

Doctoral Thesis

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**A Compassionate and Relational Understanding of Adults with a Diagnosis
of Borderline Personality Disorder**

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Thesis Abstract

Adults with a diagnosis of Borderline Personality Disorder (BPD) often experience stigma due to the reductionist narrative that accompanies its conceptualisation. The aim of this research was to challenge the reductionist narrative by exploring a relational understanding of BPD and integrating the construct of compassion.

In Chapter 1, qualitative research that explored the relationships between adults with a diagnosis of BPD and mental health professionals was synthesised. Twenty-four themes that described relational dynamics emerged. These dynamics were reconceptualised by applying psychological theory to develop 12 3rd order interpretation themes. During this process, compassionate terminology based upon psychological theory was integrated into the understanding. In addition, four cycles of relational dynamics were identified between adults with a diagnosis of BPD and mental health professionals based upon these 3rd order interpretations.

In Chapter 2, a qualitative research study was conducted which explored experiences of compassion in adults with a diagnosis of Borderline Personality Disorder (BPD) to further the development of the construct of compassion in relation to BPD. Interpretative Phenomenological Analysis was used to develop themes from the narratives of six adults with a diagnosis of BPD. Five themes emerged: Emotional Connection to Suffering, Empathic Understanding, Prioritisation of Needs, A Model of Genuine Compassion and Developing Self-acceptance and a Sense of Worthiness. The themes were integrated into a recovery model that highlighted the process of recovery through therapeutic relationships that model genuine compassion. In addition, barriers to compassion and factors which facilitate compassion emerged from the analysis which have implications for clinical practice.

In Chapter 3, a critical appraisal was conducted which outlined the rationale for the research and compared findings from the previous two chapters to consider how a compassionate and relational understanding can be integrated into the BPD narrative to challenge stigma and inform positive therapeutic relationships.

Declaration

This thesis records research activity completed between May 2016 and May 2017 for the Doctorate in Clinical Psychology at Lancaster University. The work presented in this thesis is my own except where reference to authors is made. The work has not been submitted for any other academic award.

Name: Stephanie Fagan

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I would like to thank the people who participated in this research for sharing their thoughts and experiences. I was humbled and inspired by your strength in the face of suffering and will keep hold of the insight into compassion that I received from you. I would also like to thank all the people who have touched my life with their warmth and kindness, particularly my mother: your gentle heart taught me the healing power of compassion. I will carry this with me always. This work is dedicated to you.

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Chapter 1: Literature Review

Applying Psychological Theory to Understanding the Relationship between Mental Health Professionals and Adults with a Diagnosis of Borderline Personality Disorder: A Compassionate Reframing

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Abstract

Adults with a diagnosis of Borderline Personality Disorder (BPD) often experience stigma due to the reductionist and individualising narrative that accompanies its conceptualisation. This review offered a compassionate reframing of the relational dynamics between individuals with a diagnosis of BPD and mental health professionals. Interpersonal dynamics described in qualitative literature were identified and reconceptualised by utilising psychological theory. Metaethnography was used to synthesise the relational dynamics described in 11 qualitative studies. Twenty-four themes emerged which were synthesised into 12 themes by integrating psychological theory to produce a compassionate reframing. In considering the relationship between the themes, four patterns of relational dynamics emerged which have implications for developing positive therapeutic relationships. Moreover, the review offers compassionate language, based upon a psychological understanding, to replace stigmatising language and reconceptualise difficulties within the relationships.

Key words: Borderline Personality Disorder, Interpersonal Relationships, Mental Health Professionals, Meta-synthesis, Metaethnography.

Practitioner Points

- Utilising language which contains a psychological understanding facilitates a shift in perspective and enables a more compassionate narrative towards clients.
- Bolstering the recognition that positive therapeutic relationships facilitate recovery and healing in this client group can help professionals to feel more of a sense of hope and agency.
- A shared outlook and clear guidance in working with this client group can help manage intrateam inconsistency and conflict.

The Impact of a Reductionist Narrative

Borderline Personality Disorder (BPD) is a diagnostic label described in the Diagnostic and Statistical Manual for Mental Disorders (DSM). The DSM was originally produced by the American Psychiatric Association as a tool to categorise and understand the array of experiences of people accessing support from psychiatrists (Cooper, 2014). The scope and influence of the DSM has grown since its first publication in 1952 (Cooper, 2014) and diagnosis is often accompanied by a reductionist narrative of “dysfunction in biological or ‘underlying’ psychological processes” (Moncrieff, 2014, p257). This narrative assumes that mental distress is elicited from within an individual (Division of Clinical Psychology (DCP), 2013) and overlooks the wider context of human suffering including relational and societal factors (Gambrill, 2013).

It is pertinent to consider the impact of this individualising narrative in relation to BPD as the emotional and behavioural difficulties experienced by people with the diagnosis are often elicited and perpetuated by interpersonal dynamics (Giffin, 2008). Moreover, the individualising narrative has been proposed to contribute to the stigma associated with a diagnosis of BPD (Bonnington & Rose, 2014) which results in pejorative labelling by mental health staff and the wider community (Byrne, 2000; Furnham, Lee & Kolzeev, 2015; Nehls, 1999). Commonly-used terms include “dangerous” (Markham, 2003), “difficult; treatment-resistant; manipulative; demanding; and attention-seeking” (Aviram, Brodsky & Stanley, 2006, p. 250). These negative attitudes impact upon the care and treatment of this group and result in lower standards of care (Kling, 2014).

Weight and Kendal (2013) found that, when professionals have a framework for understanding some of the behaviours associated with BPD, stigma reduces and the relationship improves. Furthermore, by creating a compassionate understanding and replacing

judgemental language, mental health professionals can challenge stigma attached to the BPD label (Aguirre, 2016). As language shapes the way we think and group discourse impacts upon the development of shared values, it has been suggested that developing compassionate terminology is a priority for mental health care (Crawford, Gilbert, Gilbert, Gale & Harvey, 2013).

The current review will offer a compassionate reframing of the relational dynamics between individuals with a diagnosis of BPD and mental health professionals by identifying interpersonal dynamics described in the literature and utilising psychological theory to develop a compassionate understanding. This will be aided by replacing judgemental language with terms from a psychological theoretical understanding. I will now describe some of the psychological theories that have been applied to BPD research to inform the analysis.

Psychological Theories of BPD

Due to the heterogeneity of difficulties associated with the BPD diagnosis and their idiosyncratic development (Lewis, Caputi & Grenver, 2012), it is unlikely that one overarching theory can sufficiently encapsulate the experience of every individual. I believe that a person-centred approach (i.e. individual psychological formulation) has the most explanatory power in understanding the development of difficulties described by an individual's diagnosis. Nonetheless, psychological theories can offer heuristic frameworks that can usefully be applied to explore common mechanisms of development in the group as a whole.

Emotional Difficulties

Linehan's (1993) biosocial model proposes that individuals who receive a diagnosis of BPD have emotional difficulties which include heightened emotional sensitivity, emotion regulation difficulties and a slow return to baseline following emotional reactivity. One of the most prominent features of the relationship between professionals and this client group is also the strong emotional responses elicited within staff members. Dickens, Lamont and Gray (2016) conducted a descriptive metasynthesis of mental health nurses' attitudes, behaviour, experience and knowledge of working with adults with a diagnosis of BPD. Their synthesis yielded a theme entitled 'human response' which described strong emotional reactions in professionals ranging from empathy and interest to anger and inadequacy. These strong emotional reactions may reflect the process of counter-transference in which one individual transfers their emotions from early experiences to another person who, in turn, experiences these transferred emotions (Lowe, 2015). For example, if a client has experienced trauma which has resulted in the internalisation of a belief that they have no control over their life, the feeling of being unable to control the situation can be elicited within staff (King, 2014). This counter-transference can result in a professional feeling deskilled, withdrawing from their client or attempting to transfer this feeling back to their client (King, 2014).

Cognitive Representations of Self and Other

Ryle (1997) suggested that multiple patterns of relating to the self and others are developed in early relationships and provide templates for relating to others throughout life. He proposed the self-states model and described that individuals with a diagnosis of BPD experience extreme switches between different patterns of relating and the specific

emotions and behaviour that are elicited by them (Ryle, 2004). Another theory which provides a similar explanation for extreme switches between ways of relating is Young's schema modes (i.e. patterns of thought, emotion and behaviour; Arntz, Klokman & Sieswerda, 2005). Young suggested that people with a diagnosis of BPD fluctuate between four primary schema modes: the abandoned child, the angry/impulsive child, the punitive parent and the detached protector (Arntz et al., 2005). Although similar to Ryle's self states model, Young's theory argued that schemas are the underlying mechanism for the abrupt shifts in emotions and behaviour; while Ryle's model proposed that the underlying mechanism is that of dissociation, a common response to trauma, which is elicited due to unmanageable external threat and recurs in response to actual or perceived threat (Ryle, 1997).

Reinecke and Ehrenreich (2005) posited a cognitive-developmental model of BPD in which maladaptive schemas, formed during early life experiences, contribute to the difficulties experienced by this client group. They suggested that specific schemas present in individuals with a diagnosis of BPD include: 1) the world is threatening, 2) others are potentially rejecting, uncaring or malevolent and 3) the self is inherently unlovable and incapable of coping effectively. They propose that, upon being exposed to a perceived schema-congruent life event (e.g. another as rejecting), overwhelming emotions are elicited due to emotion dysregulation.

Trauma and Interpersonal Functioning

A large majority of individuals with a diagnosis of BPD have experienced childhood trauma including abuse and/or neglect (Van der Kolk, Hostetler, Herron & Fisler, 1994). Some researchers believe that repeated exposure to traumatic experiences in childhood results

in the presentation of a personality disorder (Wilkins & Warner, 2000). Horsfall (1999) suggested that the impacts of trauma (e.g. incest, rape, emotional abuse, neglect) are often minimised by professionals or not understood in the context of current difficulties. The difficulties experienced interpersonally in individuals with a diagnosis of BPD may be better understood from a trauma-informed approach (Trippany, Helm & Simpson, 2006). For example, traumatic experiences can result in difficulty trusting others (Ma et al., 2009) and trust has been identified as essential for the maintenance of a positive therapeutic relationship with this client group (Langley & Klopper, 2005). Traumatic interpersonal experiences can also result in a tendency for individuals to exhibit fear or anger towards others due to an anticipation of being rejected or abused (Purnell, 2010). Purnell suggested that this tendency is a self-protective response which functions unconsciously, but can be perceived as manipulative behaviour by others.

Specific Psychological Processes and Behavioural Motivations

Defence Mechanisms

Defence mechanisms are a universal human experience (Horsfall, 1999). They are unconscious psychological processes which serve to reduce anxiety (Zanarini, Weingeroff & Frankenburg, 2009). According to object relations theory, individuals with a diagnosis of BPD are considered to have formed polarised impressions of others; a defence mechanism known as splitting (Clarkin, Levy, Lenzenweger, Yeomans & Kernberg, 2007). If a young child received inconsistent care from one or more caregivers (i.e. sometimes loving and available; sometimes neglectful or abusive), the child can experience difficulty integrating a sense of both 'good' and 'bad' within one individual

(Zanarini et al., 2009). These polarised impressions can result in extreme, opposing emotional reactions and behaviours towards others.

Zanarini et al. (2009) conducted a study investigating the defensive functioning of people with a diagnosis of BPD compared to those with other personality disorder diagnoses. They found that the defences of acting out (behaving without conscious awareness of the underlying emotion driving the behaviour) and undoing (behaving in a way that is the opposite from that which is desired) are significant predictors of BPD diagnosis. This consideration of unconscious mechanisms challenges the view that behaviours of individuals with a diagnosis of BPD are intentional (Sulzer, 2015).

Motivations for Behaviour

Berthoud, Kramer, de Roten, Despland and Caspar (2013) used Plan Analysis to qualitatively analyse the motives underlying interpersonal events during psychotherapy with individuals with a diagnosis of BPD. The most prevalent motives identified included: stay in control, avoid being alone, protect yourself, keep your self-esteem, make sure of support, be accepted by others, ensure the therapist makes a commitment to you, control the therapeutic relationship, avoid being hurt, point out how bad you feel and avoid being confronted with your emotions. Berthoud et al. (2013) suggested that behaviours which impact upon the therapeutic relationship are not elicited consciously or rationally, but through subconscious motives. Acknowledging that motives may not be consciously explicit allows for a more compassionate, therapeutic response.

Sheffield, Barlow, Lambert, Hoyal, Thompson and Garbutt (1999) explored paradoxes within the narratives of 10 people with a diagnosis of BPD when discussing relationship events during psychotherapy. They identified two themes: intimacy dilemmas and self-destructiveness. The intimacy dilemma was described as the desire for both

closeness and distance while experiencing intolerable feelings in both positions. They proposed that distance was created as a way to protect the self from potential abuse, control or abandonment. However, distance from others elicited feelings of loneliness and depression. Some participants described a desire for nurturance, but rejected this when it was offered to them due to fears around being criticised or controlled. The second theme described self-destructiveness as a form of self-protection. Behaviours such as suicidality, self-injurious behaviour, self-sabotage and impulsivity were considered to be a way of controlling distress. Sheffield and colleagues suggested that these conflicting positions are held simultaneously and impact on therapeutic relationships with this client group.

Rationale and Aim of the Study

Interpersonal difficulties are a key component of the distress experienced by individuals with a diagnosis of BPD (Giffin, 2008) and positive therapeutic relationships are important for recovery (McMain, Boritz & Leybman, 2015). However, mental health professionals describe difficulty forming effective therapeutic relationships with this client group (Bender, 2005). Negative, stigmatising narratives pervade the literature exploring mental health professionals' attitudes (Aviram et al., 2006). Insofar as individual qualitative studies utilise stigmatising language, reviews on this topic which use descriptive methodology (Dickens et al., 2016; Sansone & Sansone, 2013; Westwood & Baker, 2010) reiterate and consolidate negative labelling. This is because descriptive methodology collates and describes findings from individual qualitative studies exploring relational dynamics in the absence of an alternative framework for understanding. Therefore, in order to change the current narrative, it is essential to utilise interpretative methodology. Interpretative methods provide an opportunity to reframe relational dynamics by incorporating a psychological understanding of the behaviours of people with a diagnosis of BPD (Weight & Kendal, 2013).

