'". This concern about inflexibility was echoed by Participant 5 when he suggested that, "The recovery model sits as a kind of agenda if you like, that the clinician will come in with a kind of template that the patient then needs to slot in to, so it's something the patient describes, a set of goals that leads to a particular set of outcomes which we call recovery." Participant 11 expressed particular concern about recovery plans as they are commonly used, "I've seen clients come to us and they've shown us their recovery star that you know, the case managers and things are doing with them. And the clients' experiences, it feels like it's really being done to them, that they must get better and they must do it in this time and they've got to achieve all these things. And they seem quite distressed by it."

Recovery as Potentially Invalidating if Not in Tune with Clients' Experience

Framing treatment in terms of recovery could be invalidating and counterproductive when clients are in crisis, early in treatment, or when the client's experience is not 'in

tune' with the possibility of change. The majority of participants (10/16) expressed concerns about recovery being potentially invalidating if it was too focused on regaining something from the past, or if it did not sufficiently value actual experience or is not in tune with the client's current experience, at times of crisis for instance. Participant 1 commented that, "I think the majority of clients, the ones I work with in [names unit] … their understanding of recovery is that they are going to get something back that they have never had", adding that "So it leaves them with nowhere to go really….in some ways". This participant then asked, "If you have been the victim of abuse or neglect and you perceive that you haven't had something that has been very important, how do you recover that?" Participant 2 also expressed concern about invalidation of experience, commenting that "Language is important . . . I think there is a time where the client needs you to know how impossible it is, or how hard it is, and how bad it is, or how difficult. So I would think any language that is particularly with BPD that is overly positive is invalidating and then you hit a wall". Participant 13 went further, questioning whether recovering from one's experience was actually helpful or if there was more value in accommodating that experience and also in recognising the value of having lived with BPD. This participant added that, "I don't think actually BPD is something I would want clients to recover from, [laughs] in a way. Like I wouldn't want that to be so painful for them anymore, but … that experience, the experience that they've had, the kind of not something to get over, in a way, they're something to make sense of, make peace with, find a place for, so it's not so painful, it's not damaging, they can do other things. But, to try and be free of it, I don't know". Expanding on this point, the same participant commented that "the BPD experience is actually like a really important part of them…it's something valuable…in a way. Like it sensitises them to humanity and selves and, you know, in a way I think that people that haven't had that experience …I don't know, but would benefit from [that]".

Supporting Recovery

Most participants (14/16) suggested that recovery from BPD needs to be supported within a trusting relationship with another person who may be a clinician or maybe a partner, friend or family member, meaning that recovery or change intrinsically involved a supportive relationship with another person. Participants also had clear ideas about the kinds of relationships that are therapeutic, emphasizing the need to be 'aligned', 'attuned' or 'alongside' the client.

Change is Relational

Recovery was seen as relational, with introspection being insufficient to lead to positive change or recovery by many participants (11/16). Perhaps unsurprisingly, the consensus among clinicians was that the key to such positive change lay in developing and strengthening the therapeutic relationship between client and clinician. Participant 8 described this relationship as potentially "transformative" but also "frightening and unsettling" because "all that stuff from past relationships gets projected onto it". Despite these challenges, the perceived value of the clinical relationship resided in clients "being heard" while being offered a safe space for individual reflection. In the context of what clinicians bring to this relationship, Participant 6 reflected that:

> "I think there is something that happens through interaction, something that you might say is dynamic, that is different to, say, reflection. We can sit and contemplate who one is, (which will be bound up with a whole load of cultural and historical experiences that you can't really break free of through just self-reflection), through interaction with others."

'Aligned', 'Attuned' and 'Alongside'.

Clinicians were also clear about the therapeutic stance that is needed to promote recovery: adopting a non-expert stance whereby the clinician is 'attuned'. 'aligned' or 'alongside' their client. Several participants (8/16) spoke about the therapeutic relationship as a 'space' or 'place' that privileges radical acceptance of all of the client's experiences. Moreover relationships that promote recovery are non-didactic and adopt a stance of curiosity and non-expert understanding. For instance, Participant 11 spoke of the therapeutic relationship as being about, "being there and being available, … and being a bit of … a holding place for the clients to try and play out and test out, you know, all their difficulties, so you've got to be kind of in it with them… I think acceptance … around a not-knowing stance and you know, trying to work through that stuff with the clients is really important." The 'place' or 'space' of therapy was also about a radical acceptable of all of the client's experience, no matter how distressing this may be. For instance, Participant 6 suggested that a radical acceptance of all experience was critical, commenting that,

> "it is a fairly agenda-free wondering about one's life and what is happening in one's life, and setting up an environment in which a patient can speak about things that they are most ashamed of, the things that they find most difficult and that they realize that the clinician that they are sitting with will accept anything they say quite radically. And that is not about believing or disbelieving, but regardless of what the patient might say that the deepest fears and shames are, that there is a kind of unblinking acceptance of that."

How the clinician 'positions' him or herself in relation to the client was also seen as critically important. For Participant 3, "You almost have to be alongside them [client], be doing it with them and that has to be well-established and known in the relationship." Participant 4 also emphasized the need to be alongside the client's willingness to

change. For her, the role of the clinician was "to be a recipient of their willingness, work alongside them and coach them and possibly support them in their endeavours in learning new ways of being". Participant 2 spoke more explicitly of attunement, commenting that what was critical to the relationship was, "The attunement with the client and beginning with and doing with them… and I think that … [is] a nice way of saying you need to be in a position with the client where you are not the expert, but say 'well together let's see if we can find a way out'".

Discussion

The present study had four aims: (1) To explore the meaning of 'recovery' as it is understood by clinicians; (2) To explore what clinicians think are the key processes underlying recovery from BPD; (3) To explore how clinicians believe that they can best support recovery, and (4) To explore what recovery means in practice to clinicians. Clinicians' understanding of recovery was largely consistent with established models of recovery such as CHIME and the existing recovery literature, although notably there were inconsistencies among clinicians. An important point of divergence was the clinical understanding of recovery expressed as remission of symptoms and improved psychosocial functioning; this is not consistent with the concept of personal recovery. The emphasis on the client's self as suggested by a small number of clinicians, and while this focus is not incompatible with the existing literature on personal recovery, it seems to align better with the needs of clients with BPD. The emphasis on self-inquiry or curiosity about the self is consistent with the emphasis on developing a strong identity within existing models such as CHIME, but also suggests a process that is more specific to recovery from BPD. The emphasis on inquiry about oneself suggests that curiosity is a specific skill that is necessary for developing a stronger sense of identity or a more coherent sense of self for people living with BPD. This finding is more specific than the

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emphasis placed on identity within CHIME, as it pinpoints the centrality of curiosity about oneself in the recovery process. It is notable that work on the self has been identified as central to recovery within Gillard, Turner and Neffgen's (2015) study of the experience of living with BPD. From this perspective, reconciling difficulties between internal representations of the self and external representations of the self in relation to others is at the heart of recovery from BPD. However, the process required for reconciling the tensions between internal and external self representations is not clear. Our results go some way towards identifying the mechanism that may underpin this aspect of recovery from BPD with 'curiosity about oneself' appearing to be crucial.

While the creative aspect of recovery has been noted in the literature (e.g., Turner, Lovell, & Brooker, 2011), there was a different emphasis by the clinicians we spoke with. The importance of agency within recovery from BPD is also clearly consistent with the existing recovery literature, although the emphasis placed on agency rather than autonomy is notable here. Agency, autonomy and empowerment are used somewhat interchangeably within the literature, perhaps creating the sense that choices are offered to individuals with mental illness or they are empowered by others to act in the world. Our participants' conceptualisation of agency had a somewhat different emphasis. Agency, in the sense that it was invoked by clinicians, is about finding ways to act in the world on one's own behalf. Although this is entirely consistent with principles of autonomy and empowerment, the emphasis on agency offered by our participants suggests a somewhat different focus.

It is also notable that most of our participants expressed some caution, even ambivalence about the concept of recovery as it pertains to BPD. Of particular concern are reports from clinical practice that recovery models are enacted in relatively simplistic

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ways, usually in the form of narrow recovery goals and pro-forma case management tools such as the 'recovery star'. To be clear, our participants did not reject the recovery paradigm, and most conveyed a strong understanding of its central concepts and principles. However the kinds of clinical practices our participants endorsed were those that are highly individualized, and rest on a radical acceptance of all of their client's experience. Although this seems entirely consistent with established recovery principles, there appear to be difficulties with how a recovery framework is enacted in clinical practice. Despite the awareness that recovery as a paradigm is a powerful means for advocating for more individualized and attuned clinical interventions, in practice this may be substituted by generic or standardized templates as part of 'recovery' oriented treatment. It is notable that recovery definitions used in mental health policy in Australia are consistent with the principles of personal recovery by suggesting for instance that recovery is a highly individual process (Commonwealth of Australia, 2010 & 2013). However, there is evidence from the present study that actual 'recovery-oriented' practices do not necessarily accord with Australian policy, or with the principles of recovery described within the personal recovery literature. In particular, the use of pro-forma worksheets or identical protocols for all consumers within a given service does not accord with the principle that interventions be individualized.

As the second part of a two-part project, this paper also offers opportunities for comparison of the perspectives of consumers and clinicians. Across the two data sets there was strong agreement along with notable differences of perspective. Both consumers and clinicians emphasised the importance of changes to self-representation and the need to nurture and sustain personal relationships. However, consumers were more specific about the range of conditions that need to be in place for recovery to occur. For instance, accepting the need for change and taking responsibility for one's

own behaviour was emphasized by consumers but not clinicians. The richness of consumers' insights in relation to the specific, everyday features of recovery may well reflect their particular lived experiences. In contrast, clinicians were more abstract in their insights emphasizing, for example, agency and creativity (in the sense of resourcefulness). The emphasis on agency is of direct relevance to our discussion of the role of changes in self-representation and the growth of personal relationships in promoting recovery in BPD, with clinicians expressing greatest clarity about the therapeutic conditions that need to be in place to foster agency. The views of our participants would suggest that there may be a reciprocal relationship between increased sense of agency (acting in the world) and having a space for self-reflection. As some clinicians argued, recovery is not wholly a matter of introspection, but it is also the case that the capacity to act in the world may also not be sufficient for recovery. Space and support for self-reflection may also be needed. Overall, the differences between the consumer and clinician perspectives may reflect differences between consumer perspectives of living with BPD and the clinicians' perspective as an observer of change. The importance of understanding recovery from the perspective of lived experience is clear in our data, but clinicians also have an important contribution to make to improved understandings of the specifics features, practices and dynamics of recovery.

Limitations and future directions

Despite these clear findings, the current study is exploratory in nature. Further qualitative investigation of progress or change in BPD is needed to determine if the emphasis placed on agency and creativity by clinicians interviewed in this study is relevant to consumers. Future exploration of personal recovery from the perspective of carers may also clarify how support for recovery can be tailored to the needs of individuals diagnosed with BPD.

Conclusions

The principal goal of this paper was to examine how the process of recovery may best be conceptualised within the treatment of BPD. This study highlights how recovery for people living with BPD requires skills, attributes, experiences and conditions that while broadly consistent with recovery models such as CHIME, may need to be specifically targeted or refined in clinical practice. Of particular note is the concern that in practice, recovery oriented interventions are being implemented as a one-size-fits-all 'template' or in ways that involve recovery protocols being applied in a generic way to all individuals presenting to a particular service. This is antithetical to the principles that our participants endorsed: that clinical interventions need to be highly individualised and grounded in the individual's lived experience. Further work to elucidate how self-inquiry, creative transformation and agency can be facilitated within the context of BPD treatment will expand our understanding of recovery from BPD and inform clinical practice.