This has been shown to reduce stigma by promoting a more compassionate stance (Weight & Kendal, 2013). Moreover, using an interpretative method allows the development of compassionate language to replace existing judgemental terminology which perpetuates stigma (Aguirre, 2016).

Therefore, the aim of the current review is to, firstly, examine the relational dynamics described within qualitative literature exploring the relationship between individuals with a diagnosis of BPD and mental health professionals. Secondly, I will produce a compassionate reframing of these dynamics by integrating psychological theory and compassionate terminology. This will be done by: 1) Conducting a review which identifies the main interpersonal dynamics described by qualitative research on this topic and 2) Interpreting the reason for these dynamics by utilising psychological theory and compassionate terminology.

Method

Design

Qualitative research was chosen as the basis for this review as it provides rich detail and aims to understand the ‘how’ and ‘why’ of experiences (Noblit & Hare, 1988). A meta-synthesis was conducted as it enables the integration of inter-related qualitative research findings (Jensen & Allen, 1996) and aims to “portray an accurate interpretation of a phenomenon and to compare and contrast the constructs of individual studies to reach consensus on a new construction of that phenomenon” (Pearson, Field & Jordan, 2009, p. 95). As the aim of the study was to reconceptualise phenomena which are currently portrayed using stigmatising language, meta-ethnography was chosen to synthesise the findings. Meta-ethnography provides the opportunity to offer “an alternative theory of social explanation” (Noblit & Hare, 1988, p. 30) by reconceptualising interpretations from the synthesised papers.

Search Strategy and Study Selection

In order to explore relational experiences, studies which investigated an array of aspects of the relationship were considered (e.g. interpersonal dynamics, communication, perceptions and attitudes, beliefs, opinions and therapeutic alliance). The SPIDER tool was used to develop the search strategy (Cooke, Smith & Booth, 2012; Table 1) and search terms were combined using Boolean operators. Three databases were accessed: PsycInfo, Medline and CINAHL. The specific terms used when searching the PsycInfo database are provided as an example in Table 1.

Key papers were identified from the database searches. They were used in citation tracking and their reference lists searched. In addition, the first five pages of a Google Scholar search were examined. In total, 385 papers were identified from database searching and six from other sources, with 334 papers after duplicates were removed (Figure 1).

Eligibility Criteria. The inclusion criteria were as follows: 1) relationships were listed as a main focus of the study, 2) participants consisted of professionals working with adults with a diagnosis of BPD, 3) peer-reviewed, published studies and 4) English language. The exclusion criteria were: 1) themes could not be extracted due to insufficient information and 2) mixed participant groups (in which separate themes were not developed).

Titles and abstracts were screened according to the inclusion and exclusion criteria. This resulted in 35 papers which were read in full and a total of 11 papers were identified for inclusion in the meta-synthesis (see Figure 1 for the reasons for exclusion). The characteristics of these studies were extracted and this information is provided in Table 2.

Critical Appraisal

The Critical Appraisal Skills Programme (CASP, 2014) was used to assess the quality of the synthesis studies. Each paper was in accordance with CASP guidance and recorded evidence related to each criterion. A cross-comparison was conducted for each criterion in which the ratings for individual papers were compared to one another. During this process, it was identified that reporting quality and the length of the synthesised papers impacted upon the CASP ratings. Therefore, in addition, a subjective rating was given in accordance with guidance provided by Dixon-Woods et al. (2007). Studies were recorded as ‘key papers’ (KP), ‘satisfactory papers’ (SAT) or papers in which the methodology was ‘fatally flawed’ (FF). These subjective ratings were informed by the two key areas of quality appraisal discussed by Toye et al. (2013): Conceptual clarity and interpretive rigour. Critical appraisal was not used to exclude papers, but provided an opportunity to quality-check the synthesis (as

demonstrated by Malpass et al., 2009). CASP and Dixon-Woods ratings are provided in Table 3.

Synthesis

Noblit and Hare (1988) described seven stages of conducting a meta-ethnography. Although the phases are discrete, they are conducted iteratively. Phases 1 and 2 involve identifying the research topic, reading key studies and consolidating the specific aim of the research. Phase 3 involves reading and re-reading the synthesised papers. In Phase 4, the relationship between the studies is determined. In this stage, Noblit and Hare (1988) recommend that interpretations from the synthesis studies are juxtaposed in a table and visually scanned. They differentiate between three levels of interpretation: first order interpretations are the perspectives of the phenomena from participants within the synthesised papers; second order interpretations are the authors' perspectives of the phenomena; and third order interpretations are the reconceptualisation of the second order interpretations by the meta-ethnographic researcher. During Phase 5, the studies are translated into one another by noting how the key metaphors, ideas and concepts from one study relate to those from another. For example, by noting "one case is like another, except that..." (Noblit & Hare, 1988, p. X). In Phase 6, the translations are synthesised and third order interpretations formed. This is illustrated in Phase 7, 'expressing the synthesis', by taking into account the intended audience of the research. A detailed description of the actions taken at each stage during the current meta-ethnography is available in Table 4.

Findings

Four aspects of the relational experience from the perspective of mental health professionals were identified in Phase 4: perceptions of clients with a diagnosis of BPD, perceptions of services, emotional responses and actions. These aspects represent third order constructs and were preserved during the construction of the synthesis. During Phase 5, key metaphors, themes and concepts from the synthesised papers were juxtaposed in regard to these four aspects of the relational experience. Through reciprocal translation, 24 second order interpretations were identified. The language of the synthesised papers' second order interpretations was preserved at this stage. During Phase 6 of the synthesis, the 24 second order interpretations were synthesised into 12 themes (third order interpretations) by utilising psychological theory to offer a compassionate reframing. I will now describe the synthesis and its constituent second order translations concurrently (see Table 5 for a summary).

Staff's Perceptions of Clients

Complexity and professional challenge. Clients were described as psychologically complex whereby mental health professionals 'strugg[led] to make sense' of their clients' behaviour (O'Brien & Flöte, 1997). Complexity was described through recognising the 'history of trauma, neglect or emotional abuse' (O'Connell & Dowling, 2013) that many clients had experienced as well as their 'enmeshed and dysfunctional families' (Hazelton, Rossiter & Milner, 2006) and 'lack of social support' (O'Connell & Dowling, 2013). One of the impacts of the level of complexity was a belief that clients have a 'limited ability to change' (Millar, Gillanders & Saleem, 2012) and that 'longevity of input' is required (Stroud & Parsons, 2013). In some studies, participants described perceiving this client group as 'untreatable' (Woollaston & Hixenbaugh, 2008) or 'sabotaging' their attempts at progress

(McGrath & Dowling, 2012). This led professionals to feel that their efforts were ‘a waste of time’ (Commons Treloar, 2009).

Professionals described having both ‘positive and negative perceptions’ of clients (Millar et al., 2012). On one hand, clients were perceived as ‘likeable’ with professionals embracing the ‘professional challenge’ and having a ‘desire to help’; on the other hand, the degree of complexity engendered a sense of ‘dread’ in working with this client group. This ‘variation in professionals’ perceptions’ (O’Connell & Dowling, 2013) was evident both within individual professionals and within teams.

Emotional sensitivity. Clients were described as having a ‘heightened sense of humanity and vulnerability’ in which they were ‘very attentive and attuned’ within relationships (Rizq, 2012). This led to an emotional sensitivity in which clients were ‘easily upset’ (Commons Treloar, 2009). Some participants regarded this emotional over-reaction occurring in relation to ‘small things’ and, as such, the emotionality was viewed as ‘unnecessary and inappropriate’ (Nehls, 2000) or ‘over the top’ (Millar et al., 2012). Other interpretations regarded heightened emotional reactivity as functional, purposeful attempts to ‘exaggerate feelings’ (McGrath & Dowling, 2012) or ‘dramatise self-harm’ (Rizq, 2012). Yet other interpretations described this reactivity as a result of ‘intense emotional issues’ with self-harm a way of ‘communicating distress’ (Commons Treloar, 2009). The discrepancy between interpretations demonstrates one example of the aforementioned difficulties in ‘making sense of clients’ behaviours’ (O’Brien & Flöte, 1997) and resulting ambivalence.

In the third order interpretation, ‘emotional sensitivity’ was chosen as a descriptive term for this perception of clients as it reflects the psychological process of emotional dysregulation which has been implicated in people with a diagnosis of BPD (Linehan, 1993).

It aligns with the experiences of the second order interpretations discussed above, but refutes the interpretation that this phenomenon arises due to an exaggeration or dramatisation of affect.

Attempts to control overwhelming emotions. Professionals described clients as ‘chaotic’ (Commons Treloar, 2009) and ‘oscillating between extremes’ in relation to their emotions and behaviours (Millar et al., 2012). Professionals perceived that clients ‘feel out of control’ (Nehls, 2000) and are ‘unable to cope over small things’ (Nehls, 2000). Some interpretations alluded to clients having an absence of coping skills (O’Connell & Dowling, 2013) or poor ways of managing their emotions such as through self-harm or ‘destructive behaviour’ (Nehls, 2000; O’Connell & Dowling, 2013; Woollasten & Hixenbaugh, 2008). One suggested interpretation of this phenomenon was that clients have ‘unresolved issues which they take out on professionals’ (McGrath & Dowling, 2012). Yet, in other interpretations, this ‘destructive behaviour’ (which included self-harm, suicidal intent, verbal and physical aggression) was described as functional. For example, clients were labelled as ‘threatening’ (Woollasten & Hixenbaugh, 2008) and ‘intimidating’ (Hazelton et al., 2006) with their behaviours viewed as purposeful attempts to gain control over situations.

Similarly, clients were labelled ‘manipulative’ which was described as clients not being ‘honest or genuine’ (Woollasten & Hixenbaugh, 2008) or having a ‘hidden agenda’ (McGrath & Dowling, 2012). Some interpretations suggested that this perception arose due to a need within clients to gain a sense of control (Millar et al., 2012; Woollasten & Hixenbaugh, 2008) and thus, compassionately reframed this dynamic. Nonetheless, this led to professionals regarding clients with ‘suspicion’ (Woollasten & Hixenbaugh, 2008).

Overall, there was a tendency to perceive this phenomenon in negative terms. For example, specific themes that incorporated this phenomena were entitled: ‘difficult consumers’ (Hazelton et al., 2012), ‘challenging and difficult’ (McGrath & Dowling, 2012), ‘manipulation’ and ‘threatening’ (Woollaston & Hixenbaugh, 2008). In one study (Millar et al., 2012), participants referred to their ‘awareness of [this] negativity’ which resulted in one participant correcting themselves when using stigmatising language such as ‘manipulative’ and, instead, referred to a potential function of the phenomenon (i.e. to gain control). Therefore, this third order interpretation of Attempts to Control Overwhelming Emotions was constructed ‘in vivo’ utilising second order interpretations.

Care-seeking. Clients were described as presenting with care-seeking behaviour. An example given by participants within the synthesised papers was that of multiple telephone calls to professionals. This was labelled as ‘attention-seeking’ (McGrath & Dowling, 2012; Hazelton et al., 2006) and regarded as placing ‘excessive demands’ on professionals (Nehls, 2000). In addition, clients were perceived as continually ‘pushing boundaries’ (Rizq, 2012). McGrath and Dowling (2012) alluded to this ‘infringement upon boundaries’ as being due to clients themselves ‘having poor boundaries’; whereas Nehls (2000) described the ‘infringement of boundaries’ as attempts of ‘trying to know professionals’ which was experienced as ‘intrusive’. This second order interpretation aligns with the third order interpretation of care-seeking behaviour in which clients may wish to form relationships with professionals which are beyond professionals’ expectations of the therapeutic relationship. This was informed by attachment theory which suggests that many adults with a diagnosis of BPD identify with attachment difficulties, particularly insecure attachment, fears of abandonment and rejection which can lead to increased care-seeking behaviour (Fonagy, Target, Gergely, Allen & Bateman, 2003).

Staff's Emotional Responses

Strong, conflicting emotional response. In 'identifying the borderline client', Rizq's (2012) participants described having a 'gut reaction' of strong emotional responses. Professionals described 'having conflicting feelings' (O'Brien & Flöte, 1997) and 'oscillating between extremes' (Millar et al., 2012) of emotions. O'Connell & Dowling (2013) described experiencing both 'positives and challenges' which encompassed strong, conflicting emotional reactions to clients with a diagnosis of BPD.

On one hand, professionals described 'interest' in working with this client group due to the complexity and professional challenge (Bergman & Eckerdal, 2000; Millar et al., 2012). Professionals felt 'sympathy' (Stroud & Parsons, 2013), 'empathy' (Bergman & Eckerdal, 2000; Millar et al., 2012) and 'a desire to help' (Stroud & Parsons, 2013) in response to difficult life experiences that clients had endured. On the other hand, many interpretations discussed feelings of frustration within professionals. This was both in direct response to the client (Commons Treloar, 2009; McGrath & Dowling, 2012; Millar et al., 2012; O'Connell & Dowling, 2013; Woollasten & Hixenbaugh, 2008) and 'feelings of professional frustration' (Bergman & Eckerdal, 2000). In some instances, this arose due to a 'resentment of being made to feel responsible' (Woollasten & Hixenbaugh, 2008), feeling 'used' (McGrath & Dowling, 2012) or 'manipulated' (O'Brien & Flöte, 1997) by clients. Woollasten and Hixenbaugh (2008) described a reaction whereby professionals experienced anger as a response to feeling scared.

Professional (in)effectiveness and personal agency. Professionals reported feeling uncertain and confused when working with individuals with a diagnosis of BPD. This

included feeling 'unsure of how to respond' (Commons Treloar, 2009), 'being unsure of interventions' (O'Brien & Flöte, 1997) and 'questioning their profession' (McGrath & Dowling, 2012). There was also a feeling of 'inadequacy' evoked within professionals (Commons Treloar, 2009; Woollasten & Hixenbaugh, 2008) and feelings of 'letting the client down' (Rizq, 2012). Many second order interpretations alluded to feelings of 'helplessness' and 'hopelessness' within professionals. Synthesised papers suggested that this emotional reaction was a response to the uncertainty of how to help clients (O'Brien & Flöte, 1997), the belief that clients were untreatable (Commons Treloar, 2009; Woollasten & Hixenbaugh, 2008) or a lack of belief in their own ability (Millar et al., 2012). Woollasten and Hixenbaugh's (2008) interpretation described feeling 'devalued as a person' in addition to professional crisis.