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4.3   Additional Results: Clinician Qualitative Data

Curiosity about oneself
or the ability to play

Building trust / attachment
security in at least one
relationship

Creating a holding place / the
ingredients of secure attachment

Recovery and BPD: conditions of change

Creating a space
to speak freely

Work with shame /
confusion

Agency as central
to change

Understanding that other
people struggle

Creating an environment
of discovery / curiosity
about oneself

Ability to self-reflect /
need for supervision

Listening without reacting
/ ability to tolerate
distress

Complex individual process of
moving towards a more satisfying

What clinicians can do to help

Understanding Recovery

Therapeutic stance –
ot being the expert /
not knowing

Hear what is being said

Symptom relief
and improved
psychosocial
functioning

Being
genuine /
real

Being curious, attentive
and accepting

Different ways of
relating to oneself

'Self-compassion' as
invalidating to a self-
loathing client

Self-loathing as
shutting down or a
defence

Self-compassion as
starting with self-
soothing / managing
distress

Self-loathing as an
internalization of
criticism by others

**Self-compassion as intrinsic to
therapeutic change**

Directly opposing self-
loathing as counter
indicated

Language of self-
compassion sometimes
problematic

Self-compassion
needs to be felt not
just understood
cognitively

Self-loathing as one of the most
difficult issues when working with BPD

Figure 2 Coding Tree: Clinician Qualitative Data

5. The Role of Self-Compassion in Personal Recovery from Borderline Personality Disorder

5.1 Introduction to Chapter 5

This chapter presents the results of a quantitative study of the relationship between personal recovery in BPD and self-compassion and personal recovery and self-criticism. Self-loathing has been identified as a barrier to recovery based on clinical observation. As noted in the introduction, there is no existing measure of self-loathing so a measure of self-criticism has been used as a proxy for self-loathing. .This chapter aims to explore if there is an association between personal recovery and self-loathing as a preliminary to investigation of self-loathing more directly in future research. The central purposes of this investigation was to (1) establish if there is an association between personal recovery and self-compassion and self-criticism and to further explore the strength of that association and (2) to explore the component parts of self-compassion and self-criticism in relation to the component parts of personal recovery. Interpretation of these results is included in this chapter.

5.2   Results

All participants ($n = 19$) were diagnosed with BPD on the SCID-IV-II. Descriptive statistics

including the mean, standard deviation, range and skewness and kurtosis for all variables are

presented in Table 1. Assumptions of normality, linearity and homoscedasticity were examined.

Assumptions of normality were not violated on the RAS or the NSCS and in the case of the

relationship between these two variables Pearson's r was calculated. In the case of the FSCSR,

the assumptions of normality were violated and Spearman's rho was calculated in this case. To

examine relationships between personal recovery and self-compassion, and personal recovery and

self-criticism, correlations were calculated. There was a strong positive correlation between

personal recovery (as indicated on the RAS) and self-compassion as indicated on the NSCS), r

$=.75$ $n = 19$, $p < 0.01$. There was a strong negative correlation between personal recovery (as

indicated on the RAS) and self-criticism (as indicated on the FSCSR), $rho = -.67$, $n = 19$, $p <$

0.01. Correlations between the subscales of the RAS and the NSCS and the RAS and the FSCSR

were also calculated. Results of these correlations are given in Table 2 for the RAS and the NSCS

and in Table 3 for the RAS and the FSCSRS.

Table 1

Descriptive Statistics

	Mean (*n* = 19)	Standard Deviation	Range	Skewness	Kurtosis
RAS	3.36	0.72	2.00 – 4.77	- 0.23	-0.54
NSCS	2.26	0.81	1.1 – 4.1	0.5	.05
FSCSR	2.85	0.95	1.3 – 4.0	-.91	.04

Note: RAS is the Recovery Assessment Scale. NSCS is the Neff Self-compassion Scale and the FSCSR is the Forms of Self-Criticism and Self-Reassurance

Table 2

Pearson's r Correlations for Subscales of the RAS and the NSCS

RAS	NSCS					
	Self-Kindness	Self-Judgment	Common Humanity	Isolation	Mindfulness	Over-Identification
Personal Confidence & Hope	.57*	-.71**	.56*	-.62**	.45	-.53*
Willingness to Ask for Help	.38	-.22	.60**	-.13	.37	-.28
Goal and Success Orientation	.66**	-.53*	.79**	-.49*	.67**	-.43
Reliance on Others	.56*	-.70**	.57*	-.71**	.51*	-.61*
No Domination Symptoms	.56*	-.59**	.62**	-.52*	.51*	-.70**

Note: RAS is the Recovery Assessment Scale. NSCS is the Neff Self-compassion Scale
* Correlation is significant at the 0.05 level (two tailed)
** Correlation is significant at the 0.01 level (two tailed)

Table 3

Spearman's Rho Correlation for Subscales of the RAS and the FSCSR

	FSCSR		
RAS	Reassured Self	Inadequate Self	Hated Self
Personal Confidence & Hope	.71**	-.65**	-.53*
Willingness to Ask for Help	.44	-.36	-.30
Goal and Success Orientation	.75**	-.57*	-.54*
Reliance on Others	.55*	-.65*	-.54*
No Domination Symptoms	.62 **	-.69**	-.57*

Note: RAS is the Recovery Assessment Scale. FSCSR Forms of Self-Criticizing / Self Attacking and Self Reassurance Scale
* Correlation is significant at the 0.05 level (two tailed)
** Correlation is significant at the 0.01 level (two tailed)

5.3 Interpretation of Results

This study aimed to examine the relationship of self-compassion and self-criticism with personal recovery in relation to BPD. It was hypothesized that greater levels of self-compassion would be associated with greater levels of personal recovery and that higher levels of self-criticism would be associated with lower levels of personal recovery. Both these hypotheses are supported by the study results. Notably the mean score for our participants on the RAS was *M*= 3.36 *SD* = 0.72. As previously noted in Section 2.2.6, the RAS has not be used with samples with BPD previously making comparison with BPD samples not possible. However, the mean score from 28 studies of mental illness in general was *M*= 3.78 *SD* = 0.19 with a range of *M* = 3.14 to 4.12 (Salzer & Brusilovskiy, 2014). This suggests that our participants' progress in recovery was comparable with previous studies of recovery from a range of mental illnesses.

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Interestingly, the correlation between self-compassion and personal recovery was large (r = .75) accounting for 56% of the variance. The correlation between self-criticism and personal recovery was also large (rho = -.67) accounting for 45% of the variance. Both consideration of self-compassion / self-criticism and personal recovery in relation to BPD are both comparatively new. The strength of the relationships described above suggests that both a focus on recovery and interventions to enhance self-compassion and diminish self-criticism may be important in supporting positive change in BPD. It may be the case that as individuals recover from BPD they find a more self-compassionate and less self-critical stance towards themselves. For instance, it may be that an acknowledgement of human fallibility is part of the recovery process as individuals come to terms with a mental health diagnosis and this is associated with a more compassionate and less self-critical attitude towards oneself. Alternatively, it may be that by cultivating a more self-compassionate attitude towards the self personal recovery is supported. It is of course not possible within a correlational study such as the current one to determine the direction of the relationship. Nevertheless, our results suggest that a broadly based focus on personal recovery rather than interventions narrowly focused on remission of symptoms is important in the context of interventions for BPD. Personal recovery or possible change in BPD may also be supported by interventions designed to support self-compassion. To date the two studies that have aimed at supporting self-compassionate attitudes towards the self have had mixed outcomes without clear impacts in increasing self-compassion or decreasing self-criticism (Lucre & Corten, 2012; Felieu-Soler et al., 2015). On the basis of clinical observation it has also been suggested that individuals diagnosed with BPD who also present with severe self-loathing may find interventions aimed directly at cultivating self-compassion and diminishing self-criticism superficial or even invalidating in relation to their globally negative attitudes towards themselves (Kravitz, 2012 a & b). In other words, suggesting to a severely self-loathing individuals that they need to be kinder and more compassionate towards themselves may be ineffectual or even iatrogenic. This may explain the mixed results of trials of interventions

designed to decrease self-loathing in individuals with BPD. This further suggests that therapeutic interventions designed to diminish self-loathing and cultivate self-compassion through more specifically focused means may be more effective.

The second aim of this study was to examine the relationships between aspects of personal recovery and self-compassion and personal recovery and self-criticism by examining the relationships between the subscales of the RAS and the NSCS and the FSCSRS respectively. In relation to the RAS and the NSCS, there was a particularly strong relationship between goal orientation and success and common humanity. There were also strong negative relationships between personal confidence and self judgment although this may indicate that these two factors of the RAS and the NSCS are tapping a similar psychological construct. Similarly, there was a strong negative relationship between no domination of symptoms and over identification. This may also be suggest that these two factors are tapping similar constructs. The relationships between the two aspects of self-criticism, self-hatred and the view of the self as inadequate were generally quite strong. There were also generally large positive correlations between reassuring attitudes towards the self and factors of personal recovery although the relationship between self-reassurance and willingness to ask for help did not meet significance. However, some factors on the RAS and the FSCRS may be tapping similar constructs. For instance, the strong positive correlation between personal confidence and hope and the reassured self may indicate that these two constructs are similar. Nevertheless, these results in relation to all three aspects of self-criticism were as predicted.

However, it is exactly the process of cultivating self-reassurance and managing the twin aspects of self-criticism that individuals with BPD may have most difficulty with. As previously noted, interventions designed to directly increase self-reassurance and diminish self-criticism have generally produced limited results. This suggests a more specific approach to cultivating a kind and compassionate attitude towards the self may be of therapeutic value. The pattern of relationships between personal recovery and self-compassion presented above are of interest in

this regard: the correlations between factors of personal recovery (as measured by the RAS) and common humanity (as measured on the NSCS) were particularly strong with each of the correlation of the subscales meeting significance. Common humanity refers to the tendency to see one's fallibilities as a part of the human condition rather than as a uniquely negative aspect of oneself. It may be that the process of personal recovery means that individuals come to terms with their personal limitations or fallibilities as a part of that process. Alternatively, it may be that cultivating attitudes towards the self that emphasize commonality with others in relation to personal fallibilities may support recovery from BPD. The correlational nature of the data presented here means that it is not possible to determine the direction of the relationship. Nevertheless, it may be that a therapeutic emphasis not only on recovery (rather than remission only) and interventions designed to foster attitudes related to common humanity may be effective in fostering self-compassion and decreasing self-criticism or self-loathing.

Overall, our results highlight the importance of the relationship between personal recovery and self-compassion. The strength of the correlation observed suggests that a focus on both personal recovery and self-compassion may be worthwhile in supporting progress or change for individuals diagnosed with BPD. Nevertheless, there are limitations to the current study. The very small sample size may limit interpretation of the results and the study may lack sufficient power to reveal relationships between all aspects of personal recovery and self-compassion and self-criticism respectively. Given the very small sample size the strength of the relationships reported here are nevertheless noteworthy. Future studies would benefit from a larger sample size to increase statistical power. Given the strength of the relationship between aspects of personal recovery and common humanity (as measured by the NSCS) it may also be worthwhile for future interventions designed to assist individuals with BPD to focus both on personal recovery and also on the common humanity aspects of self-compassion. Such interventions may also be designed to cultivate self-compassion specifically in relation to common humanity rather than via a direct focus on compassion or kindness towards the self.

6.   Integrated Discussion

The purpose of this integrated discussion is not to repeat the points made in each of the manuscripts prepared for publication, but to discuss the major findings that have emerged from this study as a whole and consider their implications for BPD. To this end, the major findings will be summarised in the context of the literature review and research aims presented in Chapters 1 and 2 and interpreted from a clinical perspective. The limitations of the research and future direction will also be discussed.

6.1   Thesis Rationale

This thesis extends established work on recovery from BPD by asking a different set of questions to those addressed by outcome studies. The focus was on the *process* of change rather than the possibility of positive *outcomes*. Further, this thesis moves beyond global goals as identified in the existing literature on personal recovery towards much more specific strategies that support recovery. Moreover, both consumer and clinician perspectives on personal recovery are considered, broadening the range of perspectives currently represented within the literature. This thesis contributes to our current understanding of personal recovery in relation to BPD by identifying the specific conditions that support recovery. The identification of specific conditions allows for the further identification of strategies (rather than global goals) that can support recovery. The value of personal recovery for consumers and clinicians and carers will now be enhanced by specific clinical strategies alongside the global goals already presented in the existing literature on personal recovery.

6.2   Overview of Research Findings

The possibility of positive change was endorsed by both consumers and clinicians despite concerns about the word 'recovery' as appropriate to the processes of change in BPD. Broadly, both consumers and clinicians identified that recovery involves at least one supportive relationship with another person. As clinicians particularly emphasized recovery is not a matter of

lonely introspection although processes of self-reflection are important. Rather these processes of self-reflection are best achieved in dialogue with another supportive other. For consumers, the support of others was critical to the process of recovery and further as the progress they had made was recognised by others they too recognized the possibility of change. In this sense, consumers recognized their own progress through other people's noticing of change. While the emphasis is somewhat different the role of others in recovery from BPD was clearly recognized.

Consumers further identified four additional conditions that supported recovery: Accepting the need for change; Working on trauma without blaming oneself; Curiosity about oneself and Reflecting on one's behaviour. Each of these conditions required the acquisition of a specific skill or a change in the individual's attitudes. For instance, curiosity about oneself is a skill which supports the wider goal of change towards greater self-acceptance by allowing for a more balanced appraisal of the self. Accepting the need for change implies a change in attitude from a minimizing of difficulties towards more help-seeking behaviours. Clinicians also identified efforts to increase curiosity about the self as a key way in which they supported recovery.

In additional to the 'conditions of change' that consumers identified, clinicians highlighted the importance of agency on the part of the individual with BPD. Agency as clinicians described it involved speaking or acting on one's own behalf. This concept of agency involved autonomy understood as the freedom to make choices about one's own life but extended beyond autonomy to crucially involve acting within one's social environment. In this sense, agency involves much more than being offered choices or being 'empowered' by others. Clinicians further emphasized the creative nature of recovery. Creativity in this context refers to the resourcefulness needed within recovery to find ways to act within one's social environment.

In addition to identifying key conditions of change this thesis also considers self-loathing as one of the key barriers to change. Self-loathing or harsh self-criticism has been identified as a key barrier to change on the basis of clinical observation (Kravitz, 2012 a & b). Difficulties with

self-acceptance have also been identified as a barrier to recovery (Katsakou et al, 2012). This further suggests a limited ability to be self-compassionate on the part of individuals with BPD. A better understanding of the relationship between self-loathing and personal recovery is a first step towards developing more effective interventions for BPD. The strong positive correlation found within the third component of this thesis between a measure personal recovery and a measure of self-compassion and the strong negative correlation between self-criticism and recovery suggest that higher levels of harsh-self-criticism may be associated with limits to recovery and conversely higher levels of self-compassion are associated with higher levels of recovery. As previously highlighted, low levels of self-compassion and high levels of self-criticism are not necessarily indicative of self-loathing but rather have been used as proxy measures in the absence of a direct measure of self-loathing. Accordingly, the findings presented here do not establish an association between self-loathing and personal recovery directly. However, the findings presented here suggest that future investigation of self-loathing in relation to recovery from BPD may have considerable merit. Without a measure of self-loathing, these findings are preliminary and indicative only but nevertheless point to the importance of further investigation of self-loathing in relation to recovery from BPD. The implications of these findings will be discussed below.

Although consumers may be most able to reflect through their own experience on recovery, clinicians observe recovery as part of their work and are also in a strong position to contribute to an understanding or recovery from BPD. This thesis includes the insights of both consumers and clinicians and accordingly allows for a broader range of perspectives than the previous literature. Considering consumer and clinician perspectives may allow for a more meaningful understanding of recovery for both consumers and clinicians because the similarities and differences between these perspectives may add to our overall understanding of personal recovery in BPD. Similarities and differences in the meaning of recovery for clinicians and consumers will be presented. The five conditions of change will then be discussed with particular attention to the

insights of both consumers and clinicians The implications of the findings of this thesis in relation to the existing literature will then be considered before the clinical implications are described.

6.3   Overview of Research Methodology

As previously noted, Grounded Theory informed the development of the qualitative component of this thesis. However, Grounded Theory is not a unified approach and many aspects of the development of a Grounded Theory study remain controversial. Some clarification about the approach taken within this thesis is warranted alongside reflection on how this approach has been utilized within the conduct of the two qualitative studies. Grounded Theory was first developed in the sixties by Strauss and Glaser and lead to the publication of *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). The central contention within Glaser and Strauss (1967) was that many studies of a specific phenomenon (field studies)within the social sciences simply verified an existing theory rather than build theory from the observation of the social phenomenon itself. Grounded Theory was offer as an approach to correct an over reliance on a few grand theories (Henwood, 2006). In essence, Glaser and Strauss (1967) argued that the interpretation of individual studies was excessively reliant on a few, pre-existing theories rather than being 'discovered' by systematic investigation of the data itself. Grounded Theory as described by Glaser and Strauss (1967) emphasized a commitment to induction rather than deduction and the 'form of inquiry' designed to encourage an inductive approach was the iterative process of 'constant comparison' (Charmaz, 2000). The process of constant comparison involves coding elements of the data (such as a participant's comments in an interview) and then comparing those codes within the one data source (for instance a single interview) and across the data set (the set of multiple interviews). This is achieved within a coding journal by writing constant speculative 'memos' than are compared and revised as higher order or more theoretical ideas 'emerge' from the data.

However, Glaser and Struss subsequently developed and published quite different approaches to developing a study using Grounded Theory. Strauss' subsequent approach (while retaining some of the language of the original proposal) is highly focused on technique and on the process of verification (Strass, 1987; Strass & Corbin, 1990). In contrast, Glaser emphasised an inductive logic (Glaser, 1978, 1992). Which emphasized that theory was allowed to emerge from the data rather than be 'forced' within an overall framework that retains 'theoretical sensitivity'. Theoretical sensitivity allows for researchers to bring disciplinary understandings to the process of data interpretation. Indeed, it may not be possible for researchers to 'forget' or 'disown' knowledge from their discipline. However, the concept of theoretical sensitivity also refers to the researcher being attuned to the possibility of discovering new theoretical perspectives within the process of analysing the data itself (Glaser, 1978).

The current thesis is founded on the vision of Grounded Theory articulated in the original 1967 version of constant comparison and as subsequently refined by Glaser. Specifically in relation to the current study of recovery and BPD, the study was conducted within a disciplinary context (clinical psychology) which commonly conceptualizes BPD as a form of psychopathology with recovery understood as remission of symptoms and then meeting normative standards of social functioning. Efforts were taken throughout the research process not to rely on a model of BPD that rests on psychopathology. For instance, the emphasis was on consumer participants' experiences rather than on a model of BPD that assumes pathology within the individual. Indeed, some of the results of the two qualitative studies may be seen as an alternative to, or even a challenge to, disciplinary assumptions about BPD. For instance, the view that individuals diagnosed with BPD are not able to change or accept responsibility is still commonly heard within discussions of individuals with BPD by professionals (Aviram, Brodsky & Stanley, 2006). Similarly, a model of psychopathology also assumes that the distress and difficulties individuals with BPD face are based in deficiencies within the individual. Both these assumptions are challenged by themes within the consumer data and also to a lesser extent by the

clinician data. For instance, consumers directly suggested that accepting the need for change and accepting responsibility for their own behaviour were conditions of change within BPD. Similarly, the emphasis on the need for help for others within both data sets suggests that change within BPD occurs within the interactions between the consumers and others. This may be seen as challenging interventions that emphasize pathology within the individual and further suggest change only with that individual. From the data presented within this thesis, change may in fact be far more relational or intersubjective.

6.4   Meaning of 'Recovery' in Borderline Personality Disorder: Consumer and Clinician Ambivalence

Clinicians and consumers understood the meaning of the word 'recovery' in different ways but despite these differences both consumers and clinicians expressed ambivalence about 'recovery'. Clinicians understood recovery in three distinct ways: as moving towards a more satisfying and meaningful life; as developing different ways of relating to oneself and as symptom relief and improved psychosocial functioning. The first (clinician) meaning of recovery as developing a more satisfying and meaningful life is clearly consistent with the literature on personal recovery. The second meaning of recovery is not incompatible with the concept of personal recovery, for instance, the emphasis on identity identified within CHIME (Bird et al., 2014; Leamy et al., 2011). However, 'recovery' understood as new ways of relating to oneself appears to be more specifically related to the difficulties associated with self representation within BPD and can be considered a BPD-specific understanding of recovery. The third way that clinicians understood recovery as symptom relief and improved psychosocial functioning is not consistent with the literature on personal recovery because that literature emphasizes that personal recovery is possible without complete remission of all symptoms. 'Recovery' understood as symptom relief and improved psychosocial functioning is more consistent with clinical definitions of recovery such as those used in outcome studies rather than personal recovery.

'Recovery' for consumers was associated with a cure, however, the possibility of a cure was consistently rejected. The association of 'recovery' with cure is not consistent with the meaning of personal recovery within the consumer and scholarly literature. However, our participants are unlikely to be familiar with the history of the construct of personal recovery as it has developed within this literature. Their experience of 'recovery' as the word is used in the everyday contexts may suggest that recovery is akin to cure. 'Recovery' may be used in natural settings such as everyday clinical interactions in ways that imply cure and this may have led to differences in how the word is understood by consumers and others such as scholars of personal recovery. Consumers in this study also consistently rejected the possibility of complete cure and indeed cautioned against the possibility of life within any difficulties associated with BPD. About half of the current consumer sample also suggested that recovery was not an adequate construct to describe their experiences of living with BPD. This is directly comparable with Katsakou and colleagues' (2012) study with about half of their sample also expressing concerns about the concept of recovery in relation to their experiences.

The ambivalence that both consumers and clinicians expressed about 'recovery' arose for different reasons. As highlighted above, 'recovery' for consumers was associated with a complete cure and this possibility was universally rejected. Consumers expressed notably modest expectations for recovery noting that life without any difficulties associated with BPD was unlikely. The ambivalence associated with 'recovery' may have also been associated with the modesty of their expectations in relation to satisfying or meaningful future life. The word 'recovery' may have been associated with possibilities of a life without difficulties that were considered to be unlikely or unrealistic by consumers 'Recovery' for clinicians was problematic not because it was necessarily associated with cure, but rather because it was used in practice in ways that were often simplistic and even invalidating of the current experience of individuals with BPD. For instance, the use of a 'recovery star'; pro forma or other standardized protocols may be simplistic and also not consistent with the principles of personal recovery because if all

clients of particular service are treated using the same protocol or pro forma worksheets this is clearly not individualized treatment. Although the sources of the ambivalence expressed by consumers and clinicians were different, the experiences of consumers may have informed the clinicians' viewpoint. Consumers in associating 'recovery' with cure may have felt that recovery is a possibility that is unrealistic or unlikely for them. Use of the word 'recovery' may be invalidating of consumers' actual life experience particularly if it is associated with a 'wonderful life' which seems impossible or unlikely. It is exactly this invalidation of lived experience particularly early in treatment or at times of crisis that clinicians highlighted in relation to the use of the word 'recovery'. Moreover, the use of standardized pro formas may be invalidating to the extent that it does not respond to the individual experience of consumers.