Similar ambivalence was present within this concept, with some professionals 'enjoy[ing] the challenge of working with' these clients (Rizq, 2012). This related to 'optimism' (Hazelton et al., 2006; Woollasten & Hixenbaugh, 2008) and believing that 'there is the possibility of change' (Millar et al., 2012). O'Connell and Dowling (2013) described that 'seeing the client progress' required a great deal of effort and skill and that they had to 'put in work to see results'. Therefore, it was extremely rewarding to witness clients' progress (Millar et al., 2012).

Frightened, trapped and overwhelmed. Professionals reported feeling overwhelmed (Millar et al., 2012), challenged (Commons Treloar, 2009), drained (O'Connell & Dowling, 2013) and exhausted (Stroud & Parsons, 2013). They reported 'feeling like a prisoner' (Nehls, 2000) with a constant 'pressure to do something' (Millar et al., 2012) for a client whose 'neediness is bottomless' (Rizq, 2012).

Professionals felt particular ‘anxiety over [the client’s] self-harm’ (Woollasten & Hixenbaugh, 2008) and a constant ‘unease about risk’ (Rizq, 2012). Professionals were distressed in response to witnessing self-harm and suicide in these clients (Woollasten & Hixenbaugh, 2008) and ‘listening to [their] trauma’ (O’Brien & Flöte, 1997). Professionals also described a ‘fear of connecting with clients’ (Nehls, 2000) and fears of clients ‘getting inside’ them (Rizq, 2012). O’Brien and Flöte (1997) discussed the impact of clients’ experiences as ‘being traumatis[ing]’ to professionals through a process of vicarious traumatisation. In this third order interpretation, feeling ‘frightened, trapped and overwhelmed’ is considered a response to clients’ care-seeking behaviour coupled with a threat of personal traumatisation.

Staff’s Actions

Establishing a therapeutic relationship and calibrating emotional involvement.

This theme refers to the actions taken by professionals to establish a therapeutic relationship while reflecting upon boundaries and attending to their own level of comfort in emotional involvement. O’Connell and Dowling (2013) suggested that ‘skills are required’ to build a therapeutic relationship with these clients and that ‘establishing trust is a slow process’. Similarly, Millar et al. (2013) identified ‘working on engagement’ as a key component in their research exploring the experience of clinical psychologists.

One aspect of managing the relationship was to ‘calibrate emotional involvement’ (Rizq, 2012). O’Brien and Flöte (1997) described that professionals can ‘easily get emotionally involved’ with these clients and that ‘remaining distant, but safer conflicts with the therapeutic relationship’. The notion of being safe by remaining emotionally distant was described as a response to ‘frightening behaviour’ which had the potential to be ‘personally

damaging' to professionals. This resulted in professionals 'avoiding giving care, giving minimal care or limiting their time with the client' (McGrath & Dowling, 2012). Stroud and Parsons (2013) visualised this process of calibrating emotional involvement on a spectrum from 'connected to disconnected' where professionals fluctuated between engaging emotionally with a client and 'withdrawing emotionally'. This was done by suppressing their emotions and 'putting up a professional front'. This disconnection led to the display of 'rigid boundaries'. Stroud and Parsons (2013) described how their participants perceived the ability to set rigid boundaries and limits as 'being strong'. This aligns with O'Brien and Flöte's (1997) interpretation that professionals can 'easily get emotionally involved'; that it takes strength to emotionally withdraw from this client group and set rigid boundaries. Two papers also alluded to the way in which the professionals self-monitored to express an appropriate level of concern and monitor their own reactions to protect themselves (Nehls, 2000; Rizq, 2012).

Assessing Risk and Managing Professional Threat. Six papers acknowledged the monitoring of risk as an action inherent within the relationship (Nehls, 2000; O'Brien & Flöte, 1997; O'Connell & Dowling, 2013; Rizq, 2012; Stroud & Parsons, 2013; Woollaston & Hixenbaugh, 2008). This included 'closely monitoring disclosures and self-destructive impulses' (Nehls, 2000) and being 'extra alert' (Rizq, 2012) which provoked anxiety in professionals. The community psychiatric nurses in O'Connell and Dowling's (2013) study alluded to the necessity to take risks with this client group. However, this was in an environment of 'managing professional threat' (O'Brien & Flöte, 1997; Stroud & Parsons, 2013) in which professionals felt 'the organisation held them responsible for the patient's safety'. The nurses in Woollaston and Hixenbaugh's (2008) study described how this

‘professional threat’ led to them documenting communications with these clients to ensure that ‘nothing can be used against them’.

Attempts to understand. Although professionals ‘struggle to make sense of a client’s difficulties’, only in two papers did professionals describe a meaning-making process in which there was a focus upon the emotions and functions of behaviours rather than the behaviours themselves. One study was a study of clinical psychologists (Millar et al., 2012) and the other was a staff team working with the one client (O’Brien & Flöte, 1997). However, although not explicitly stated in the other studies, it is evident from the translation process that the interpretations themselves are ways to try to make sense of clients’ behaviours and the interpretations given are meaning-making. For example, interpretations included ‘being involved in a mystery’ (O’Brien & Flöte, 1997) and the ‘need for a common outlook’ (Bergman & Eckerdal, 2000). This process of meaning-making appeared to impact upon professionals’ perceptions of clients.

Staff’s Perceptions of Services

Inconsistency and conflict. Many papers alluded to conflict between colleagues and mistrust within staff teams. This intrateam conflict was often referred to as ‘splitting within teams’ with individual professionals having drastically opposing opinions about a client and their care (Commons Treloar, 2009). In this sense, splitting is used to describe the observation that polarised impressions of clients exist between groups of staff members and is distinguished from psychological splitting (a defence mechanism). Some studies regarded this intrateam conflict as being ‘purposeful’ (Hazelton et al., 2006) by clients by, for example, ‘preying on the vulnerable [staff members]’ (McGrath & Dowling, 2012). Woollaston and

Hixenbaugh (2008) interpreted team splitting as arising due to professionals being either 'sympathetic' towards or 'disliking' of clients. The former were perceived as 'overinvolved' and the latter as 'harsh and uncaring' by others. The authors suggested that individual stances arose as a result of 'seeing the emotional needs' or 'the behaviours' of clients, respectively. They interpreted team splitting as the result of 'manipulative' intent of clients through 'game-playing' and a wish to 'gain control'. However, in the third order interpretation of this phenomenon, splitting within teams is regarded as a direct consequence of the ambivalence within professionals as opposed to intentional, 'manipulative' behaviour of clients. Moreover, team splitting may arise as the result of internal psychological processes within professionals (i.e. psychological splitting).

Service-related factors can also account, in part, for variation in professionals' perceptions. For example, professionals report inconsistent treatment (Hazelton et al., 2006) and a lack of training and experience in working with people with a diagnosis of BPD (Commons Treloar, 2009; O'Connell & Dowling, 2013; Stroud & Parsons, 2013). Bergman and Eckerdal's (2000) mixed professionals participant group discussed the 'need for a common outlook' and a 'shared philosophy' in caring for individuals with a diagnosis of BPD. The clinical psychologist participant group in the study by Millar et al. (2012) described the impact of 'working in contrast to the system' due to insufficiencies in the diagnostic system. Within the third order interpretation, this inconsistency impacts upon professionals' attempts to understand clients and resulting negative attitudes.

Inadequate services. Service factors which impacted upon the relationship between professionals and clients included resource issues and the high demands placed upon professionals (e.g. high caseloads, administration; Stroud & Parsons, 2013). Participants

within the synthesised papers commented, in particular, on the lack of time in which to complete their work (Commons Treloar, 2009; Rizq, 2012) and being 'unable to refer clients onwards' to other services (Rizq, 2012). There was also reference to the inadequate care offered to, and neglect of, clients with a diagnosis of BPD which included offering ineffective interventions (Hazelton et al., 2006; Commons Treloar, 2009). In addition, it was reported that there was a lack of emotional support for professionals within services and that this input is essential when working with this client group (Bergman & Eckerdal, 2000; O'Connell & Dowling, 2013; Rizq, 2012; Stroud & Parsons, 2013).

Synthesis

In considering the interaction between third order interpretations, four salient relational dynamics were identified which are described below:

- 1) Clients seek care (Care-seeking) which places demands upon professionals and leads to professionals feeling that their boundaries are being infringed. Professionals feel Frightened, Trapped and Overwhelmed in response to this and this impacts upon the therapeutic relationship and their emotional involvement with clients (Establishing a Therapeutic Relationship and Calibrating Emotional Involvement). Some professionals feel 'indifferent', 'avoid giving care' or 'give limited care' as a way of protecting themselves from traumatisation and personal threat. Clients are attuned in relationships (Emotional Sensitivity) and so become aware of professionals' emotional responses and boundary shifts. This must be carefully managed as, otherwise, it can result in a cycle of Care-seeking and boundary rigidity which is compounded by clients' sensitivity to perceived rejection (Fig. 2).
- 2) Professionals perceive clients as complex (Complexity and Professional Challenge) and services as lacking resources and support (Inadequate Services). As a result of

this, professionals can feel a sense of hopelessness in their efforts to help (Professional In(e)ffectiveness and Personal Agency). These feelings of helplessness reinforce the perception of clients as ‘untreatable’ (Complexity and Professional Challenge) and impact upon the actions that professionals take within their relationship with clients (Establishing a Therapeutic Relationship and Calibrating Emotional Involvement; Fig. 3) such as ‘withdrawing emotionally’ if they feel that their efforts will be unsuccessful for clients while impacting upon their own wellbeing. This can lead on to the cyclic relational dynamics described in pattern 1 in which changes in boundaries and emotional connectedness impact upon increased levels of Care-Seeking and feelings within staff of being Frightened, Trapped and Overwhelmed.

- 3) Client’s Attempts to Control Overwhelming Emotions result in behaviours including suicidality, self-injurious and threatening behaviour. Professionals feel Frightened, Trapped and Overwhelmed in response to this. Due to the level of risk associated with these behaviours, anxiety is elicited in professionals who are continually alert to Assessing Risk and Managing Professional Threat from the wider organisation. This impacts upon the boundaries they set with clients and their emotional involvement which can result in distancing behaviour as a protective function to professionals (Establishing a Therapeutic Relationship and Calibrating Emotional Involvement). Similar to pattern 1, clients’ sensitive attunement to changes within relationships and heightened emotional reactions (Emotional Sensitivity) can elicit unmanageable feelings that result in further Attempts to Control Overwhelming Emotions (Fig. 4).
- 4) The complexity of clients (Client Complexity and Professional Challenge) coupled with the absence of a shared understanding within services (Inconsistency and Conflict) result in a process of Attempts to Understand clients’ experiences and

behaviour. In the absence of a shared outlook from the service, different interpretations result in widely varying perceptions of clients and conflicting emotional responses (Strong, Conflicting Emotional Responses). This process directly impacts Inconsistency and Conflict within teams, diminishing the possibility for a much-needed support network between professionals (Fig. 5).

Discussion

Integration of Psychological Theory

Emotional sensitivity and counter-transference. The theme Emotional Sensitivity is reflective of Linehan's (1993) biosocial model of BPD in which people with a diagnosis of BPD experience heightened affect, emotion regulation difficulties and a slow return to baseline following emotional reactivity. Applying the concept of counter-transference to the relationship would suggest that Strong, Conflicting Emotions elicited within professionals are a result of clients transferring their emotions from their early relational experiences. The perceptions of clients' experiences are similar to the emotions elicited within professionals. For example, experiencing Strong, Conflicting Emotions is similar to the overwhelming emotions perceived to exist within clients (Attempts to Control Overwhelming Emotions). It is also similar to the theme of Professional (In)effectiveness and Personal Agency in which professionals describe feeling out of control and unable to help clients. This is similar to what Kling (2014) describes where, if a client holds the belief that they have no control over their life, counter-transference processes result in professionals feeling unable to control the situation.

Dichotomous states. Care-seeking was thought to result in attempts to get closer to staff and receive care. Conversely, Attempts to Control Overwhelming Emotions was perceived to result in distancing behaviours such as aggression and self-harm. The contrast between these thematic perceptions of clients reflects the intimacy dilemma outlined by Sheffield et al. (1999), where closeness and distance are both desired and intolerable. This results in an alternating pattern between care-seeking to gain closeness while simultaneously creating distance as a way of gaining a sense of safety and control. This may also reflect

Ryle's (1997) concept of state shifts or Young's schema modes, where specific templates for interacting with others are activated.

From a trauma-informed approach, interpersonal trauma can result in difficulties trusting others (Ma et al., 2009) or displays of fear or anger in anticipation of rejection or abuse (Purnell, 2010). Rejection of care may also be elicited by schema including 'others are potentially rejecting, uncaring or malevolent' and 'I am unlovable', as proposed by Reinecke and Ehrenreich (2005). This alternation between Care-Seeking and Attempts to Control Overwhelming Emotions may explain why some professionals perceive clients' behaviour as 'self-sabotaging'. Sheffield et al. (1999) suggest that this behaviour is, in fact, a form of self-protection.

Underlying motives and defences. The process of Attempts to Control Overwhelming Emotions includes behaviours such as aggression towards professionals, distancing or pleasing. Berthoud et al.'s (2013) plan analysis can provide an explanation of the motives behind these behaviours (i.e. to stay in control, protect yourself, keep your self-esteem, control the therapeutic relationship, avoid being hurt, point out how bad you feel, avoid being confronted with your emotions). Similarly Care-seeking overlaps with the motives specified by Berthoud and colleagues (i.e. to avoid being alone, be accepted by others, make sure of support, ensure the therapist makes a commitment to you). It is important to note that these motives may not be explicit or conscious and so can lead to misperceptions by professionals who may interpret conflicting behaviours as 'manipulative'. While Attempting to Understand, misinterpretations can occur (e.g. beliefs that behaviours are intentional; Sulzer, 2015) which impact negatively upon the therapeutic relationship (Kling, 2014).