Despite the concerns associated with 'recovery' both consumers and clinicians were of the view that positive change or progress with BPD was possible. The concept of personal recovery originated in reaction to the view that mental illness was usually of a chronic nature and often deteriorating in course. At the heart of the concept of personal recovery is the counterview that mental illness is not necessarily chronic in nature and that it is possible to live a meaningful and satisfying life even with some symptoms. The view on the part of both consumers and clinicians that change is possible accords, in this sense, with the principles of personal recovery. This would further suggest that the principles of personal recovery, particularly an emphasis on the possibility of progress, have had some effect on everyday practices both in relation to consumer experience and also in relation to clinicians' attitudes and practices. However, the emphasis on the possibility of positive change does not explain why both consumers and clinicians were wary about the word 'recovery'. As highlighted above the associated of 'recovery' with cure and concerns about 'recovery' being invalidating may best explain this ambivalence. Further, for some consumers, recovery was not only hard work but also 'scary' or 'risky'.

'Recovery' may be a 'scary' word or a risky possibility for individuals diagnosed with BPD at least in part as a result of the nature of personality disorder itself. Personality disorder is

pervasive and also present since adolescence or early adulthood (APA, 2015). This suggests that the experience of having a personality disorder such as BPD is intertwined with the formation of a sense of self in adolescence or early adulthood. Change or recovery in this context involves a shift in a longstanding understanding of the self. The concept of recovery or even change is risky because the sense of self or core aspects of each individual's understanding of him- or herself is being challenged or at least questioned. This process may easily feel overwhelming with the terrifying possibility of a total absence of any sense of self. In other words, the individual may be left with no viable answer to the question of who he or she is. The complete absence of a sense of self is of course a terrifying possibility and may explain why recovery as a word is 'scary' and the possibility of change 'risky'. The clinical implications of the risky nature of change for individuals with BPD will be discussed below under 'Clinical Implications'.

6.5   Personal Recovery in Borderline Personality Disorder: Specific Factors or 'Conditions of Change'

A total of eight factors that support recovery as drawn from both the consumer and clinician data were identified which have been summarized as the 'conditions of change'. Three conditions were identified within the clinician interviews: "Curiosity about Oneself'; 'Fostering Agency' and 'Recovery as a Creative Process'. In addition, two additional aspects of recovery were identified within the clinician data with relevance to the conditions of change: "Change is Relational" and in relation to the therapeutic process "Aligned, Attuned and Alongside'. Five conditions of change were identified within the consumer data: 'Support of Others'; "Work on Trauma without Self-blame'; 'Acceptance of the Need for Change', "Curiosity about Oneself" and 'Reflection on One's Behaviour'. There was some overlap between the clinician and consumer data particularly in relation to the role of relationships within recovery ('Support from Others' and "Change is Relational') and also in relation to the role of curiosity within recovery

processes ('Curiosity about Oneself'). Notably each of the conditions of change identified within this thesis involves changes within self-representation or within relationships with others.

Relationships or the support of others appears to be the most overarching factor within recovery from BPD. As clinicians highlighted recovery is not a solitary process of introspection but rather involves self-reflection within a dialogue with a trusted and supportive person or people. Change was relational for clinicians in this sense of being a matter of dialogue with other(s). The nature of this dialogue was also important from clinicians' perspectives. The specific nature of a helping relationship was revealed within clinicians' understanding of an effective, therapeutic relationship. The skilled clinician (or by extension other helper) needed to be 'aligned, attuned or alongside' the individual in recovery. Clinicians further emphasized that the skilled helper needs to take a non-expert stance. The importance of being alongside the individual in recovery without being the expert may also relate to the value that clinicians placed on agency on the part of the person with BPD. An expert stance would underpin the sense of agency on the part of the client and accordingly disturb recovery and possibly also the therapeutic relationship itself. Consumers also placed a high value on the support of others from both clinicians and others such as carers, or family and friends. The value that consumers placed on the support of others suggests that within a supportive dialogue with another person the individual with BPD begins to recognise himself or herself. Processes of self-inquiry may then occur within the context of a trusting and supportive relationship.

Each of the other four conditions of change identified by consumers all involve a change to the way in which the self is perceived or to self-representation. Changes to self-representation involved the development of specific skills or attitudes on the part of the individual with BPD. For instance, accepting the need for change may involve changes to the self-concept early in the recovery process to allow for help-seeking. In other words, the need for change and for help must be incorporated in the self-concept for recovery to begin. Further, work on past trauma is at the heart of all therapies for BPD. However, consumers emphasized the need for work on trauma to

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also involve a crucial shift in self-perception, that is, the shift from self-blame to a sense of self that accepts the reality of trauma without blaming oneself. A lack of self-acceptance may be one of the sequelae of trauma. Our participants (both consumer and clinicians) identified curiosity about the self as a concrete skill that must be supported if individuals with BPD are able to develop a new sense of self in place of a sense of self that is harshly self-critical, punitive or self-loathing. Consumers further suggested that alongside curiosity about the self, individuals with BPD also need to reflect on their own behaviour particularly as it may have affected other people such as children. Consumers went further than clinicians in suggesting the processes of self-inquiry (curiosity about oneself) need to occur alongside reflection about the impact of one's one behaviour in relation to others.

The clinician interviews not only revealed that changes to self-representation and to relationships are critical factors in relation to recovery but also revealed much about the nature of that process. Clinicians emphasized both the creative nature of recovery and also the need to foster agency as a part of recovery from BPD. Recovery requires creativity on the part of the individual in recovery in the sense that they need to be resourceful in seeking out opportunities for improving their lives or taking action within their social environment. The creativity that clinicians spoke about did not necessarily involve the creative arts but involved resourcefulness in relation to highly individual changes that individuals might make to their lives. Creativity understood in this way as seeking opportunities to act within a particular social environment also related to the emphasis clinicians placed on fostering agency as part of their support of the recovery process. Agency was understood as the ability to 'speak for oneself' and take other action within the specific opportunities (and limitations) of a particular social situation. Clinicians in understanding agency in this sense extended beyond an understanding of agency that involves autonomy or freedom of choice. Clinicians' understanding of agency may incorporate autonomy as a basic right but extends beyond this to the right to action within the social environment. In other words, agency in this sense involves more than being offered a range of choices to the right

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to act on one's own behalf. The implications of the emphasis within this project on the specific factors or 'conditions of change' in relation to the existing literature on recovery from BPD will be discussed before the clinical implications are then considered

6.6 Beyond Aspirational Goals towards Specific Attitudes and Skills for Recovery in BPD: "Conditions of Change' in Relation to the Existing Literature

A particular strength of the current project is that specific processes that support recovery from BPD have been identified and are described in shorthand as 'conditions of change'. The specific nature of these insights lends itself to concrete recommendations to both clinicians and carers. In relation to the specific processes that support recovery (and as previously noted) changes to self-representation and relationships are at the heart of the work needed in recovery. Further, these changes involve specific attitudes and skills. For instance, acceptance of the need for change is one example of a specific attitudinal change and developing curiosity about the self is a specific skill needed within the wider process of self-inquiry. Reflecting on one's behaviour particularly in relation to others is another example of a specific skill needed in recovery from BPD.

Existing models of recovery such as CHIME offer highly important aspirational goals for how recovery from BPD may be best supported. These goals are important because they offer overarching guidance to both clinicians and carers about how to support recovery. The existing recovery literature offers an important ethos for the conduct of services and informs attitudes towards consumers. However, in relation to BPD the strategies (rather than goals) that might be used to support recovery-informed practice have been largely absent from the literature. This thesis extends the existing literature to identify specific strategies for supporting recovery. Each of the 'conditions of change' previously identified provides a concrete basis for a clinical strategy in relation to recovery from BPD.

Each of the conditions of change also implies a strategy in relation to the self or relationships and this also extends the existing literature beyond identifying the self / relationships as central to recovery towards the specific means for supporting change. For instance, the focus on self-representation and relationships with others within Gillard, Turner and Neffgen's (2015) and Agnew and colleagues' (2016) studies suggests that changes to overly negative self-representation may be at the heart of process of recovery from BPD. Data from the current thesis supports these broad insights but also goes further to suggest that the specific changes outlined above are needed within the more general process of self-inquiry. Both these studies and also Katsakou and colleagues' (2012) study suggest that greater self-acceptance is a general goal in relation to the difficult and at times overly negative self-representations of individuals diagnosed with BPD. The current project suggests that self-inquiry or more specifically curiosity about the self may be a more specific skill needed to support the more general aspiration of greater self-acceptance. The quantitative part of this thesis supports the view that changes in relation to self-loathing may lead to greater self-acceptance may be central to recovery from BPD. The strong positive correlation found between measures of self-compassion and personal recovery and the strong negative correlation between self-criticism and personal recovery suggests that self-loathing or harsh self-criticism is indeed an impediment to recovery from BPD.

In relation to relationships, Castillo and colleagues (2013) and Holm and Severinsson (2011) within the very different contexts of a therapeutic community and an acute inpatient unit suggest that changes to relationships are central to recovery form BPD. This project supports those general conclusions but extends that work to include more specific changes such as the ability on the part of the individual with BPD to reflect on his or her behaviour. This process of reflection further suggests that actions to repair relationships may also be needed. Overall, this project supports the conclusions of past studies. However, the need for quite concrete strategies to support change has also been identified and emphasized within this thesis.

Further, the actual ways in which both consumers and clinicians understood recovery are not only in line with the most recent, advanced scholarship around the concept of recovery but can also be seen to extend existing conceptual understandings of recovery. Davidson, Rakfedt and Strauss (2010) within an historical account of the concept, identify three distinct historical movements that have contributed to the concept of recovery. The first of these phases dates to the 1950s and involved calls for individuals with mental illness to live within the community wherever possible. Arguments in favour of community living were also closely associated with deinstitutionalization. The recovery movement from the 1970s to the early 1990s was associated with the civil rights movement and proponents of recovery argued for the empowerment of people with mental illness and for their right to autonomy in the sense of the right to make decisions for themselves. Davidson, Rakfedt and Strauss (2010) argue that the current scholarship around the concept of recovery incorporates these past claims but that contemporary scholars at the vanguard of understanding the concept of recovery also emphasize the need for agency on the part of individuals with mental illness. Clinicians within the current project highlighted the need for exactly this: agency on the part of the individual with BPD. Further, the view that recovery is a creative process is present within the existing literature but is not emphasized within much of the existing scholarship. For instance, Turner, Lovell, and Brooker (2011) suggest that self-discovery is central to recovery and that the creative arts may be an important means by which self-discovery can occur. These insights while present are not prominent within the existing literature. The clinicians in the current project extend Turner, Lovell and Brooker's insights to suggest that creativity in relation to recovery can be understood much more broadly in relation to a sense of agency which allows for action within the social environment. Acting within one's social environment may then be the most concrete way that recovery can be experienced. Indeed, a satisfying and meaningful life is unlikely within the opportunity to act within one's social world.

To summarize, it is the specific nature of these insights from both consumers and clinicians in relation to the 'conditions of change' and also the advanced nature of participants' understanding of recovery that suggests quite concrete and practical recommendations in relation to supporting recovery from BPD. The next section will summarize the recommendations for clinicians and carers that arise from this project overall.

6.7   'Conditions of Change': Implications for Clinicians and Carers

A number of recommendations for practices that support recovery from BPD are made below in relation to each of the papers presented within this thesis. In the first instance, the word 'recovery' may need to be used judiciously. As consumers highlighted 'recovery' when taken at face value is readily associated with cure. The possibility of a complete cure was universally rejected by consumers and use of the word recovery when it is associated with cure may be experienced as a pressure to change that is in fact iatrogenic. 'Recovery' understood as cure may also not been in tune with consumer experiences particularly early in treatment or at times of crisis. Clinicians or carers may then choose to talk about 'positive change' or 'progress' rather than 'recovery' particularly if it is possible that 'recovery' is not currently in line with the experience of the individual with BPD.

A series of conditions of change were also identified and each of these factors has implications of support of individuals with BPD. Harsh self-criticism and an associated lack of self-compassion were identified within this thesis as an impediment to recovery. Greater self-acceptance has also been identified as a goal for consumers in their recovery (Katsakou et al, 2012). How greater self-acceptance can be fostered is unclear. One possibility suggested by both the qualitative consumer and clinician data within this thesis is that the specific skill that is required to promote self-inquiry and associated increases in self-acceptance is curiosity about oneself. Clinicians and carers may be able to promote the more specific skill of curiosity about oneself rather than the more generic goal of increasing self-acceptance. Curiosity about oneself

may also promote a balance between acceptance (What is positive about who I am?) and change (What would l like to do differently?). As Marsha Linehan (1993) has highlighted effecting a balance between acceptance and change is central to effective clinical work with individuals with BPD.

Promoting a balance between acceptance and change may be at the heart of work in supporting the other conditions of change identified within this thesis. For instance, consumers highlighted the need for a non-blaming environment in relation to past trauma. Clinicians and carers may need to anticipate self-blame in relation to trauma and actively explore and change any self-blame. At the same time, consumers identified reflection on their own behaviour as another conditions of change. Again, finding a balance between taking responsibility for one's actions (What was I responsible for?) and accepting that the sequelae of trauma (What were the things that I could not have changed?) may be at the heart of recovery from BPD. Clinicians and carers need to be mindful of the balance between self-reflection and recognition of the effects of trauma within an overall project of self-inquiry.

The difficulties associated with finding a workable balance between acceptance and change was also implied by consumers. For some consumers, recovery was 'risky' with the word 'recovery' being described as 'scary'. Clinicians and carers need to be sensitive to the potential costs associated with change for individuals with BPD. Consumers suggested that the prospect of personality change was 'risky' or even 'scary' because there was the possibility of a loss of any sense of self at all within the dynamic of change. To be left with no sense of self at all is potentially terrifying with the possibility of re-traumatization. The importance of sensitive support in relation to change within the personality itself cannot be overstated. Clinicians and carers need to mindfully strike a balance between change and acceptance and to time interventions to void the possibility of a crisis in relation to a loss of any of self at all.

The need for a balance between acceptance and change is clear but how to promote this balance is less clear. Clinicians highlighted the need for a non-expert stance on the part of the

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skilled helper. In striking a balance between acceptance and change strategies clinicians and carers may need to take a non-expert stance that uses curiosity as a key therapeutic skill. A curious, non-expert stance may also be the most appropriate approach to fostering agency. As clinicians highlighted fostering agency is at the heart of the work of recovery. Again, curiosity is much more likely to foster agency on the part of the individual with BPD than a didactic stance on the part of clinician or carer. However, fostering agency may not be easy. As clinicians recognise the work of recovery involves considerable creativity on the part of the individual with BPD. Being 'alongside' the individual with BPD may help that individual to seek out opportunities within his or her social environment to act in ways that confirm his or her (positive) sense of self. Agency in the sense of creatively finding opportunities for engagement with others and self-expression may be the ultimate aim of recovery-oriented practices. Clinicians and carers have a key role to play in being 'alongside' the individual with BPD within this process of identifying opportunities to act within the individual's social environment.

6.8   'Conditions of Change": Implications for Services

Existing models of recovery such as CHIME offer important global goals for treatment and an ethos for how treatment services are conducted. However, goals for treatment need to be supported by specific strategies that allow those goals to be achieved. This thesis suggests has a number of implications for services. In the first instance, it is important that services support clinicians to work in ways that support personal recovery for their clients. At a minimum, this requires that services are highly tailored to the needs of each individual. In this sense, protocols that involve pro formas that are given to every consumer within the service do not represent highly individualized treatment and should not be used even if the content is notionally related to recovery. Alongside supporting clinicians, services may also have a role in disseminating information about the range of treatments available to consumers with BPD. Greater access to

information about treatment options would also uphold the principle of highly individualized treatment as it would allow consumers to make more informed choices about services.

6.9   Strengths, Limitations and Future Directions

The current project has a number of strengths: a mixed methods approach was taken to exploring personal recovery from BPD with both consumer and clinician perspectives considered. A further strength of this project is that it provides specific recommendations (as outlined above) for both clinicians and carers in relation to how to practically support recovery from BPD. However, there is still much that is not well understood about recovery in BPD and this project also had a number of limitations.

Some extension to the interview component of the research might have allowed for further discoveries regarding the relevance of recovery in BPD. For example, the perspectives of carers may have contributed to better understanding of the process of recovery from BPD. A two-part process would have allowed for reflection on the part of participants regarding changes in their understanding of recovery and this may have strengthened the findings. In fact, a follow up interview that was delayed by 3 months for example might have allowed for changes in the consumers' understanding of recovery, for instance, over the course of treatment. It has also been suggested that there may be a complex interplay between the conditions of change identified within the consumer component of this study, but this has not been tested empirically within research presented within this thesis. Again, a longitudinal design may reveal much about the interplay of these different conditions.

The quantitative component of this study is of preliminary nature with a notably small sample size. As previously highlighted the use of self-compassion and self-criticism to explore the relationship between self-loathing and personal recovery in the absence of a measure of self-loathing is also a limitations of the current study. Nevertheless, the current results from that component of the study suggest a strong, positive relationship between self-compassion and

recovery and a strong negative relationship between self-criticism and recovery. This further suggests that a greater emphasis on self-loathing in relation to recovery from BPD may be fruitfully examined within future research. Despite the suggestive nature of these preliminary results, a larger sample size may clarify the strength of these relationships. At the same time, other studies of self-criticism and self-compassion in relation to BPD have found that acceptance is an important variable (e.g., Felieu-Soler et al., 2015; Lucre & Corten, 2012). Given the emphasis on the relational nature of recovery within the current study, it may be that social support is also an important variable. Future research that examines the relationship between personal recovery and self-compassion, acceptance and social support may explain more of the variance within that relationship.

Our understanding of recovery from BPD would also be strengthened by future exploration longitudinal studies with a mixed methods approach. None of the evidence-based therapies for BPD have been examined in terms of their efficacy for personal recovery but rather solely in relation to remission of symptoms. A longitudinal mixed methods approach to examining whether or not existing treatments have a positive impact on personal recovery is needed. A mixed methods approach using both an interview and questionnaire based protocol with therapeutic dyads (clinicians and consumer) over the course of treatment would be valuable in understanding the interventions in relation to recovery that clinicians use and the impact on recovery for the consumer. A similar approach could be taken to the questions that remain around self-loathing. A longitudinal, mixed methods approach with therapeutic dyads could also be taken to understand what interventions clinicians use in responding to self-loathing with (longitudinal) tracking of how these interventions are received by consumers.

A note on the measured used within this thesis is also needed. Work on self-loathing would be facilitated if there was a specific measure of self-loathing. The current thesis relied on a proxy measure (self-criticism) but future work on self-loathing would be enhanced by the development of a specific measure of self-loathing.

6.10 Conclusions

Much of the existing recovery literature suggests global goals for recovery-oriented practices rather than suggesting specific factors or strategies for supporting recovery. The global goals of recovery-oriented practice described within models such as CHIME are highly important because they describe how mental healthcare systems should be organized. However, one current limitation is the lack of specific recommendations for everyday practices that support recovery. This is particularly the case in relation to personality disorders including BPD. This thesis argues that it is possible to identify specific factors that support recovery. Those factors have been described in terms of the 'conditions of change' associated with recovery from BPD. Each of these conditions involves a change to the individual's self-representation or to relationships. Key amongst those factors that consumers identified as key to recovery are recognition of the need for change, curiosity about oneself and self-reflection about one's behaviour. Self-acceptance has been identified as a key goal for consumers in their recovery, but the more specific skill of curiosity may be needed to start processes of self-inquiry that also increase self-acceptance. Certainly, a relationship between higher levels or self-compassion and greater progress with personal recovery was empirically verified by the quantitative component of this thesis. This supports existing commentary based on clinical observation that a lack of self-compassion is an impediment to recovery from BPD. The highly social nature of recovery was also emphasized by both consumers and clinicians. It may not be possible for individuals to work on improving self-acceptance or greater self-compassion outside of supportive relationship with others. Clinicians suggested that fostering agency and approaching the work of recovery as a creative process were also important to recovery. The strongest indicator of personal recovery in BPD may then be changes in agency that allow for the creative process of finding opportunities for connection with others and avenues for changes within the self through acting within one's social environment.

Clinicians and others who support an individual with BPD need to not only incorporate the global goals that have been articulated within the existing recovery literature into their work. It may be necessary but not sufficient to aspire to increasing connectedness or improving an individual's self of identity as suggested by CHIME. Clearly, changes to the sense of self and relationships are critical to personal recovery from BPD. However, the much more concrete strategies suggested within this thesis need to be taken up by clinicians and others in everyday practices. Only when the specifics of everyday clinical conversations incorporate these conditions of change will recovery become an embedded practice rather than an aspirational goal.

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Appendices A: Invitation Letters to Participants

Appendix A.1 Letter Inviting Clinicians to Participate

4 Bona Street (PO Box 135) Ringwood East Victoria Australia 3135
Telephone (03) 8833 3050 **Facsimile** (03) 9871 3911 **Email**

Dear [insert name]

I am writing seeking your support of a research project that is examining recovery from Borderline Personality Disorder. The project is being conducted by myself, Fiona Donald as part of my Doctor of Psychology training under the supervision of Dr Sabura Allen and Dr Sathya Rao.

The project has three broad components:

- A qualitative study of client perspective on recovery and how from a client perspective clinicians can support recovery; and
- A qualitative study of clinician perspectives on recovery and from a clinician perspective how recovery can be supported; and
- A quantitative study of the relationship between self-compassion and recovery.

We would very much appreciate our support of the project and invite you to participate in an interview for the second component of the project. If you have any questions or would like to discuss participation further you are very welcome to contact me on **0449 809 464** or **fiona.donald@monash.edu**.

Yours Sincerely,

Fiona Donald

Appendix A.2 Letter Inviting Consumers to Participate

MONASH University   **spectrum** Personality Disorder Service for Victoria   **easternhealth** GREAT HEALTH AND WELLBEING

4 Bona Street (PO Box 135) Ringwood East Victoria Australia 3135
Telephone (03) 8833 3050 **Facsimile** (03) 9871 3911

Dear [Insert name]

I am writing to let you know about a research project that is currently being conducted at Spectrum. The project is focused on recovery from Borderline Personality Disorder (BPD) and is being conducted jointly by Spectrum, Eastern Health and Monash University. Very little is known about recovery within the scientific literature, and while recovery and BPD can be discussed from a clinician perspective, it is important that we get your view too. We are seeking past or current clients from Spectrum who might be interested in taking part in the Recovery Project.

A Spectrum researcher, Ms Fiona Donald will contact you next week to see if you are interested in participating in the project. The project involves two interviews focused on different aspects of recovery, each of which takes about 40 to 60 minutes. In the second interview you would also be asked to complete a questionnaire about recovery and levels of kindness and criticism you have towards yourself. You can choose to participate in one or both of the interviews. Before we start the interviews about recovery you may also be asked to take part in a short interview to confirm the diagnosis of Borderline Personality Disorder.

While you will not be paid to participate, you will be offered a $25 Coles Myer gift voucher for each of the recovery interviews in which you participate in appreciation of your contribution.

Please feel free to contact Ms. Fiona Donald before she calls you if you have any questions about the project or would prefer not to be contacted. Fiona can be contacted on **0449 809 464** or **fiona.donald@monash.edu**.