Defence mechanisms such as splitting, acting out and undoing may also result in Strong, Conflicting Emotions within professionals. That is, if a client is not consciously aware of the underlying emotion driving their behaviour (acting out) or if they are acting in direct contradiction to their true thoughts and feelings (undoing), it becomes difficult to make sense of a client's presentation. This in turn gives rise to misinterpretations and subsequent negative labelling. Mental health professionals may also utilise defence mechanisms in response to the strong emotions elicited within them, particularly if experiencing fear and threat. For example, Woollaston and Hixenbaugh (2008) described that professionals feel anger in response to feeling scared. Although some professionals described emotional-calibration and boundary-setting as intentional, other staff may be unaware of this process within the relationship. Thus, emotional detachment may be conscious and intentional, but can also occur as an unconscious coping mechanism in response to anxiety or threat.

Changes within the therapeutic relationship. The emotional calibration process described in managing the therapeutic relationship is self-protective for professionals, protecting them from emotional harm. However, clients with a diagnosis of BPD are sensitive to potential rejection and abandonment (Bungert et al., 2015) and so this process of emotional calibration through withdrawal and boundary-setting may serve as a trigger for the client. Foster (2001) argued that suppressing emotional experience serves a healthy function in mental health professionals and is necessary at times for professionals to ensure their own mental wellbeing and facilitate caring for clients. However, she proposed that that this must be managed carefully as, at its most extreme, this splitting can result in unhealthy team dynamics and a poor standard of care for clients.

Clinical Implications

Due to the level of attunement within relationships for this client group, the high levels of distress caused by interpersonal dynamics and the finding that positive therapeutic relationships are implicated in recovery (McMain et al., 2015), it is essential that mental health services place emphasis on managing the relationship between clients and professionals. Furthermore, professionals' negative attitudes impact upon the quality of the therapeutic relationship and so it is essential to understand the dynamics of these relationships and the process by which negative attitudes occur.

Specific dynamics that occur have been outlined within the synthesis. For example, professionals' feelings of professional (in)effectiveness impact upon emotional involvement and the building of a therapeutic relationship which, in turn, appears to impact upon clients' levels of care-seeking. This is further impacted by professional threat within the service context. Cultures of professional threat, as reflected in the perception of services within the synthesis, have been suggested as a barrier to the development of compassion within services (Rothschild, 2006). Crawford et al. (2013) argues that these cultures are created by target-driven health care and that a change in mental health services is imperative to provide the condition for a compassionate understanding within services.

One way in which services can facilitate the development of a compassionate understanding is through increased training and emotional support for professionals. An increased psychological understanding by professionals would be helpful in mitigating the negative attitudes which impact upon the therapeutic relationship. Utilising language which contains a psychological understanding (e.g. transference of emotions) would facilitate this shift in perspective and enable a more compassionate narrative towards clients. It would also replace negative labels which misrepresent the underlying motives of clients' behaviours (e.g.

discussing behaviours as unconscious attempts to gain control over strong, painful emotions as opposed to 'manipulative' behaviours). Moreover, applying the same concepts and theoretical explanations to the emotional responses and behaviours of professionals can help break down negative and stigmatising attitudes.

An understanding of the role of therapeutic relationships in recovery may circumvent the feelings of professional inadequacy experienced by professionals. For example, if mental health services bolstered the recognition that positive therapeutic relationships impact recovery and healing in this client group, professionals may feel more of a sense of hope and agency. Furthermore, a shared outlook and clear guidance in working with individuals with a diagnosis of BPD can help manage intrateam inconsistency and conflict.

Finally, the synthesis identified the emotional impact on professionals working with this client group. Not only were strong, conflicting emotions elicited, but the synthesis identified a process whereby closeness within the therapeutic relationship could be emotionally damaging for professionals and that emotional distancing was used as a self-protective emotional regulation strategy. The majority of synthesised papers referred to the importance of emotional support for professionals in order to contain these feelings and, thus, to allow professionals to engage in appropriately close and therapeutically helpful relationships. The model of supervision used by clinical psychologists would be valuable for other professionals, not only for emotional containment, but through offering a space to reflect on the emotional calibration process and discuss the best manner in which to respond to clients. Clinical psychologists are regularly employed in a capacity to disseminate psychological knowledge within teams (Onyett, 2007) and so have a role in helping to promote the psychological reframing process that the synthesis represents.

One such intervention which addresses these concerns, and has been shown to be effective in improving outcomes for individuals with BPD, is that of Structured Clinical Management (SCM; Bateman & Fonagy, 2009b). SCM presents a rationale for an intervention through developing the therapeutic relationship between individuals with a diagnosis of BPD and mental health professionals (Bateman & Krawitz, 2013). The approach provides training to help professionals offer containment and consistent, bounded care. In addition, it facilitates the development of a common psychologically-informed language and offers emotional containment for staff through team support and supervision.

Strengths, Limitations and Future Research

A strength of the current review was the use of interpretative methodology to offer a compassionate reframing of the understanding of relational dynamics between individuals with a diagnosis of BPD and mental health professionals. This was in response to the observation that stigmatising narratives were being perpetuated through descriptive qualitative research on this topic. Future research which adopts compassionate language would support this new paradigm.

The heterogeneity of the professional groups represented in the synthesis and the contexts in which they work is a potential limitation. There is marked difference in the role and experiences of professionals working within different contexts. For example, nurses working in inpatient settings will generally encounter higher levels of risk than primary care therapists and risk was described as a factor impacting upon emotional involvement. Moreover, perception of services was a factor demonstrated in the synthesis to impact upon relational dynamics. Therefore, it would be valuable for future research to explore service context and whether feelings of hopefulness and professional agency are related to

knowledge, experience or training provision. Finally, the current review explored relational dynamics from the perspective of mental health professionals. This was due to an early literature search identifying a lack of research exploring relationships from the perspective of clients. In order to get a fuller understanding of the relational dynamics, it is imperative to collate findings from the perspective of clients and contrast this with staff perceptions.

In conclusion, this review offered a compassionate reframing of the relational dynamics between individuals with a diagnosis of BPD and mental health professionals by identifying interpersonal dynamics described in the literature and utilising psychological theory to develop a compassionate understanding. In considering the relationship between the synthesised themes, four patterns of relational dynamics emerged which have implications for developing positive therapeutic relationships. Moreover, the review offered compassionate language, based upon a psychological understanding, to replace stigmatising language and reconceptualise difficulties within the relationships.

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Tables

Table 1

SPIDER tool to inform search strategy and PsycInfo example

SPIDER Heading	Sample	Phenomenon of Interest	Design	Evaluation	Research Type
Description	Mental health professionals	People with a diagnosis of BPD / EUPD	Any qualitative or mixed methods design.	The relationship and interpersonal dynamics	Qualitative or mixed method
PsycInfo Search Terms	Mental Health Personnel (DE) Clinicians (DE) Counselors (DE) Physicians (DE) Psychologists (DE) Therapists (DE) Professional* Nurse* Psychiatrist* Psychologist* Counsel* Therapist* Clinician*	Borderline Personality Disorder (DE) "Borderline Personality Disorder" BPD "Emotionally unstable personality disorder" EUPD		Interpersonal Relationships (DE) Interpersonal Interaction (DE) Attitudes (DE) Relation* Interperson* Interaction* Dynamic* Mutuality View* Experience* Opinion* Attitude* Perce* Belie* Feel* Reciproc*	Qualitative Research(DE) Qual* "mixed method" Narrative "interpretative phenomenological" IPA Thematic* Grounded

N.B. Search terms in columns combined using 'OR'; search terms in rows combined using 'AND'

Table 2
Characteristics of Included Studies

Study Number	Author(s)	Research Question / Aims	Recruitment Setting	Country	Sample	Method of Qualitative Data Collection	Analysis
1	McGrath & Dowling (2012)*	Aim: to explore registered psychiatric nurses' (RPNs') interactions and level of empathy towards service users with a diagnosis of borderline personality disorder (BPD).	Mental health community service (day setting and residential setting)	Ireland	17 registered psychiatric nurses (twelve females and five males)	Semi-structured interviews incorporating the staff-patient interaction response scale (SPIRS)	Thematic analysis
2	Rizq (2012)	Aim: to explore how counsellors experience working with borderline clients in the context of contemporary primary care services and how to support their work with this client group.	Primary Care Mental Health Service	UK	five primary care counsellors (counsellors or psychotherapists with more than five years' experience of working in NHS primary care services)	Semi-structured interviews	IPA
3	Commons Treloar (2009)	Aim: to collect clinician views on working with patients diagnosed with BPD	Mental health services and department of emergency medicine	Australia and New Zealand	140 registered health practitioners; 48 males and 92 females	Free response questionnaire	Thematic analysis
4	Woollasten & Hixenbaugh (2008)	Aim: to explore nurses' relationships with BPD patients from their own perspective	an acute adult ward, community mental health service, a supported tenancy scheme.	UK	6 psychiatric nurses (Their age range is between early 20s and late 40s. Two of the participants were women; four of them were men.)	Semi-structured interviews	Thematic Analysis
5	Millar et al. (2012)	Aim: to explore clinical psychologists' experiences and perceptions of working with clients with BPD.	Adult Clinical Psychology Department (those working	UK	Sixteen female clinical psychologists (including trainees	4 Focus Groups	IPA

			within primary care and mental health services)			and qualified staff)	
6	Stroud & Parsons (2013)	Aim: to gain a fuller understanding of how community psychiatric nurses (CPNs) make sense of the diagnosis of BPD and how their constructs of BPD impact their approach to this client group	Community Mental Health Team	UK	Four CPNs, three women and one man	Semi-structured interviews	IPA
7	Bergman & Eckerdal (2000)	Aim: to broaden the understanding of what it means for caregivers to manage BPD patients.	Inpatient and Outpatient Services	Sweden	29 caregivers (78% women and 22% men) aged 30 - 62 years (mean = 47 years); licensed nurses, 15% physicians, 11% social counsellors and 11% psychologists	Semi-structured interviews	Grounded theory
8	Nehls (2000)	To examine case management as it is practiced and experienced by case managers who care for persons with BPD	Community mental health centre	America	17 case managers	1:1 interviews	Interpretive phenomenology
9	O'Connell & Dowling (2013)	To explore the experience of psychiatric nurses who work in the community caring for clients with BPD	Adult community mental health	Ireland	10 nurses (9 women, 1 man)	Interviews	Thematic Analysis
10	Hazelton et al (2006)*	To collect staff's attitudes, knowledge and experience of working with people with BPD prior to, at one-month and six-months	Mental health service and associated health and human services	America	1 st focus group (n = 24); 2 nd focus group (n=20); 3 rd focus group (n=18)	3 Focus Groups	Discourse Analysis

		following a DBT training workshop					
11	O'Brien & Flote (1997).	To explore experiences of nursing staff providing care for a patient with BPD	Inpatient psychiatric unit	Australia	6 nurses with 12+ months experiences in unit who knew patient	Interviews	Hermeneutic phenomenology

* Mixed method studies: quantitative methods and findings not described

Table 3
Quality Appraisal of Included Studies

Study Number	Author(s)	CASP 1	CASP 2	CASP 3	CASP 4	CASP 5	CASP 6	CASP 7	CASP 8	CASP 9	CASP 10	CASP Total Score	Dixon-Woods Rating
1	McGrath & Dowling (2012)*	+	+	+	+	+	-	+	-	+	+	8	SAT
2	Rizq (2012)	+	+	+	+	+	+	+	+	+	+	10	KP
3	Commons Treloar (2009)	+	+	-	+	+	-	+	+	+	+	8	SAT
4	Woollaston & Hixenbaugh (2008)	+	+	+	-	+	+	+	+	+	+	9	KP
5	Millar et al. (2012)	+	+	+	+	+	-	-	+	+	+	8	FF ¹
6	Stroud & Parsons (2013)	+	+	+	+	+	-	+	+	+	+	9	SAT
7	Bergman & Eckerdal (2000)	+	+	+	-	+	-	-	+	+	-	6	SAT
8	Nehls (2000)	+	+	+	+	+	-	-	+	+	+	8	SAT
9	O'Connell & Dowling (2013)	+	+	-	+	-	-	+	-	-	+	5	FF ²
10	Hazelton et al (2006)*	+	+	-	-	-	-	-	-	+	+	4	SAT
11	O'Brien & Flote (1997)	+	+	+	+	+	-	+	+	+	+	9	KP

¹ Inclusion of professionals without experiences of working with individuals with a diagnosis of BPD.

² Unable to rate methodological quality: no description of how data was collected or analysed.

* Mixed method studies: quantitative methods and findings not described

Key: CASP 1: Clear statement of aims; CASP 2: Methodology; CASP 3: Research design; CASP 4: Recruitment strategy; CASP 5: Data collection; CASP 6: Consideration of relationship between researcher and participants; CASP 7: Ethical issues; CASP 8: Data analysis; CASP 9: Clear statement of findings; CASP 10: Value of research; SAT (Satisfactory Paper); KP (Key Paper); FF (Fatally Flawed).