Yours Sincerely,

Dr. Sathya Rao
Consultant Psychiatrist and Clinical Director
Spectrum Personality Disorder Service

MONASH University

spectrum
Personality Disorder Service for Victoria

easternhealth
GREAT HEALTH AND WELLBEING

4 Bona Street (PO Box 135) Ringwood East Victoria Australia 3135
Telephone (03) 8833 3050 **Facsimile** (03) 9871 3911 **Email**

Participant Information Sheet/Consent Form
Health/Social Science Research - *Adult providing own consent*

**Eastern Health
Spectrum**

Project Title Borderline	Client and Clinician Perspectives on Personality Disorder
Short Title Disorder	Recovery from Borderline Personality
Protocol Number	E09 – 1314
Project Sponsor	Monash University
Coordinating Principal Investigator/ Principal Investigators	Dr Katherine Lawrence & Dr Sathya Rao
Associate Investigator	Dr Cameron Duff
Student Investigator	Ms Fiona Donald
Location	Offices of Eastern Health & Spectrum

Part 1   What does my participation involve?

1   Introduction

You are invited to take part in this research project, which is called Recovery from Borderline Personality Disorder. You have been invited because there is very little known about recovery from Borderline Personality Disorder from a client perspective and you can provide valuable information about your perspectives / opinions about this area of research. Your contact details were

obtained by Ms Fiona Donald from your treating clinician or the database at Spectrum.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:
• Understand what you have read
• Consent to take part in the research project
• Consent to be involved in the research described
• Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2   What is the purpose of this research?

The aim of this research is to understand more about recovery from Borderline Personality Disorder and to use this information to help clinicians work better with clients with Borderline Personality Disorder. There is currently very little known about this topic within the scientific literature and by focusing on client perspectives we can help to address the lack of knowledge in this area. It is intended that the results will be published in a scientific journal and that by reading the results clinicians, researchers, and students can learn more about Borderline Personality Disorder and that this may also impact in the future on how clinicians work with clients.

The results of this research will be used by the student researcher Ms Fiona Donald to obtain a Doctor of (Clinical) Psychology degree. Ms Donald is currently a doctoral candidate at Monash University.

This research has been initiated by the researchers, Dr Sabura Allen, Dr Sathya Rao, Dr Cameron Duff and Ms Fiona Donald.

This research is funded by Monash University.

3   What does participation in this research involve?

This research has two parts:
> A questionnaire that will be completed once
> Two interviews that will take about 40 to 60 minutes each.

You may choose to take part in the questionnaire part only, or one or both of the interviews, or all three parts of the project.

As discussed when you were invited to participate in this project, Ms Fiona Donald has contacted the Spectrum Research Officer to find out whether you have received a diagnosis of BPD. This was to make sure that you were eligible to participate in this research. After you have read and signed this consent form, the Research Officer at Spectrum who is an employee of Eastern Health will be contacted by Ms Fiona Donald who will ask s/he to review your file for any other current diagnoses. This is to identify any other diagnoses aside from Borderline Personality Disorder. Ms Fiona Donald will be given this information by the Research Officer, but will not see your medical records

(1.) Questionnaires

The questionnaire component of the research will involve you answering questions about recovery and about how you currently think about yourself

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You will be asked to sign this consent form before you complete the questionnaire. Your name will not appear on the completed questionnaire.

(2.) Interviews-General Information

The interviews will involve you answering questions about your recovery from Borderline Personality Disorder. You will also be asked to sign the consent section of this form before the interview commences. Two different interviews will be conducted and you can decide to take part in either interview.

If you decide to take part in the research project, you may first be asked to participate in a screening interview asking about Borderline Personality Disorder. This will determine if you are eligible to take part.

Completing this interview will take approximately one hour. If the screening Interview shows that you meet the requirements, then you will be able to start the research project. If the screening questionnaire shows that you do not meet requirements of the research project, the research coordinator will discuss other options with you.
If you choose to take part in one or both interviews they can occur on the same day or on different days as you choose. Interviews will generally be scheduled at times when you are already visiting your clinician or at another time that suits you. All
interviews will be conducted in the offices of Spectrum or Eastern Health.

Each interview will last approximately 40 minutes to one hour. You can choose to stop the interview at any time including after it has started.

The interviews will be digitally recorded in audio format only, so only your voice will be recorded. Only first names will be used during the interview and you can choose to use a name other than your real name.

The interviews will be transcribed by student researcher Ms Fiona Donald. Your name will not appear on the transcript of the interview. A code without any identifiable information (such as Participant 001) will be used instead.

Once the interview(s) has been transcribed the digital copy will be erased. All transcribed data will be stored on the Monash University network drive and will only be accessible to the researchers named above. The files will also be password protected.

Each interview will only occur once and there will be no follow-up. Your involvement will be limited to one or two interviews but the project will run for twelve months.

Interviews can only be conducted in English. No interpreting service will be provided. Non-English speaking individuals are not able to participate in this project.

This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way and avoids study doctors or participants jumping to conclusions.

There are no costs associated with participating in this research project, nor will you be paid.

However, you will be reimbursed for your time in undertaking each interview with a $25 Coles Myer gift voucher.

4 Other relevant information about the research project

Three organizations will be involved in the research Monash University, Spectrum, and Eastern Health.

Each person who takes part in the questionnaire part of the project will complete the same questionnaire. Approximately 100 people will participate in the questionnaire part of the project. Each of the two interviews will focus on different aspects of recovery from Borderline Personality Disorder. Different participants in the interviews will be asked to talk about similar topics, but the exact questions asked may vary from interview to interview. Approximately 40 people will participate in the interview part of the project.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. For instance, if you do not wish to continue with an interview you can choose to stop the interview at any time, including after it has started.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.
Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine care, your relationship with professional staff or your relationship with Spectrum, or Eastern Health

6 What are the possible benefits of taking part?

We cannot guarantee or promise that you will receive any benefits from this Research. However, possible benefits may include a better understanding of recovery for clinicians working with people with Borderline Personality Disorder.

7 What are the possible risks and disadvantages of taking

part? Psychological distress

You may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately.

If you become upset or distressed as a result of your participation in the research project, the research team will be able to arrange for counselling or other appropriate support. Any counselling or support will be provided by qualified staff who are not members of the research team. This counselling will be provided free of charge.

8   What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, just let the research team member know either by returning the questionnaire or stopping the interview. If you choose to withdraw after
an interview has already commenced the part interview will not be used in developing the results of this project.

Please notify a member of the research team before you withdraw.

9   Could this research project be stopped unexpectedly?

This research project may be stopped unexpectedly for a variety of reasons, but it is an unlikely event. If this were to happen, you would be informed at that time.

10   What happens when the research project ends?
Participants can find out about the results of this project. A summary of the results will be sent to you if you choose. In this case a mailing address will be collected. This information will only be used for the purposes of providing the project summary to you. This summary will be available in July 2015.

Part 2   How is the research project being conducted?

11   What will happen to information about me?

By signing the consent form you consent to the research team collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential.

A record of your name and your contact details and your clinician's name and the clinician's contact details will be collected. This information will be collected in the event that you become distressed as a result of the interview. If you become distressed student researcher Ms Fiona Donald will contact your clinician to arrange follow-up counselling. This information will be kept on the secure Monash University network drive and will only be accessible to the researchers and will be password protected.

Research information such as questionnaires and transcripts of the interviews will be stored in a secure storage area at Monash University for seven years and will then be shredded. Computer files will be stored for seven years and will be deleted from the Monash network drive after seven years

At the end of your participation in this project your details will be deleted. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

The personal information that the research team collects and uses is any other diagnoses apart from Borderline Personality Disorder. Confirmation of the diagnosis of Borderline Personality Disorder will be made and information about

other mental health diagnoses will be collected. No other personal or health information will be collected from Spectrum, or Eastern Health about you.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. A numerical or letter- based code (Participant 1 or A) or pseudonym (name other than your real name) will be used in any publication of the results.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected.

You may always access your information although it is confidential. Please contact any member of the research team named at the end of this document if you would like to access your information in the future. For an interview study, your identifying information will be kept separate from the interview materials which will be identified with a code like "Participant 1". The code can be broken upon your request. No information about you will be collected on the questionnaire. At the end of the project, files with information about you will be deleted. After this time it will not be possible to access your information.

12   Complaints and compensation

If you suffer any distress or psychological injury as a result of this research project, you should contact the research team as soon as possible. You will be assisted with arranging appropriate treatment and support.

13   Who is organising and funding the research?

This research project is being conducted by Dr Sabura Allen, Dr Sathya Rao, Dr Cameron Duff and Ms Fiona Donald. Monash University is funding this research. All the organisations involved in this research will benefit only from being identified with any publication that this research produces. You will not benefit financially from your involvement in this research project directly nor will there be any direct financial benefits to the other organisations.

No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

14   Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of Eastern Health and Monash University

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to

protect the interests of people who agree to participate in human research studies.

15   Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researcher on 9905 4725 or any of the following people:

Research contact person

Name	Dr Katherine Lawrence
Position	Lecturer
Telephone	03 9905 3982
Email	katherine. lawrence @monash.edu

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	The Chairperson
Position	Deputy Chairperson Human Ethics Research Committee Eastern Health
Telephone	9895 3398
Email	*ethics @easternhealth.org.au*

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

s p e c t r u m
Personality Disorder Service for Victoria

eastern**health**
GREAT HEALTH AND WELLBEING

4 Bona Street (PO Box 135) Ringwood East Victoria Australia
3135
Telephone (03) 8833 3050 **Facsimile** (03) 9871 3911
Email

Consent Form - *Adult providing own consent*

Title	Client and Clinician Perspectives on Recovery from BPD
Short Title	Recovery from BPD
Protocol Number	E09 – 1314
Project Sponsor	Monash Univeristy
Coordinating Principal Investigator/ Investigator(s)	Dr Katherine Lawrence **Associate** Dr Sathya Rao, Dr Cameron Duff, Ms Fiona Donald
Location	Offices of Spectrum & Eastern Health

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my

future care. I understand that I will be given a signed copy of this document

to keep.

Name of Participant (please print)_____

Signature _____ Date _____

Declaration by Researcher[†]

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher[†] (please print)_____
Signature _____   Date _____

[†] An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

<u>Request for Project Summary</u>

Would you like a copy of the project summary to be sent to you at the end
of the project?
Please tick appropriate box.

Yes ☐   No ☐

<u>Address for Project Summary</u>

Please write the postal or email address that you would like the project
summary to be sent to.

…………………………………………………………………………………………………
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Form for Withdrawal of Participation - *Adult providing own consent*

Title	Client and Clinician Perspectives on Recovery from Borderline Personality Disorder
Short Title	Recovery from Borderline Personality Disorder
Protocol Number	E09 - 1314
Project Sponsor	Monash University
Coordinating Principal Investigator/	Dr Katherine Lawrence & Dr Sathya Rao
Associate Investigator	Dr Cameron Duff
Student Investigator	Ms Fiona Donald
Location	Offices of Spectrum & Eastern Health

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my routine care, or my relationships with the researchers or Spectrum or Eastern Health.

Name of Participant (please print)_____

Signature _____ Date _____

In the event that the participant's decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher[‡]

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of Researcher (please print) _____

Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.