Table 4

The seven phases of Noblit and Hare’s meta-ethnography approach

Phase of Meta-Ethnography (Noblit & Hare, 1988)	Description
Phase 1: Getting started	The research topic was identified: ‘experiences of the relationship between mental health professionals and adults with a diagnosis of BPD’. An initial literature search and reading of key studies informed the focus of the synthesis; that is, a focus on relationships from the perspective of mental health professionals.
Phase 2: Deciding what is relevant to the initial interest	The specific aim of the research was consolidated: the use of psychological theory and language to synthesise the interpretations of previous qualitative research studies. Aspects of relational experiences were identified (e.g. perceptions, attitudes, feelings, beliefs, interpersonal dynamics, communication, therapeutic alliance). Inclusion and exclusion criteria were identified.
Phase 3: Reading the studies	The synthesised papers were read repeatedly to extract information relevant to relational experiences. Notes regarding key ideas were made for each synthesised paper in turn. A table was constructed with rows pertaining to synthesised papers and columns listing second order interpretations, first order interpretations (i.e. quotes), initial ideas regarding third order interpretations and contextual information (i.e. how second order interpretations related to one another).
Phase 4: Determining how the studies are related	A list of key metaphors, ideas, themes and concepts were created and juxtaposed in Microsoft Excel. Further reading and colour-coding of the key concepts resulted in the identification of four key aspects of the relationship under investigation: perceptions of clients, emotions evoked within professionals, behaviour responses of professionals and systemic / service contexts. Key concepts were grouped within each of these four domains to examine whether the four aspects of the relationship were sufficient to encompass all themes. Reciprocal translation was chosen as the preferred method of phase 5’s translation process due to the strong similarities identified between the second order interpretations of the synthesised papers. Although there were differences in the interpretations of why the phenomena arose, a refutational synthesis was not deemed to be necessary due to the similarity of the phenomena being described across the synthesis studies. For example ‘intense emotional issues’ were described across multiple papers; there was no refutation of the existence of this phenomena. However, it was interpreted differently across studies (e.g. heightened emotional reactivity or an exaggeration of affect). Initial third order interpretations were also noted at this stage.
Phase 5: Translating the studies into one another	The main concepts and a description for each were printed and physically sorted to integrate the meanings using reciprocal translation. This was conducted chronologically. 24 key concepts were identified. This was quality-checked by a further re-reading of the synthesis studies and comparison with the contextual information recorded in Phases 3 and 4. This process was purely translational (idiomatic). Conceptualisation and third order interpretations were avoided to ensure that the original interpretations were preserved.
Phase 6: Synthesising translations	A second level of synthesis was possible through interpreting the 24 key concepts generated in Phase 5. A line of argument process, a type of grounded theorising, was used to develop third order interpretations. This was facilitated by juxtaposing competing second order interpretations of phenomena and using psychological theory and language. These decision points were recorded to ensure reflexive description when expressing the synthesis in phase 7. This resulted in new conceptual understandings of the same phenomena. Care was given to the naming of the third order interpretations to reframe language perceived as negative.
Phase 7: Expressing the synthesis	The intended audience was identified as mental health professionals. A model was constructed which integrated the conceptualisations arising from the synthesis in phase 6.

Table 5
Translation of key metaphors, ideas, themes and concepts from the synthesised papers

Aspects of the Relationship	3rd order interpretations	2nd order interpretations	Description	Papers
Perceptions of Clients	Complexity and professional challenge	Ambivalence	Having conflicting feelings; positive and negative perceptions; fluctuating between hope and hopelessness; a desire to help versus dread	O'Brien & Flöte (1997); Bergman & Eckerdal (2000); Millar et al. (2012); O'Connell & Dowling (2013); Stroud & Parsons (2013)
		Complex and difficult to make sense of	Clients are complex; they have a lack of social support and enmeshed and dysfunctional families; professionals struggle to make sense of client's difficulties	O'Brien & Flöte (1997); Millar et al. (2012); O'Connell & Dowling (2013); Stroud & Parsons (2013); Hazelton et al (2006)
		Limited ability to change	BPD is untreatable or there is a limited ability to change; change is time-consuming, requiring longevity of input; clients sometimes sabotage their own progress. Professionals feel that their input is a waste of time	Woollaston & Hixenbaugh (2008); Commons Treloar (2009); Millar et al. (2012); McGrath & Dowling (2012); Stroud & Parsons (2013); Hazelton et al (2006)
	Emotional sensitivity	Intense emotional issues	Easily-upset over small things which are seen as unnecessary and inappropriate; oscillating between extremes; over the top reactions and exaggeration of feelings; self-harm is dramatised; clients often have a history of trauma, neglect or emotional abuse; they have a heightened sense of vulnerability and are attentive and attuned	Nehls (2000); Commons Treloar (2009); Millar et al. (2012); McGrath & Dowling (2012); Rizq (2012); O'Connell & Dowling (2013)
	Attempts to control overwhelming emotions	Out of control and unable to cope	Clients are chaotic and feel out of control; they can't cope over small things and have limited or poor coping skills (e.g. use self-harm to communicate distress; destructive behaviour)	Nehls (2000); Commons Treloar (2009); O'Connell & Dowling (2013)
		Threatening	Clients are threatening, controlling and intimidating; they have destructive behaviour and unresolved issues which they take out on professionals	Woollaston & Hixenbaugh (2008); Millar et al. (2012); McGrath & Dowling (2012); O'Connell & Dowling (2013); Hazelton et al (2006)
		Manipulative	Clients are manipulative; they can control their behaviour; they purposefully cause conflict in teams and prey on the vulnerable; they can have a hidden agenda and are not honest / genuine	Woollaston & Hixenbaugh (2008); Commons Treloar (2009); Millar et al. (2012); McGrath & Dowling (2012); O'Connell & Dowling (2013); Hazelton et al (2006)
	Care-seeking	Infringe upon boundaries	Clients have poor boundaries and so push professionals boundaries; they try to get to know professionals	Nehls (2000); McGrath & Dowling (2012); Rizq (2012)

Emotions	Strong, conflicting emotional responses	Attention-seeking	Clients seek attention from and place excessive demands upon professionals	Nehls (2000); McGrath & Dowling (2012); Hazelton et al (2006)	
		Strong, conflicting feelings	Professionals have a strong 'gut reaction' to clients; their feelings oscillate between extremes from sympathy and desire to help to dread	O'Brien & Flöte (1997); Millar et al. (2012); Rizq (2012); O'Connell & Dowling (2013); Stroud & Parsons (2013)	
		Empathy and interest	Professionals have a desire to help clients; they feel empathy, interest and sympathy	Bergman & Eckerdal (2000); Nehls (2000); Millar et al. (2012); Stroud & Parsons (2013)	
		Frustration and anger	Professionals have feelings of professional frustration and resent being made to feel responsible for clients behaviours (particularly self-harm)	Bergman & Eckerdal (2000); Woollasten & Hixenbaugh (2008); Commons Treloar (2009); Millar et al. (2012); McGrath & Dowling (2012); O'Connell & Dowling (2013)	
	Professional (in)effectiveness and personal agency	Confused, helpless, hopeless and inadequate	Professionals feel confused and unsure of interventions; they feel inadequate and have a sense of failure; question their profession; feel helpless and hopeless	O'Brien & Flöte (1997); Nehls (2000); Woollasten & Hixenbaugh (2008); Commons Treloar (2009); Millar et al. (2012); McGrath & Dowling (2012); Rizq (2012)	
		Hopefulness, Optimism and Reward	Professionals feel optimistic and enjoy the challenge of working with the client; they need to put in work to see results; when clients progress, it is very rewarding. These feelings are helped by optimistic outlooks regarding clinical practice	Woollasten & Hixenbaugh (2008); Millar et al. (2012); Rizq (2012); O'Connell & Dowling (2013); Hazelton et al (2006)	
	Frightened, trapped and overwhelmed	Frightened, anxious and distressed	Professionals experience distress from listening to the client's trauma and witnessing self-harm and suicide; there is a fear of connecting with the client and getting involved in an intense relationship; anxiety over risk	O'Brien & Flöte (1997); Nehls (2000); Woollasten & Hixenbaugh (2008); Millar et al. (2012); Rizq (2012); Stroud & Parsons (2013)	
		Stressed, trapped and overwhelmed	Professionals feel professionally challenged and overwhelmed; they feel exhausted, drained, burnt-out but the 'bottomless neediness' of the client; they feel a pressure to do something which lead to them feeling like a prisoner	Nehls (2000); Commons Treloar (2009); Millar et al. (2012); Rizq (2012); O'Connell & Dowling (2013); Stroud & Parsons (2013)	
	Actions	Establish therapeutic relationship and calibrate emotional involvement	Building a therapeutic relationship	Professionals try to work on engagement, establish trust and build a therapeutic relationship; professionals also report avoiding giving care, giving minimal care or limit their time with the client	O'Brien & Flöte (1997); Nehls (2000); Millar et al. (2012); McGrath & Dowling (2012); O'Connell & Dowling (2013)
			Self-awareness and managing boundaries	Professionals need to self-monitor and maintain self-awareness in the relationship; calibrate emotional involvement and monitor boundaries; professionals report being connected or disconnected: either	O'Brien & Flöte (1997); Nehls (2000); Woollasten & Hixenbaugh (2008); Millar et al. (2012); McGrath & Dowling (2012); Rizq (2012); Stroud & Parsons (2013)

		withdrawing emotionally and forming rigid boundaries or engaging with client on an emotional level	
	Assess risk and manage professional threat	Assessing and documenting risk	Professionals are always 'extra alert', managing risk, closely monitoring disclosures and concern; they manage professional threat by documenting communications so nothing can be used against them
	Attempts to understand	Search for answers	Professionals try to make sense of the chaos; search for explanations
Perceptions of Services	Inconsistency and conflict	Team conflict	Professionals report being in conflict with colleagues, team splitting and mistrust evoked within the professionals team
		Lack of knowledge and need for a common outlook and training	Professionals report a lack of knowledge and training; variation in professionals understanding; inadequate treatment; problems with the diagnosis; inadequate care and neglect by services and the need for a common outlook
	Inadequate services	Lack of resources	Professionals report a lack of resources including professionals and time; feeling 'stuck' with the client
		Need for emotional support	Professionals report needing support and advice, particularly emotional support and that supervision is essential
			O'Brien & Flöte (1997); Nehls (2000); Woollaston & Hixenbaugh (2008); Rizq (2012); O'Connell & Dowling (2013)
			O'Brien & Flöte (1997); Millar et al. (2012)
			O'Brien & Flöte (1997); Commons Treloar (2009); McGrath & Dowling (2012); O'Connell & Dowling (2013); Hazelton et al (2006)
			Bergman & Eckerdal (2000); Commons Treloar (2009); Millar et al. (2012); O'Connell & Dowling (2013); Stroud & Parsons (2013); Hazelton et al (2006)
			Commons Treloar (2009); Rizq (2012); Stroud & Parsons (2013)
			Bergman & Eckerdal (2000); Rizq (2012); O'Connell & Dowling (2013)

Figures

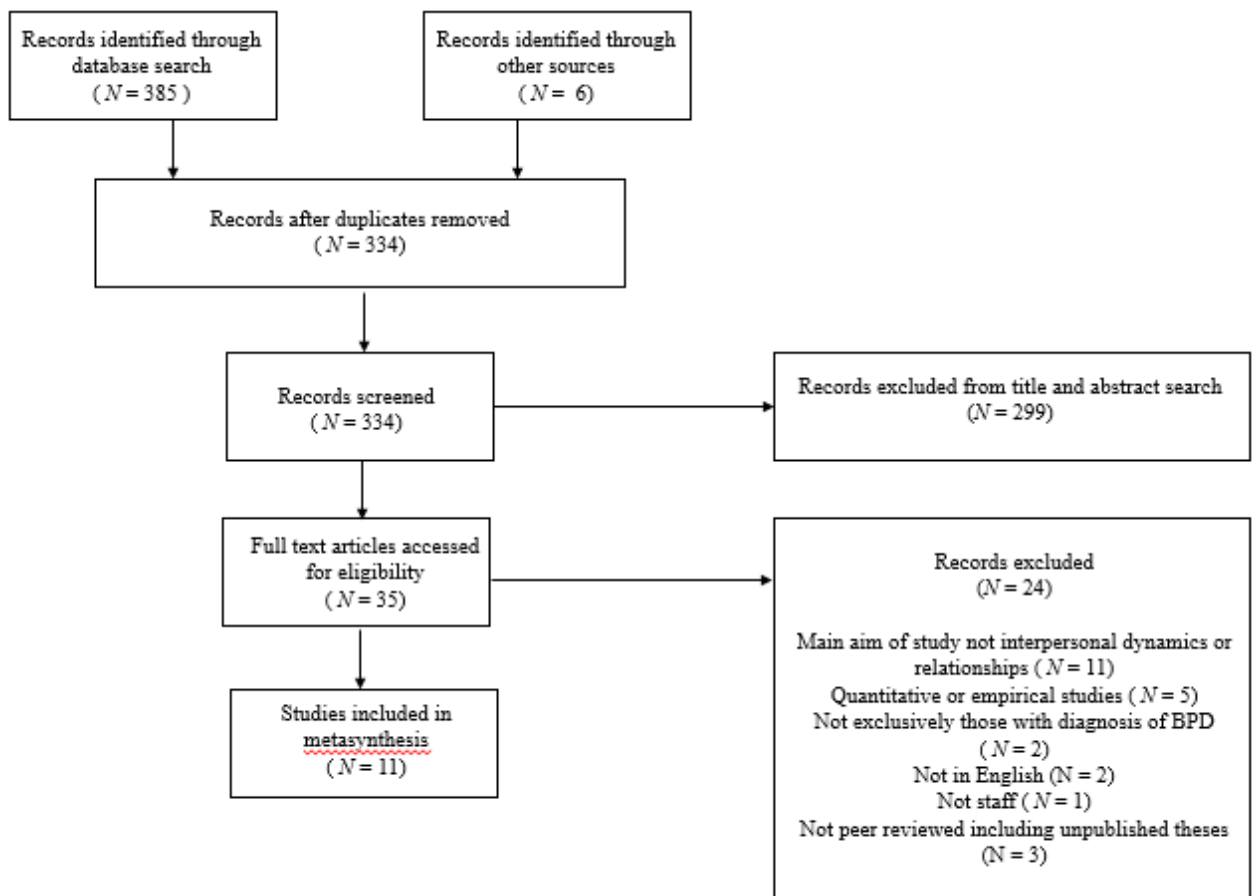


Figure 1. Systematic Search

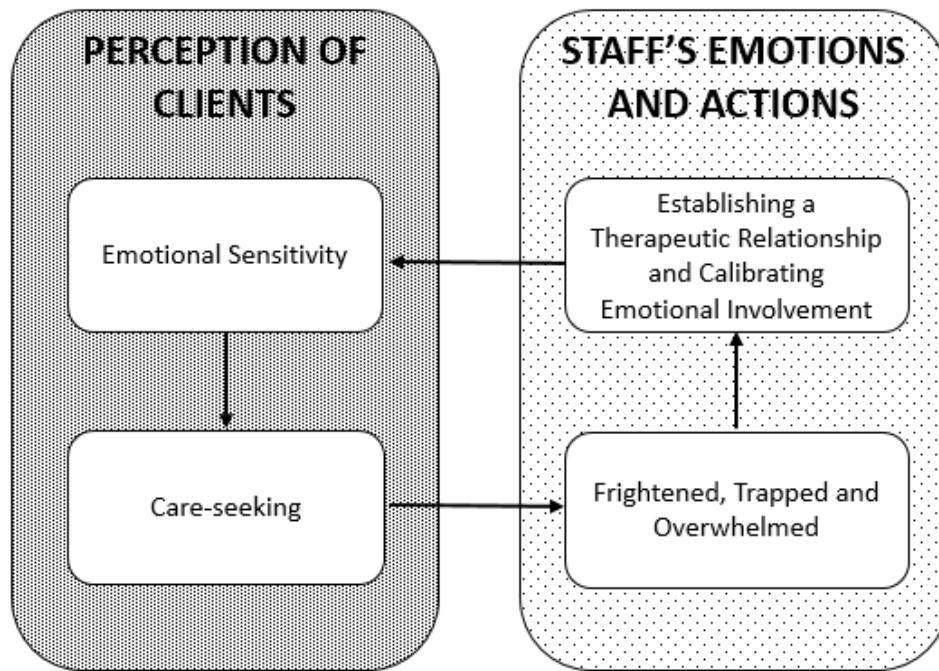


Figure 2. Relational Dynamics between Adults with a Diagnosis of BPD and Mental Health Professionals: Pattern 1.

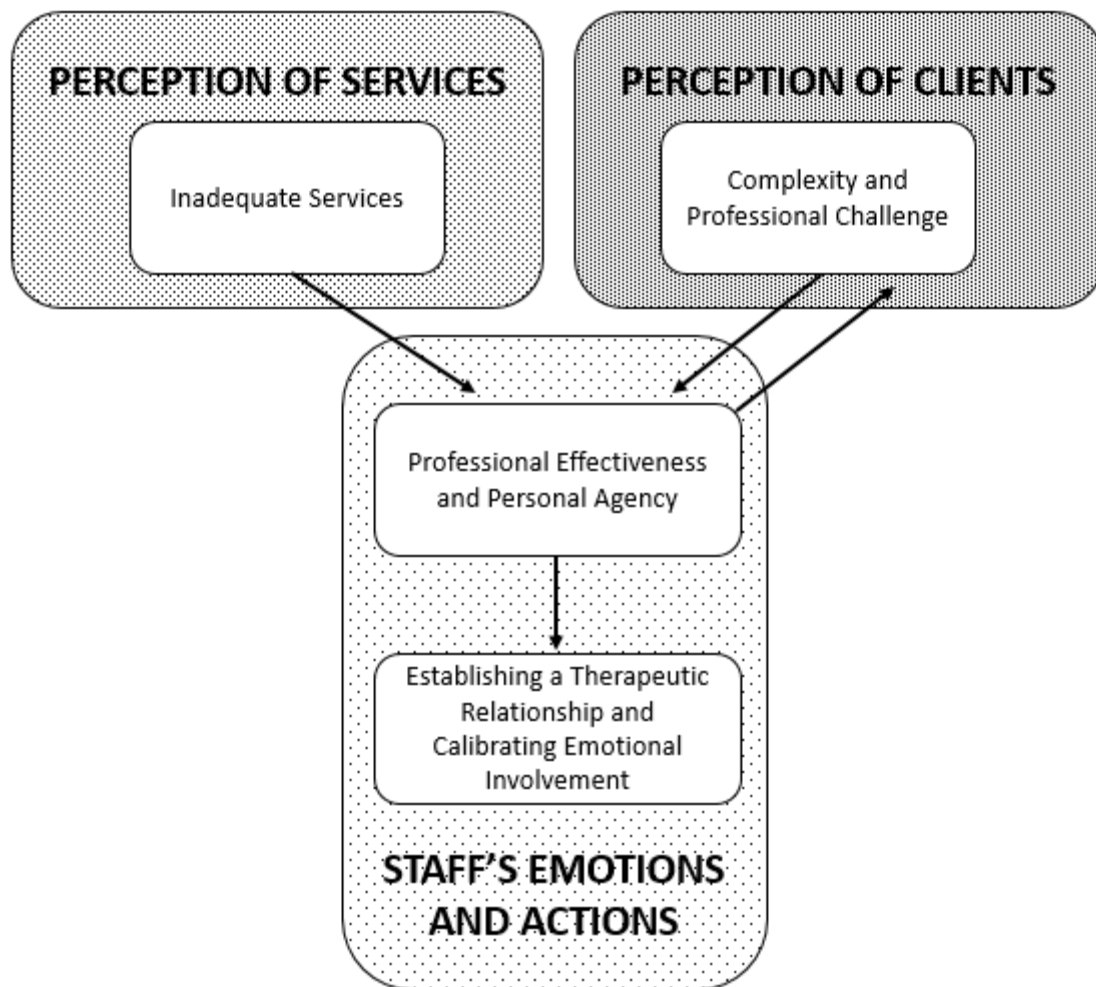


Figure 3. Relational Dynamics between Adults with a Diagnosis of BPD and Mental Health Professionals: Pattern 2.

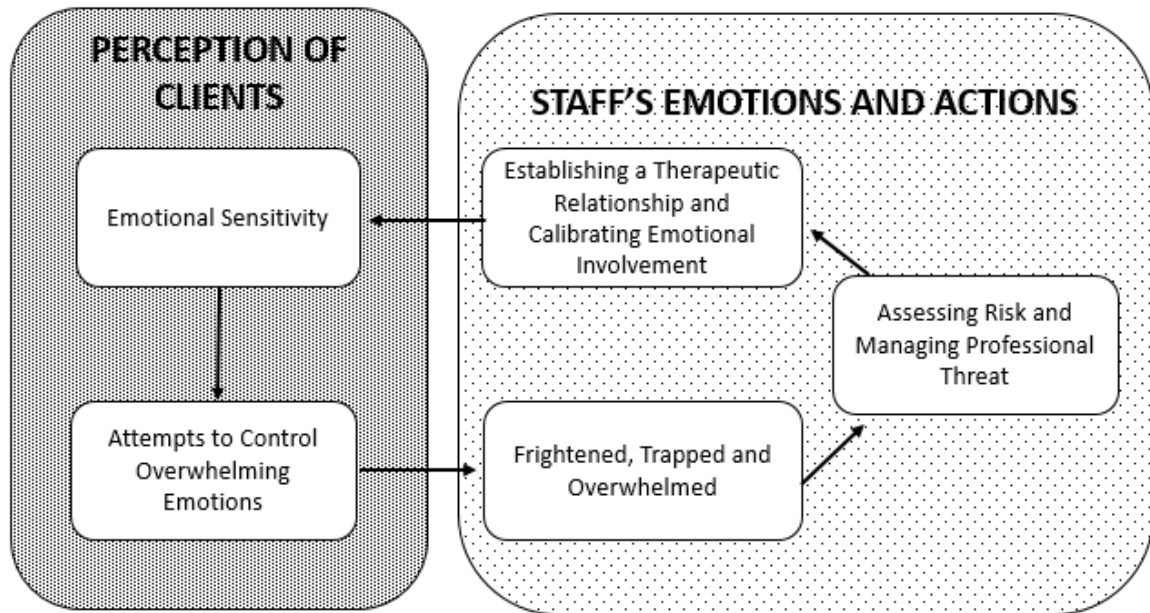


Figure 4. Relational Dynamics between Adults with a Diagnosis of BPD and Mental Health Professionals: Pattern 3.

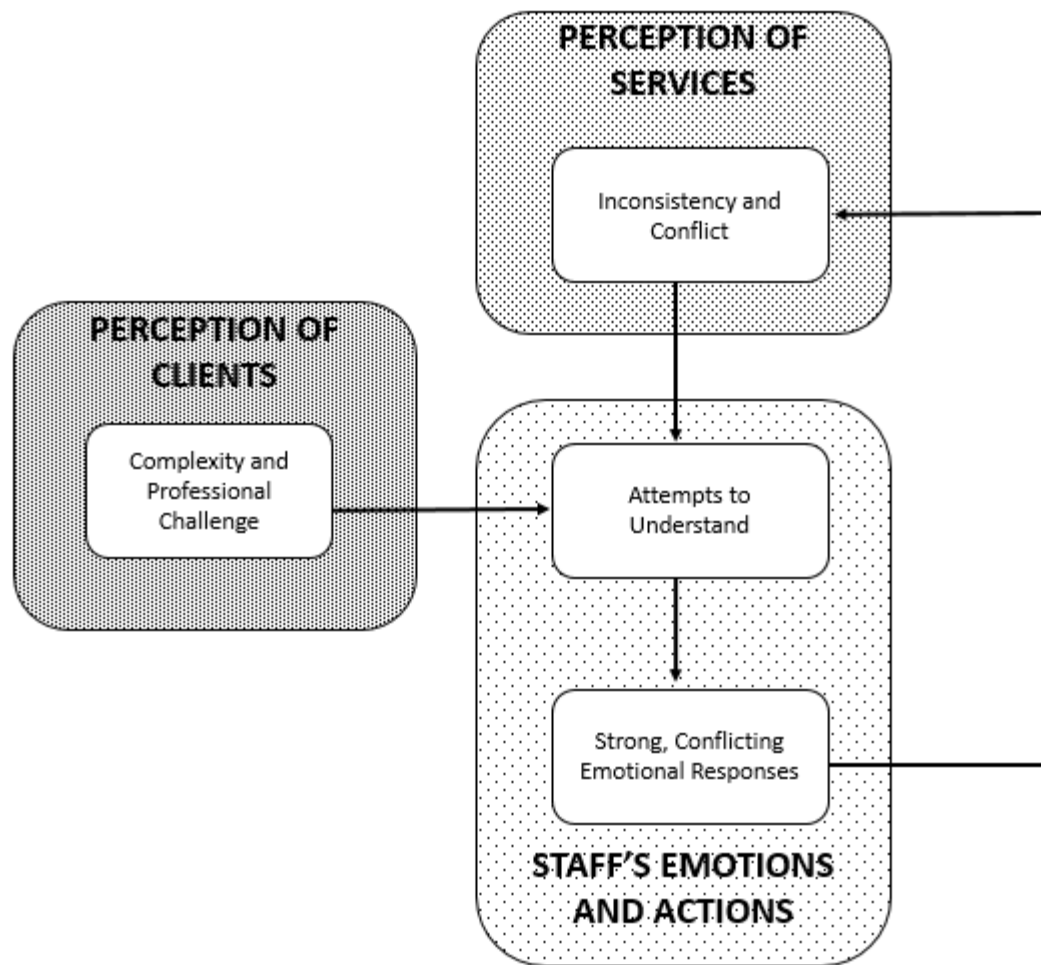


Figure 5. Relational Dynamics between Adults with a Diagnosis of BPD and Mental Health Professionals: Pattern 4.

Appendices

Appendix 1-A: Author Guidelines for The British Journal of Clinical Psychology

Author Guidelines

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

All papers published in The British Journal of Clinical Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

The word limit for papers submitted for consideration to BJCP is 5000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, figures, or tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length. In such a case, the authors should contact the Editors before submission of the paper.

3. Submission and reviewing

All manuscripts must be submitted via [Editorial Manager](#). The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the [terms and conditions of submission](#) and the [declaration of competing interests](#). You may also like to use the [Submission Checklist](#) to help you prepare your paper.

4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use [this](#) template. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the [Project CRediT](#) website for a list of roles.
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.
- All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.
- All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
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5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

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Chapter 2: Research Paper

Experiences of Compassion in Adults with a Diagnosis of Borderline Personality Disorder: An Interpretative Phenomenological Analysis

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Abstract

The study explored experiences of compassion in adults with a diagnosis of Borderline Personality Disorder (BPD) to further the development of the construct of compassion in relation to BPD. Interpretative Phenomenological Analysis was used to develop themes from the narratives of six adults with a diagnosis of BPD. Five themes emerged: *Emotional Connection to Suffering, Empathic Understanding, Prioritisation of Needs, A Model of Genuine Compassion and Developing Self-acceptance and a Sense of Worthiness*. The themes were integrated into a recovery model that highlighted the process of recovery through therapeutic relationships which model genuine compassion. In addition, barriers to compassion and factors that facilitate the development of compassion emerged from the analysis and have implications for clinical practice.

Keywords: Borderline Personality Disorder, Compassion, Qualitative, Interpretative Phenomenological Analysis

Practitioner Points

- Compassion has implications for recovery for individuals with a diagnosis of BPD.
- Compassionate relationships with mental health professionals can be therapeutic in their own right. Therefore, therapeutic relationships focusing on providing the conditions necessary for compassion can be expanded as an intervention.
- Continually prioritising the needs of another in the absence of compassion from others can lead to compassion fatigue and burn out. Therefore, it is essential that mental health professionals are supported in their work

Borderline Personality Disorder and Compassion

In order to bring a relational focus to the reductionist narrative of BPD, as described in Chapter 1, the current study considered the concept of compassion. Compassion “brings us into a felt relationship with the pain and needs of some other” (Harrington, 2002, p. 21) and is considered to flow between people in three directions: compassion received from others, compassion given to others and self-compassion (Gilbert, 2009). Compassion is defined as “a basic kindness, with deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it” (Gilbert, 2009, p.xiii). Gilbert (2010) outlined six key attributes that facilitate compassion towards self and others: 1) A motivation to be compassionate; 2) A sensitivity and openness to recognising thoughts, feelings and needs; 3) An emotional openness and sympathy towards suffering; 4) A tolerance of emotions; 5) Empathy to reflect upon and understand thoughts and feelings; and 6) A non-judgemental stance. From this perspective, compassion is not viewed as simple kindness, but as a wise and courageous stance of embracing, understanding and providing relief to the suffering of self and others.