Appendix B.2 Spectrum Clinician PICF

4 Bona Street (PO Box 135) Ringwood East Victoria Australia 3135
Telephone (03) 8833 3050 **Facsimile** (03) 9871 3911 **Email**

Participant Information Sheet/Consent Form
Health/Social Science Research - *Clinician providing own consent*

**Eastern Health
Spectrum**

Title Borderline	Client and Clinician Perspectives on Personality Disorder
Short Title Disorder	Recovery from Borderline Personality
Protocol Number	
Project Sponsor	Monash University
Coordinating Principal Investigator/ Principal Investigators	Dr Katherine Lawrence & Dr Sathya Rao
Associate Investigator	Dr Cameron Duff
Student Investigator	Ms Fiona Donald
Location	Offices of Eastern Health & Spectrum

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this research project, which is called Recovery from Borderline Personality Disorder. You have been invited because there is very little known about recovery from Borderline Personality Disorder from a clinician perspective and you can provide valuable information about your perspectives / opinions about this area of research. Your contact details were obtained by Ms Fiona Donald from Spectrum or Eastern Health.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, or friend.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:
• Understand what you have read
• Consent to take part in the research project
• Consent to be involved in the research described
• Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

## 2	What is the purpose of this research?

The aim of this research is to understand more about recovery from Borderline Personality Disorder from both client and clinician perspectives. We intend to use this information to help clinicians work better with clients with Borderline Personality Disorder. There is currently very little known about this topic within the scientific literature and by focusing on both client and clinician perspectives we can help to address the lack of knowledge in this area. It is intended that the results will be published in a scientific journal and that by reading the results clinicians, researchers, and students can learn more about Borderline Personality Disorder and that this may also impact in the future on how clinicians work with clients.

The results of this research will be used by the researcher Ms Fiona Donald to obtain a Doctor of Psychology degree.

This research has been initiated by the researchers, Dr Katherine Lawrence, Dr Sathya Rao, Dr Cameron Duff and Ms Fiona Donald.

This research is funded by Monash University.

## 3	What does participation in this research involve?

This research has three parts:

(Study 1.) A client component that involves an interview focused on recovery from Borderline Personality Disorder.

(Study 2.) A clinician component that involves one interview about how recovery from
Borderline Personality Disorder can be facilitated.

(Study 3.) A client component that involves a questionnaire about recovery from Borderline Personality Disorder and Self-Compassion to be completed once.

Self-compassion is a concept developed by Kristen Neff and involves cultivating a kind attitude towards oneself in the face of personal failure or suffering, a recognition of the universal, human nature of suffering and a mindful attitude.

You are being invited to participate in the second part of the overall project.

The interview will involve you answering questions about how recovery from Borderline Personality Disorder can be facilitated. You will also be asked to sign the consent section of this form before the interview commences.

The interview can be scheduled at a time that suits you. All interviews will be conducted in the offices of Spectrum or Eastern Health.

Each interview will last approximately 40 minutes to one hour. You can choose to stop the interview at any time including after it has started.

The interview will be digitally recorded. Only first names will be used during the interview. The interview will be transcribed by student researcher Ms Fiona Donald. Your name will not appear on the transcript of the interview. A code without any identifiable information (such as Clinician / Participant 001) will be used instead.

Once the interview has been transcribed the digital copy will be erased. All data will be stored on the Monash University network drive and will only be accessible to the researchers named above. The files will also be password protected.

Each interview will only occur once and there will be no follow-up. Your involvement will be limited to one interview but the project will run for twelve months.

This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way and avoids study doctors or participants jumping to conclusions.

There are no costs associated with participating in this research project, nor will you be paid. However, you will be reimbursed for your time in undertaking each interview with a $25 Coles Myer gift voucher.

4 Other relevant information about the research project

Three organizations will be involved in the research Monash University, Spectrum, and Eastern Health. It is also part of a larger study (described above) that looks at recovery from a client perspective.

Different participants in the interviews will be asked to talk about similar topics, but the exact questions asked may vary from interview to interview. Approximately 20 clinicians will participate in this project.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. For instance, if you do not wish to continue with an interview you can choose to stop the interview at any time, including after it has started.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with Spectrum, or Eastern Health

6   What are the possible benefits of taking part?

We cannot guarantee or promise that you will receive any benefits from this research; however, possible benefits may include a better understanding of recovery for clinicians working with people with Borderline Personality Disorder.

7   What are the possible risks and disadvantages of taking

part? Psychological distress

You may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately.

If you become upset or distressed as a result of your participation in the research project, the research team will be able to arrange for counselling or other appropriate support. Any counselling or support will be provided by qualified staff who are not members of the research team. This counselling will be provided free of charge.

8   What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify a member of the research team before you withdraw. A member of the research team will inform you if there are any special requirements linked to withdrawing. If you do withdraw, you will be asked to complete and sign a 'Withdrawal of Consent' form; this will be provided to you by the research team.

If you choose to withdraw after an interview has already commenced the part interview will not be used in developing the results of this project.

9   Could this research project be stopped unexpectedly?

This research project may be stopped unexpectedly for a variety of reasons, but it is an unlikely event. If this were to happen, you would be informed at that time.

10   What happens when the research project ends?

Participants can find out about the results of this project. A summary of the results will be sent to you if you choose. In this case a mailing address will be collected. This information will only be used for the purposes of providing the project summary to you. This summary will be available in December 2014.

Part 2   How is the research project being conducted?

11   What will happen to information about me?

By signing the consent form you consent to the research team collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential.

A record of your name and your work contact details will be collected. This information will be kept on the secure Monash University network drive and will only be accessible to the researchers and will be password protected.

Research information such as questionnaires and transcripts of the interviews will be stored in a secure storage area at Monash University for seven years and will then be shredded. Computer files will be stored for seven years and will be deleted from the Monash network drive after seven years

At the end of your participation in this project your details will be deleted. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your express permission. A numerical or letter-based code will be used such as Clinician Participant 001, or Clinician Participant A will be used in any publication. Or alternatively a first name pseudonym (name other than your real name) will be used in any publication of the results.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected.

Your information will be confidential. The interview transcript will be identified with a code such as 'Participant 01'. An alphabetic list of clinicians who have participated in the project will be maintained for the length of the project. No link will be maintained between your identifying information and the interview transcript. You can request a copy of your information from the researchers, but after the interview has been transcribed it will not be possible to identify your specific information. At the end of the project, the list of participating clinicians will be deleted.

12   Complaints and compensation

If you suffer any distress or psychological injury as a result of this research project, you should contact the research team as soon as possible. You will be assisted with arranging appropriate treatment and support.

13   Who is organising and funding the research?

This research project is being conducted by Dr Katherine Lawrence, Dr Sathya Rao, Dr Cameron Duff and Ms Fiona Donald. Monash University is funding this

research. All the organisations involved in this research will benefit only from being identified
with any publication that this research produces. You will not benefit financially from your involvement in this research project directly nor will there be any direct financial benefits to the other organisations.

No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

14   Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).
The ethical aspects of this research project have been approved by the HREC of Eastern Health and Monash University

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

15   Further information and who to contact

The person you may need to contact will depend on the nature of your query.
If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researcher on 9905 4725 or any of the following people:

Research contact person

Name	Dr Katherine Lawrence
Position	Lecturer
Telephone	03 9905 3982
Email	katherine.lawrence@monash.edu

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	The Chairperson
Position	Deputy Chairperson Human Ethics Research Committee Eastern Health
Telephone	9895 3398
Email	ethics@esternhealth.org.au

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Consent Form - *Clinician providing own consent*

Title	Client and Clinician Perspectives on Recovery from BPD
Short Title	Recovery from BPD
Protocol Number	To be advised
Project Sponsor	Monash Univeristy
Coordinating Principal Investigator/	Dr Katherine Lawrence & Dr Sathya Rao
Associate Investigator(s)	Dr Cameron Duff, Ms Fiona Donald
Location	Offices of Spectrum & Eastern Health

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my

future care. I understand that I will be given a signed copy of this document

to keep.

Name of Participant (please print)_____

Signature _____ Date _____

Declaration by Researcher[†]

I have given a verbal explanation of the research project, its procedures
and risks and I believe that the participant has understood that explanation.

Name of Researcher[†] (please print) _____

Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide the explanation of, and
information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

Request for Project Summary

Would you like a copy of the project summary to be sent to you at the end of the project?
Please tick appropriate box.

Yes ☐   No ☐

Address for Project Summary

Please write the postal or email address that you would like the project summary to be sent to.

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spectrum
Personality Disorder Service for Victoria

easternhealth
GREAT HEALTH AND WELLBEING

Form for Withdrawal of Participation - *Clinician providing own consent*

Title	Client and Clinician Perspectives on Recovery from Borderline Personality Disorder
Short Title	As Above
Protocol Number	
Project Sponsor	Monash University
Coordinating Principal Investigator/	Dr Katherine Lawrence & Dr Sathya Rao
Associate Investigator	Dr Cameron Duff
Student Investigator	Ms Fiona Donald
Location	Offices of Spectrum & Eastern Health

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my routine care, or my relationships with the researchers or Spectrum or Eastern Health.

Name of Participant (please print)_____

Signature _____ Date _____

In the event that the participant's decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.


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│                                                                 │
│                                                                 │
└─────────────────────────────────────────────────────────────────┘
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Name of Researcher (please print) _____

Signature _____ Date _____

† An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.

MONASH University   Healthscope

The Melbourne Clinic

Participant Information Sheet/Consent Form
Health/Social Science Research - *Adult providing own consent*

The Melbourne Clinic

Project Title	Client and Clinician Perspectives on Borderline Personality Disorder
Project Sponsor	Monash University
Coordinating Principal Investigator/ Principal Investigators	Dr. J. Sabura Allen / Dr. Sathya Rao
Associate Investigator	Dr Cameron Duff
Student Investigator	Ms Fiona Donald
Location	Offices of The Melbourne Clinic

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this research project, which is called Recovery from Borderline Personality Disorder. You have been invited because there is very little known about recovery from Borderline Personality Disorder from a client perspective and you can provide valuable information about your perspectives / opinions about this area of research.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:
• Understand what you have read
• Consent to take part in the research project
• Consent to be involved in the research described
• Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2   What is the purpose of this research?

The aim of this research is to understand more about recovery from Borderline Personality Disorder and to use this information to help clinicians work better with clients with Borderline Personality Disorder. There is currently very little known about this topic within the scientific literature and by focusing on client perspectives we can help to address the lack of knowledge in this area. It is intended that the results will be published in a scientific journal and that by reading the results clinicians, researchers, and students can learn more about Borderline Personality Disorder and that this may also impact in the future on how clinicians work with clients.

The results of this research will be used by the student researcher Ms. Fiona Donald to obtain a Doctor of (Clinical) Psychology degree. Ms. Donald is currently a doctoral candidate at Monash University.

This research has been initiated by the researchers, Dr Sabura Allen, Dr Cameron Duff and Ms. Fiona Donald.

This research is funded by Monash University.

3   What does participation in this research involve?

This research has two parts:
    A questionnaire that will be completed on one occasion. The questionnaire will take about 20 to 30 minutes to complete
    Two interviews that will take about 40 to 60 minutes each.

You may choose to take part in the questionnaire part only, or one or both of the interviews, or all three parts of the project.

As discussed when you were invited to participate in this project, Ms Fiona Donald has contacted the The Melbourne Clinic to find out whether you have received a diagnosis of BPD. This was to make sure that you were eligible to participate in this research. After you have read and signed this consent form, The Melbourne Clinic psychologist will be contacted by Ms Fiona Donald who will ask s/he to review your file for any other current diagnoses. This is to identify any other diagnoses aside from Borderline Personality Disorder. Ms Fiona Donald will be given this information by the Research Officer, but will not see your medical records.

(3.) Questionnaires

The questionnaire component of the research will involve you answering questions about recovery and about how you currently think about yourself

You will be asked to sign this consent form before you complete the questionnaires. Your name will not appear on the completed questionnaires.

(4.) Interviews-General Information

The interviews will involve you answering questions about your recovery from Borderline Personality Disorder. You will also be asked to sign the consent section of this form before the interview commences. Two different interviews will be conducted and you can decide to take part in either interview.

If you decide to take part in the research project, you may first be asked to participate in a screening interview asking about Borderline Personality Disorder. This will determine if you are eligible to take part.