The Role of Shame and Self-criticism

Shame is proposed to be an emotion which indicates a lack of self-compassion (Westphal, Leahy, Pala & Wupperman, 2016) and self-criticism is the cognitive precursor to shame (Warren, 2015). Negative early life experiences are proposed to underlie the development of shame and self-criticism (Satici, Uysal & Akin, 2015). Multiple studies have linked trauma such as abuse and neglect to low self-esteem and the development of shame in people with a diagnosis of BPD (Finzi-Dottan, 2006; Horn, Johnstone & Brooke, 2007; Krawitz, 2012a; Schanche, Stiles, McCullough, Svartberg & Nielsen, 2011; Warren, 2015).

In a quantitative study, Rusch et al. (2007) found that women with a diagnosis of BPD reported higher levels of guilt and shame than other people; and that levels of shame correlated with tendencies towards self-criticism. Similarly, Holm, Berg and Severinsson (2009) conducted a qualitative study investigating the impact of trauma in early life and how it influenced the daily lives of women with a diagnosis of BPD. One of the themes was entitled 'living with a sense of guilt and shame' in which participants described feelings of shame and self-loathing. Brown (2006) described the distinction between guilt and shame as "I did/said/believed something bad" versus "I am bad", respectively (p.50). Thus, guilt is considered to be a feeling of discomfort caused by an action, or lack thereof, which conflicts with our values; whereas shame is an intensely painful feeling related to a belief that we are flawed and unworthy of love and connection (Brown, 2006). Cultivating self-compassion is considered to be a promising intervention for feelings of shame (Warren, 2015), self-loathing and low self-esteem (Krawitz, 2012b).

Compassion-Focused Approaches

Compassion-focused interventions have been demonstrated as effective across a variety of diagnostic groups including people with diagnoses of eating disorders, psychosis, personality disorders and addictions (Leaviss & Uttley, 2015). The most well-known compassion-based psychological intervention is Compassion Focused Therapy (CFT; Gilbert and Procter, 2006). CFT aligns with the theory that human beings have a tripartite emotion regulation system related to threat, motivation and contentment and proposes that activating feelings of contentment can have beneficial effects upon emotion regulation (Gilbert, 2005). This has implications for interventions with people with a diagnosis of BPD as emotion dysregulation is proposed as a maintaining factor for life difficulties (Warren, 2015). In

addition, a qualitative study exploring individuals' experiences of CFT for trauma proposed that challenging self-criticism led to increased self-compassion and this, in turn, facilitated positive emotions and a positive outlook (Lawrence & Lee, 2014).

Two recent studies have been conducted to explore the effectiveness of compassion-focused approaches for people with a diagnosis of personality disorder. Lucre and Corten (2013) ran a 16-week CFT group and found a beneficial impact on a range of outcome measures which were maintained at 1-year follow-up. In addition, Feliu-Soler et al. (2016) conducted a study investigating the effectiveness of a 3-week training programme in loving kindness meditation (LKM) and compassion meditation (CM) for people with a diagnosis of BPD. Although LKM and CM are similar in practice, LKM developed from a Buddhist tradition, while CM is the term used within Western psychology practices. LKM and CM both aim to foster a deep sympathy and kindness towards all of humanity. However, CM also incorporates an earnest desire to relieve the suffering of others (Hofmann, Grossman, & Hinton, 2011). Moderate to large effect sizes were found in the LKM/CM group for reductions in 'BPD severity' and self-criticism as well as increases in mindfulness, self-kindness and acceptance.

Attachment Theory and Compassion

Attachment theory originated from John Bowlby's research exploring the impact of a caregiver's love and affection for an infant and the profound impact it had on the emotional development of a child (Gilbert, 2009). Different attachment strategies are adopted by a child in response to the type of care received from their caregiver (Gillath, Shaver & Mikulincer, 2005). The aim of these strategies is to ensure safety in response to perceived threat and meet the need for emotional regulation (Schore, 2001). Although there is likely to be a complex

interplay between biological, environmental and psychosocial factors, attachment experiences have been hypothesised as playing a role in the development of difficulties experienced by individuals with a diagnosis of BPD (Agrawal, Gunderson, Holmes & Lyons-Ruth, 2004).

Gillath et al., (2005) proposed that compassion between caregiver and child is one of the mediating variables between attachment experiences in childhood and later development. Indeed, many of the original terms used within attachment theory, including ‘availability’, ‘empathy’, ‘sensitivity’ and ‘responsiveness’ are components of compassion (Gillath et al., 2005). They also correspond with the attributes of compassion outlined by Gilbert (2010) including sensitivity, sympathy and empathy towards thoughts and feelings as well as a motivation to relieve suffering.

Gerhardt (2004) suggested that individuals with a diagnosis of BPD have primarily experienced caregiving that was emotionally invalidating, leaving them feeling “emotionally abandoned” as children (p. 176). Emotional invalidation is the lack of recognition of, and/or subsequent dismissal of emotion (Gerhardt, 2004). This definition aligns with Gilbert’s (2010) assertion that compassion includes the recognition and relief of suffering. Thus, emotional invalidation can be viewed as the absence of compassion and emotional validation a necessary component of compassionate caregiving.

Self-compassion is also thought to develop through the attachment relationship with a caregiver in early childhood (Neff & McGehee, 2010). Raque-Bogdan et al. (2011) suggested that self-compassion and mattering (the belief that others care about one’s existence) are mediators between attachment relationships in early life and later mental health. Wei et al. (2011) explored this relationship and found that self-compassion mediated the relationship between attachment anxiety and wellbeing. A study by Pepping et al. (2015) found that low levels of self-compassion were associated with high levels of parental rejection, overprotection and low warmth and that this relationship was mediated by attachment anxiety.

Westphal, Leahy, Pala and Wupperman (2016) investigated the relationship between adverse parenting (abuse and indifference), emotional invalidation, self-compassion and mental health difficulties (specifically, depression, BPD and post-traumatic stress disorder). They found that emotional invalidation in childhood was strongly associated with a lack of self-compassion in participants from these diagnostic groups.

Compassion in Services

Healthcare policies and drivers regularly cite compassion as an important value in services. Some authors argue that economic constraints and pressures on staff have resulted in the loss of a compassionate value base (Bradshaw, 2009). Pearcey (2010) described the UK National Health Service (NHS) as experiencing a crisis of compassion in which mental health nurses feel that they are unable to provide high standards of compassionate care due to time pressures. An increasing number of policies and guidelines are being developed to inform the integration of compassion within healthcare (e.g. Department of Health, 2012; de Zulueta, 2013).

A lack of compassion within services is particularly relevant for people with a diagnosis of BPD due to the stigma, pejorative labelling and difficult relationships that exist between these individuals and mental health professionals (Woollaston & Hixenbaugh, 2008). Stigma and pejorative labelling perpetuate feelings of shame within adults with a diagnosis of BPD (Aviram, Brodsky & Stanley, 2006). The recovery literature suggests that developing a sense of self-worth is important for this client group (Katsakou et al., 2012) and that compassion has positive impact upon sense of self (Krawitz, 2012a).

The aim of the current study was to qualitatively explore the experiences of compassion in people with a diagnosis of BPD to develop a relational understanding and challenge stigma associated with the reductionist narrative.

Method

Design

As experiences of compassion in adults with a diagnosis of BPD is a new and developing research area, research is required which aims to develop a theoretical understanding. No studies so far have adopted a qualitative approach to exploring this topic and so this methodology was adopted to enable an inductive, theoretically-exploratory approach.

One to one interviews were conducted to generate rich, contextual information from participants. Interpretative Phenomenological Analysis (IPA) was chosen as its phenomenological, idiographic stance enables the consideration of individuals' personal perceptions of their experiences (Smith, 2004). IPA enables the exploration of how participants interpret subjective phenomena while retaining their stories and contexts (Smith, Flowers & Larkin, 2009). The IPA researcher additionally interprets the interpretations of multiple participants to produce themes (categorised patterns within participant narratives).

Participants

Using purposive sampling, adults with a self-reported diagnosis of BPD were invited to participate. Participants were not excluded based upon having received other diagnoses and, although all participants reported a formal diagnosis of BPD, participants differed in their relationship to the diagnosis. For example, some participants renounced diagnostic classification and others described identifying more with alternative diagnoses (e.g. complex post-traumatic stress disorder).

Participants were recruited from advocacy groups, support groups and online via Twitter. To be eligible for inclusion in the study, participants were required to meet the following criteria: 1) be willing and able to give informed consent for participation, 2) be aged 18 years old or above, 3) have a diagnosis of BPD, 4) be resident in the United Kingdom (for the purpose of conducting face-to-face interviews) and 5) have a basic level of English. Individuals were not eligible to participate if they were deemed unable to consent to take part or if taking part was deemed to be detrimental to their wellbeing.

Six White British women participated in the research and their ages ranged from 28 to 57 years ($M = 41$; $SD = 12$). All participants described themselves as currently stable and felt that they did not require support from mental health services at the time of recruitment. A small, homogenous sample is required in IPA due to its idiographic stance, enabling detailed case-by-case analysis (Smith et al., 2009). Participant summary information is provided in Table 1.

Procedure

Ethical approval was obtained from Lancaster University Research Ethics Committee. All project materials were developed in collaboration with a service user expert group and are available within the ethics supplement. The language used in the study reflects the language recommended by these stakeholders.

The study was advertised online via Twitter and through attending meetings at services (advocacy groups, community support groups) located in Scotland and the North of England. Interviews were conducted using a semi-structured interview schedule which aimed to establish participants' understanding and experiences of compassion in the context of their life experiences and its relationship to their diagnosis. The broad structure was as follows: 1)

The concepts of compassion and BPD; 2) Experiences of receiving compassion from others across the lifespan; 3) Experiences of giving compassion to others across the lifespan; 4) Experiences of self-compassion across the lifespan; and 5) Overall impressions of the relationship between these aspects of compassion and BPD. Prompts were provided to encourage reflection on the meaning of experiences and deviations from the schedule were made to allow for the emergence of new information and different perspectives brought by the participants (Appendix 2-B). Interviews were recorded using an audio recording device and subsequently transcribed.

Five interviews were conducted face-to-face in the community and one interview (Catherine) was conducted via telephone. Interviews lasted between 56 and 132 minutes ($M = 86$; $SD = 27$).

Data Analysis

IPA was conducted in line with guidance provided by Smith et al. (2009). The five stages were as follows: 1) Transcripts were read and re-read and notes were recorded in a reflective field diary; 2) Transcripts were copied to an Excel spreadsheet and adjacent columns used to record annotations; 3) Emergent themes were developed from annotations for each participant; 4) Superordinate themes were developed by searching for connections between emergent themes for each participant; and 5) Overarching themes were developed by integrating superordinate themes. Table 2 provides detailed information of the five stages of the guidance outlined by Smith et al. (2009).

Quality and Reflexivity

Yardley (2000) suggested that four principles should be upheld to ensure quality in qualitative research: sensitivity to context, rigour, transparency and importance. These attributes were upheld by ensuring a reflexive approach to the analysis (acknowledging the impact of the researcher's subjectivity and assumptions). In phenomenological approaches, meaning is co-constructed through the interaction between the participant and researcher (Shaw, 2010). Therefore, qualitative analysis can never be objective and so reflexivity is an important component during interpretation and theme development to ensure quality.

I kept a reflective field diary to record notes at the post-interview, transcription and analysis phases. In addition, an iterative process of noting impressions and interpretations and then referring back to the original context of the transcript was conducted to ensure sensitivity to context and rigour. Transparency was achieved by providing a detailed account of the analysis (See Appendix). To provide a broader perspective on the interpretation of the data, each stage of the analysis was checked by my supervisor and feedback on emergent themes was provided by the participants. In addition, the analysis phase was completed before a review of the literature was conducted to facilitate an inductive, theoretically-exploratory approach and limit the impact of pre-existing assumptions.

Findings

Five overarching themes were identified: Theme 1: Emotional Connection to Suffering; Theme 2: Empathic Understanding; Theme 3: Prioritisation of Needs; Theme 4: A Model of Genuine Compassion; Theme 5: Developing Self-acceptance and a Sense of Worthiness. The superordinate themes which contributed to these overarching themes are illustrated in Appendix F.

Theme 1: Emotional Connection to Suffering

This theme represents the importance of establishing an emotional connection to suffering in order to experience compassion. Participants described experiencing intense emotions which led to a heightened compassion for others. Many of the participants engaged in vocations and personal relationships where they adopted a caring role. Some participants described this as an attempt to heal their own suffering through giving compassion to others. Despite experiencing heightened compassion for others, participants found receiving compassion from others and self-compassion difficult. They related this to difficulties in connecting with one's own emotions and fears of being vulnerable with others.

Emotional connection to suffering appeared to lie at the heart of participants' descriptions of experiencing compassion: "To be able to tolerate them if they're in pain and just accept the pain that they're in rather than trying to deflect it" (Sophie). This was described by Catherine when reflecting upon her work with children and encountering a young boy's distress: "Compassion was hearing his pain...being there in that moment with him, in that pain, and holding him while he broke his heart...moving on that journey with him because he'd never experienced pain like that".

All participants described experiencing intense emotions and how this heightened their feelings of compassion towards others. For example, Sophie described the way in which her heightened emotional experiences impacted her perception of the level of emotional distress in others: “Perhaps because of me feeling things more intensely, perhaps other people might not feel so bad but from my experience I feel like oh that would feel absolutely awful”. For some participants this led to experiencing compassion very intensely: “I’ve noticed a lot of people with borderline are the same, they’re absolutely desperate to care for other people, overwhelmingly full of compassion, but sometimes showing it in the right way can be hard” (Deborah); “I’m hyper sensitive to emotions, you know they talk about that emotional burns victim idea and I think that’s where that over-compassion can come” (Alice).

In relation to receiving compassion from others through emotional connection, Natalie recalled a memory of a psychiatrist’s response to her harming herself: “It was as if he genuinely cared, I could see in him, that yeah, you know, a sense of it hurt him to see that I was hurting so much and that he really cared”.

These experiences of giving and receiving compassion through emotional connection highlight its reciprocal nature. Three participants described a process of vicarious reparation in which they made attempts to heal themselves through being compassionate to others due to an awareness of their own needs for compassion. Natalie described this experience in her work with young children who had experienced sexual abuse: “In some ways it was about, by trying to do something for them, it was about the only way that I could relate to the young person, the child, who’d been so badly damaged back there” (Natalie). For Laylie and Deborah, this occurred within the context of friendship: “I think one of the reasons I’ve supported her for so long is that I see a lot of me in her at that age...I think I kind of want to give to people what was never given to me” (Laylie); “Was I doing it because I really wanted

to fix me and it was like making up for the things that were wrong with me if I could make it better in someone else?" (Deborah).