Completing this interview will take approximately one hour. If the screening Interview shows that you meet the requirements, then you will be able to start the research project. If the screening questionnaire shows that you do not meet requirements of the research project, the research coordinator will discuss other options with you.

If you choose to take part in one or both interviews they can occur on the same day or on different days as you choose. Interviews will generally be scheduled at times when you are already visiting your clinician or at another time that suits you. All interviews will be conducted in the offices of The Melbourne Clinic.

 Each interview will last approximately 40 minutes to one hour. You can choose to stop the interview at any time including after it has started.

The interviews will be digitally recorded in audio format only, so only your voice will be recorded. Only first names will be used during the interview and you can choose to use a name other than your real name.

The interviews will be transcribed by student researcher Ms Fiona Donald. Yourname will not appear on the transcript of the interview. A code without any identifiable information (such as Participant 001) will be used instead.

Once the interview(s) has been transcribed the digital copy will be erased. All transcribed data will be stored on the Monash University network drive and will only be accessible to the researchers named above. The files will also be password protected.

Each interview will only occur once and there will be no follow-up. Your involvement will be limited to one or two interviews but the project will run for twelve months.

Interviews can only be conducted in English. No interpreting service will be provided. Non-English speaking individuals are not able to participate in this project.

There are no costs associated with participating in this research project, nor will you be paid.

However, you will be reimbursed for your time in undertaking each interview with a $25 Coles Myer gift voucher.

4   Other relevant information about the research project

Two organizations will be involved in the research Monash University and The Melbourne Clinic.

Each person who takes part in the questionnaire part of the project will complete the same questionnaire. Each of the two interviews will focus on different aspects of recovery from Borderline Personality Disorder. Different participants in the interviews will be asked to talk about similar topics, but the exact questions asked may vary from interview to interview.

5   Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. For instance, if you do not wish to continue with an interview you can choose to stop the interview at any time, including after it has started.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.
Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine care, your relationship with professional staff or your relationship with The Melbourne Clinic.

6   What are the possible benefits of taking part?

We cannot guarantee or promise that you will receive any benefits from this Research. However, possible benefits may include a better understanding of recovery for clinicians working with people with Borderline Personality Disorder.

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

Psychological distress

You may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately.

If you become upset or distressed as a result of your participation in the research project, the research team will be able to arrange for counselling or other appropriate support. Any counselling or support will be provided by qualified staff who are not members of the research team. This counselling will be provided free of charge.

8   What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, just let the research team member know either by returning the questionnaire or stopping the interview. If you choose to withdraw after an interview has already commenced the part interview will not be used in developing the results of this project.

Please notify a member of the research team before you withdraw.

9   Could this research project be stopped unexpectedly?

This research project may be stopped unexpectedly for a variety of reasons, but it is an unlikely event. If this were to happen, you would be informed at that time.

10   What happens when the research project ends?

Participants can find out about the results of this project. A summary of the results will be sent to you if you choose. In this case a mailing address will be collected. This information will only be used for the purposes of providing the project summary to you. This summary will be available in December 2015.

Part 2   How is the research project being conducted?

11   What will happen to information about me?

By signing the consent form you consent to the research team collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential.

A record of your name and your contact details and your clinician's name and the clinician's contact details will be collected. This information will be collected in the event that you become distressed as a result of the interview. If you become distressed student researcher Ms. Fiona Donald will contact your clinician to arrange follow-up counselling. This information will be kept on the secure Monash University network drive and will only be accessible to the researchers and will be password protected.

Research information such as questionnaires and transcripts of the interviews will be stored in a secure storage area at Monash University for seven years and will then be shredded. Computer files will be stored for seven years and will be deleted from the Monash network drive after seven years

At the end of your participation in this project your details will be deleted. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

The personal information that the research team collects and uses is any other diagnoses apart from Borderline Personality Disorder. Confirmation of the diagnosis of Borderline Personality Disorder will be made and information about other mental health diagnoses will be collected. No other personal or health information will be collected from The Melbourne Clinic about you.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. A numerical or letter- based code (Participant 1 or A) or pseudonym (name other than your real name) will be used in any publication of the results.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected.

You may always access your information although it is confidential. Please contact any member of the research team named at the end of this document if you would like to access your information in the future. For an interview study, your identifying information will be kept separate from the interview materials which will be identified with a code like "Participant 1". The code can be broken upon your request. For the questionnaire study, your information will be identified based on a code created in a format suggested by the researchers. A separate file will be kept with your identifying information so that the researchers can contact you on the second and third occasions when they will ask you to complete the questionnaire again. The code on the questionnaire materials can be broken upon your request. However, at the end of the project your details will be deleted. After this time it will not be possible to access your information.

12   Complaints and compensation

If you suffer any distress or psychological injury as a result of this research project, you should contact the research team as soon as possible. You will be assisted with arranging appropriate treatment and support.

13   Who is organising and funding the research?

This research project is being conducted by Dr Sabura Allen, Dr Cameron Duff and Ms Fiona Donald. Monash University is funding this research. All the organisations involved in this research will benefit only from being identified with any publication that this research produces. You will not benefit financially from your involvement in this research project directly nor will there be any direct financial benefits to the other organisations.

No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

14   Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).

The ethical aspects of this research project have been approved by the HREC of The Melbourne Clinic and Monash University

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

15   Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researcher on 9905 4725 or any of the following people:

Research contact person

Name	Dr. J. Sabura Allen
Position	Senior Lecturer
Telephone	03 9905 4725

| Email | sabura.allen@monash.edu |

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	Dr Harry Derham
Position	Chairperson Human Ethics Research Committee The Melbourne Clinic
Telephone	9420 9350

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

CONSENT FORM FOR INVOLVEMENT OF PARTICIPANTS IN RESEARCH
at ………………. (The Melbourne Clinic) …………………
(Approved by The Melbourne Clinic Research Ethics Committee)

I, ...
(Name of participant)
agree to participate in a research project entitled ....
.... being
conducted by ....
(Name of researcher)
My agreement is based on the understanding that:
1. My involvement entails:
....
....
2. The following risks, discomforts and inconveniences have been explained to me:
....
....
3. I have read the attached "Information Sheet" and understand the general purposes, methods and demands of the project.
4. I understand that the project may not be of direct benefit to me.
5. I can withdraw from the project at any time without my further therapy being affected in any way.
6. I am satisfied with the explanation given in relation to the project in so far as it affects me.
7. My consent to participate in this project is given freely.
8. I have been informed that the information I provide will be confidential.

SIGNED ....

DATE...
(Participant)

SIGNED ....

 DATE ....
(Researcher)

INDEPENDENT WITNESS: This document has been signed before me.

SIGNED .... DATE ....
Name of Witness (block letters) ....
Address of Witness (block letters) ....

Request for Project Summary

Would you like a copy of the project summary to be sent to you at the end of the project?
Please tick appropriate box.

Yes ☐ No ☐

<u>Address for Project Summary</u>

Please write the postal or email address that you would like the project summary to be sent to.

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Appendices C: Questionnaires

Appendix C.1 Recovery Assessment Scale (RAS)

RECOVERY FROM BPD QUESTIONNAIRE

Please read the list of statements that describe how people sometimes feel about themselves and their lives. To the left of each item, indicate whether you strongly disagree (1), disagree (2), are not sure (3), agree (4), or strongly agree (5) with these statements.

HOW I FEEL ABOUT MYSELF AND MY LIFE

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

_____1. I have a desire to succeed.

_____2. I have my own plan for how to stay or become well.

_____3. I have goals in life that I want to reach.

_____4. I believe I can reach my current personal goals..

_____5. I have a purpose in life.

_____6. Even when I don't care about myself, other people do.

_____7. I understand how to control the symptoms of my mental illness.

_____8. I can handle it if I get sick again.

_____9. I can identify what triggers the symptoms of my mental illness.

_____10. I can help myself become better.

_____11. Fear doesn't stop me from living the way I want to.

_____12. I know that there are mental health services that do help me.

_____13. There are things I can do that help me deal with unwanted symptoms.

_____14. I can handle what happens in my life.

_____15. I like myself.

_____16. If people really knew me they would like me.

_____17. I am a better person than before my experience with mental illness.

_____18. Although my symptoms may be worse, I know I can handle it.

_____19. If I keep trying, I will continue to get better.

_____20. I have an idea of who I want to become.

_____21. Things happen for a reason.

_____22. Something good will eventually happen.

_____23. I am the person most responsible for my own improvement.

_____24. I'm hopeful about my future.

_____25. I continue to have new interests.

_____26. It is important to have fun.

_____27. Coping with my mental illness is no longer the main focus of my life.

_____28. My symptoms interfere less and less with my life.

_____29. My symptoms seem to be a problem for shorter periods of time each time they occur.

_____30. I know when to ask for help.

_____31. I am willing to ask for help.

_____32. I ask for help when I need it.

_____33. Being able to work is important to me.

_____34. I know what helps me get better.

_____35. I can learn from my mistakes.

_____36. I can handle stress.

_____37. I have people I can count on.

_____ 38. I can identify the early warning signs of becoming sick.

_____ 39. When I don't believe in myself, other people do.

_____ 40. It is important to have a variety of friends.

_____41. It is important to have healthy habits.

Appendix C.2 Neff Self-Compassion Scale (NSCS)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

_____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.

_____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.

_____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.

_____ 5. I try to be loving towards myself when I'm feeling emotional pain.

_____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.

_____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.

_____ 8. When times are really difficult, I tend to be tough on myself.

_____ 9. When something upsets me I try to keep my emotions in balance.

_____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.

_____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____ 14. When something painful happens I try to take a balanced view of the situation.

_____ 15. I try to see my failings as part of the human condition.

_____ 16. When I see aspects of myself that I don't like, I get down on myself.

_____ 17. When I fail at something important to me I try to keep things in perspective.

_____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.

_____ 19. I'm kind to myself when I'm experiencing suffering.

_____ 20. When something upsets me I get carried away with my feelings.

_____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.

_____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.

_____ 23. I'm tolerant of my own flaws and inadequacies.

_____ 24. When something painful happens I tend to blow the incident out of proportion.

_____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.

_____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

Appendix C.3. Forms of Self-criticism / Self-attacking and Self-reassurance Scale (FSCRS)

HOW I TYPICALLY THINK ABOUT MYSELF WHEN THINGS GO WRONG

When things go wrong in our lives or don't work out as we hoped, and we feel we could have done better, we sometimes have *negative and self-critical thoughts and feelings*. These may take the form of feeling worthless, useless or inferior etc. However, people can also try to be supportive of themselves. Below are a series of thoughts and feelings that people sometimes have. Read each statement carefully and write a number in the space next to the question that best describes how much each statement is true for you.

Note: This scale is based on a scale of 0 to 4, please use numbers between 0 and 4.

Not at all like me	A bit like me like me	Moderately like me	Quite a bit like me	Extremely
0	1	2	3	4

_____ 1. I am easily disappointed with myself.

_____ 2 There is a part of me that puts me down

_____3 I am able to remind myself of positive things about myself.

_____4 I find it difficult to control my anger and frustration at myself.

_____5 I find it easy to forgive myself.

_____6 There is a part of me that feels I am not good enough.

_____7 I feel beaten down by my own self-critical thoughts.

_____8 I still like being me.

_____9 I have become so angry with myself that I want to hurt or injure myself.

_____10 I have a sense of disgust with myself.

_____11 I can still feel lovable and acceptable.

_____12 I stop caring about myself.

_____13 I find it easy to like myself.

_____14 I remember and dwell on my failings.

_____15 I call myself names.

_____16 I am gentle and supportive with myself.

_____17 I can't accept failures and setbacks without feeling inadequate.

_____18 I think I deserve my self-criticism.

_____19 I am able to care and look after myself.

_____20 There is part of me that wants to get rid of the bits I don't like.

_____21 I encourage myself for the future.

_____22 I do not like being me.