Despite experiencing an emotional connection with others and the resulting heightened compassionate response towards them, all participants described difficulty in connecting with their own emotions: "I tend to shut my emotions down, I'm scared of uncomfortable feelings so I tend to just turn them off as soon as I feel them" (Laylie). Some participants related this to their experiences of emotional learning in childhood: "I was constantly having to rein in my own emotions and not have them justified or validated to kind of care for others" (Alice). Moreover, the emotional connection that is elicited with another when receiving compassion resulted in uncomfortable feelings of vulnerability for some participants: "You don't want people in your guts, it feels like a million hands in your guts" (Alice). These feelings of discomfort in relation to vulnerability were a barrier for sharing emotional distress with others and so inhibited the potential of receiving compassion: "If I'm at all vulnerable, then all the shutters come down, and padlocks go on" (Catherine).

In addition to emotional disconnection as a barrier to receiving compassion from others, it impacted upon participants' ability to offer themselves compassion. Participants discussed finding self-care (i.e. practical ways of caring for themselves) easier than self-compassion due to the absence of emotional connection involved. For example, Catherine described: "I can do practical things, have a bath, lie down for an hour or read a book for an hour, because I can just dissociate from it and get on with it and do it".

Theme 2: Empathic Understanding

This theme reflects the importance of understanding another's emotions as a consequence of their life experiences. For some participants, self-understanding enabled them

to receive compassion from others as they were able to communicate the reason for their emotions and actions. In particular, this related to understanding the impact of trauma. Emotions were more readily made sense of as a result of this and it led to a sense of empowerment and increased self-esteem. Empathic understanding was also necessary in order to provide compassion in a person-centred and helpful way.

Participants described how understanding facilitated compassion: “I would struggle to give someone compassion if I didn't understand” (Deborah). This was achieved through genuine connectedness by making a conscious effort to understand the mind of another: “‘It all comes back to listening’ is a really shite, trite line that I was going to trot out there, but you know that active listening, not just listening, you know, but hearing and acting upon that”. Participants described the way in which stereotypes and labels can hinder this process of genuine connectedness and understanding. For example, Sophie described the impact of her diagnosis upon a psychiatrist’s understanding: “I think it maybe comes back to judgement as well because he [psychiatrist] had clearly judged me based on the diagnosis rather than as a person”. Similarly, having “expectations about how others should act in a given situation” (Deborah) and “making assumptions” (Alice) obstructed genuine connectedness and understanding.

The development of self-understanding facilitated compassion from others through enabling the communication and sharing of this understanding. As described by Alice: “I know what's wrong with me, I know what's going on, so I can turn round to someone and say actually that's made me really paranoid because of this, this and this; whereas before I would've just internalised it”. For some participants, this related specifically to gaining insight through understanding the impact of trauma upon them. For example, Deborah described: “My mum really is probably compassionate in the true sense in that she's using empathy because she knows my history and she knows the things that I have been through”.

Catherine described how having knowledge of the impact of trauma can facilitate understanding in the moment and so facilitate a compassionate response:

They can hear the bigger picture so it's not just oh that's happening in the here and now, they can hear the whole big picture attached to that...I can hear the abuse and I can empathise and I can feel and I get it, that's compassion: 'I get it'.

Natalie described how her self-understanding of the impact of the trauma upon her emotions and personality was impeded by her diagnosis of BPD:

My BPD label was something which I was very clear about, this is what I have and this is why I feel like this, but you know I also related as a survivor of abuse and didn't really connect the two so much as I do now, I can see now that that had a big impact on how a lot of things about me developed.

Gaining this understanding of the impact of her experiences of abuse, Natalie gained a sense of empowerment and self-esteem:

I got involved in things like women's groups and started to question some of the things I'd been told and also started to, em, think about my experiences of abuse and see them in a different way rather than just this sense of guilt about things and blaming myself.

Understanding further facilitated compassion as this knowledge could be utilised to offer compassion in a person-centred way. As described by Deborah: "Compassion is so different for everyone, what works for one person is not going to work for another person". Therefore, in order to provide compassion in a way that is helpful, it is important to understand the needs of another. Alice described the distinction between the genuine feeling of compassion and the way in which it is demonstrated: "It might be a display of very well meant, very deeply felt compassion, but the act itself might not be compassionate". This was

in reference to someone she perceived as being genuinely compassionate towards her, but who lacked the understanding of how she would have liked to have received this compassion: “She thought that a lot of the stuff she was doing was being compassionate without actually checking in with me”.

Theme 3: Prioritisation of Needs

This theme reflects the selflessness involved in giving compassion to others and the necessity to prioritise one’s own needs to offer compassion to oneself. Participants described how the selfless subjugation of one’s own needs to give compassion to others can become draining over time and lead to feelings of resentment. For some participants, this also led to them becoming unwell through not attending to their own needs. Participants described difficulty with self-compassion due to concerns that prioritising their own needs was a selfish or self-indulgent act and, as such, elicited feelings of guilt.

All participants described the selflessness involved in compassion: “I think it is very much on the scales towards being an act that is all about giving” (Deborah). Alice described the genuine nature of compassion and the way in which it is given freely: “I think it's compassion that just comes from very genuine love and it's, there's not anything else driving it, there's not a kind of self-serving nature behind it” (Alice). When participants described receiving genuine compassion from others, they alluded to their needs coming first and the potential cost to the other: “he [my psychiatrist] was able to, first of all make a decision in my interest, which felt like he was putting himself, like, he was taking a risk but, you know, trying to do things that he felt were right for me” (Natalie).

A pattern evident within the participants’ accounts of compassion was that of putting others’ needs before their own, while having difficulty attending to their own needs: “I’m

really good at giving compassion to other people, but I'm shit at giving it to myself" (Laylie). They described this as being "overly compassionate" (Alice) or providing "over the top compassion" (Deborah) and questioned whether this was genuine compassion: "I thought what I was doing was being kind and caring, however what I've realised since I've been doing CAT [Cognitive Analytic Therapy] is that I'm just repeating patterns from childhood where I try and fix everybody" (Laylie). According to three participants (Alice, Laylie and Natalie), this arose from having been a young carer and so learning, and being expected, to prioritise the needs of others above themselves: "The interesting thing about self-compassion is we're really not taught it, we're taught to do the complete opposite from when we are children, that it's right to put other people before yourself" (Alice).

Participants described the feelings elicited by continually putting the needs of others before themselves. Laylie described her compassion towards others as leading to "anger, resentment and frustration...then feeling bad for feeling resentful and angry". In the same way, Deborah described the impact upon others of them showing compassion towards her and receiving none in return: "People who had to do a lot of caring for me became really resentful towards me because of the lack of compassion people showed them". She described compassion as being finite: "People are like a bottle of water you've only got so much to give and then you are empty". She suggested that a lack of compassion arises due to people "becom[ing] toughened to a point where [they] stop caring and stop showing compassion because compassion can be incredibly draining".

Moreover, by placing their own needs second to others', some participants became unwell. For Natalie, this led to a "hospital admission" while Laylie described becoming "burnt out, because all I was doing was caring about these other people and listening to their traumas and not having dealt with mine" (Laylie).

All participants described difficulty with self-compassion due to difficulties in attending to their own needs. Participants related this to their early life experiences of not having had their needs met as children: “I was never taught kindness...basic human rights and basic human needs were never taught to me” (Catherine); “I really, really struggle with food which I suppose is a basic self-compassion...I never really got my basic needs met as a child so, I don't know how I'm supposed to meet them now, food is a big one” (Laylie).

In addition to not having learned how to meet their own needs as children, some participants described difficulty with self-compassion due to a learned pattern of placing others' needs before their own: “Perhaps that sense of put other people before yourself stops self-compassion” (Alice). Many participants felt uncomfortable about practising self-compassion due to feelings of being selfish or self-indulgent that arose from prioritising their own needs: “If I'm compassionate to myself, I feel like I'm being selfish” (Laylie); “The biggest compassionate act to myself to allow something a little bit selfish in there that I wanted to be doing” (Deborah); “I know with me it's very like a feeling of being self-indulgent or weak that will stop me” (Alice).

Theme 4: A Model of Genuine Compassion

The previous three themes described participants' views of the elements that constitute compassion, including emotional connection to suffering, empathic understanding and the prioritisation of needs. Theme four reflects the way in which participants' experiences of care from others contributed to the development of their models of compassion. Through having not received compassion from others, or experienced feigned displays of compassion, participants described that they had not developed a model of genuine compassion in early life. This led to a reluctance to receive compassion from others.

However, participants described that, through receiving compassion, they were able to develop a model of compassion which they could use to be compassionate towards themselves and provide compassion to others in a healthy way. This ability to embrace compassion was facilitated by feelings of safety and trust.

Participants discussed that they had either “never had any model for compassion” (Sophie) or had unhealthy experiences of “false compassion” (Alice). This resulted in “the wires [of what compassion is] becoming very, very crossed” (Alice). For example, Alice described viewing “compassion as a form of power” and having seen compassion “used as quite a manipulative thing, where people are giving the air of being compassionate very much for self-validation or to control other people”. Laylie described a similar experience: “I’ve been through a lot of domestic violence and, you know, these guys, they can be compassionate, you know, couldn't have been nicer until it turned”. These experiences led to a reluctance to receive compassion from others: “At first you do bat it [compassion] off” (Alice). This was related to feelings of distrust and suspicion: “If somebody is kinda nice to me, I automatically think what are you after...because I don’t trust their motives” (Laylie);

Compassion seems quite difficult for me to receive because I don't trust people, I'm very untrusting, em, I find it's possibly one of my biggest issues so it always comes with a bit of a why, why, what do you want, what are you asking for, why are you asking, what's the ulterior motive (Catherine).

In order to enable the development of a healthy model of compassion and allow compassion into their lives, participants described the importance of the relationship between themselves and the person offering them compassion as well as their life context at the time. For example, Laylie described the importance of safety and stability in allowing others to be

compassionate towards her: “I feel safe, I feel safe, and I had never felt safe in my life until I went into treatment, that helped”.

The development of a healthy model of compassion was described by Catherine: “She [social worker] gave me compassion, she boxed it up and provided me with it, if it wasn't for her, I wouldn't know what compassion is”. Similarly, Alice described the lasting effects of receiving compassion: “It's a very powerful thing that I've really been able to take and carry with me...it really gives you something to keep a hold of”. This learning had an impact on participants' ability to provide compassion to others as well as practise self-compassion: “By receiving that compassion, it's kind of triggered off maybe a more compassion side to myself, not just in paying it forwards, but in being, you know compassion breeds compassion” (Alice); “As I started to develop self-compassion, the compassion for other people has developed alongside it” (Sophie).

Theme 5: Developing Self-acceptance and a Sense of Worthiness

Theme five reflects the impact that receiving compassion had upon participants' sense of self. Participants associated a lack of compassionate experiences and the presence of non-compassionate acts, such as trauma and abuse, with a sense of themselves as flawed and undeserving. Through receiving genuine compassion from others and developing self-compassion, participants described an increase in self-worth and self-acceptance which had implications for recovery.

All participants described a sense of feeling inadequate, flawed and unworthy. Alice suggested that this sense of self related to having experienced an unhealthy model of false compassion in early life: “Because BPD is quite often linked to childhood trauma, I think we maybe have experienced compassion in an unhealthy way before” (Alice). Although trauma

was not explicitly explored within the interviews, all participants alluded to having experienced this in their lives. Across the six interviews, participants recalled instances of sexual abuse, emotional abuse, emotional neglect, domestic abuse, parental substance abuse and parental mental health difficulties: “My initial experiences as a teenager in hospital were extremely negative, extremely abusive, very difficult and traumatic” (Natalie). This lack of compassion was described by some participants as the absence of emotional connection to their suffering: “I wasn’t shown compassion by either of my parents at all...if I was upset, she [my mother] would lock me in a room and just walk away” (Sophie).

For some participants, these feelings were consolidated through receiving a diagnosis. Natalie described the impact of the diagnosis on her sense of self:

It was about telling me I was some sort of misfit, and it wasn’t that I was ill so much, it was just that I was a bad person or, you know, there was something wrong with me as a person and who I was: your personality is wrong, who you are is wrong.

Participants’ deep sense of unworthiness impacted upon their ability to allow compassion into their lives as they felt “undeserving” (Deborah; Laylie): “I really struggled to look after anyone or care for anyone because I was hell bent on destroying me” (Laylie);

I had just given up because I felt I was so unimportant...once you're in a place where you hate yourself compassion does completely go out the window, you won't let it in for yourself, you won't let it in from anyone else, because I was locked in really hating myself and not particularly wanting to live anymore (Deborah).

Participants described the way in which receiving compassion from others had a positive effect on their sense of self. For many participants this was as a result of their interactions with mental health professionals. Catherine described the impact of receiving compassion from a social worker when she was a teenager: “It taught me to believe in who I

am”. Laylie described the impact of bonding with mental health professionals in a therapeutic community: “It made me feel like I mattered and it made me feel like I'm not this horrible, bad, evil person...if other people are kind to me then I must be ok” (Laylie).

This development of a more positive sense of self had implications for recovery. For Natalie this was in relation to the compassion she received from a psychiatrist and, for Alice, as a result of the compassion she received from a friendship group:

The fact that somebody was really showing that, well, actually I was somebody who mattered, I was somebody who had value and I think that that was a real important thing, an important first step for me to start to see myself as somebody who had some value and somebody who was worth fighting for almost (Natalie);

That's what got me through, that is the reason that I'm still alive today, had it not been, and I am not over exaggerating this at all, were it not for that lot [friendship group], I would be dead, simple as, and you know being dead wouldn't have bothered me (Alice).

Similar to the difficulty in allowing compassion from others due to a deep sense of being unworthy and undeserving, participants described how a lack of self-acceptance was a barrier to self-compassion: “I think showing self-compassion is the hardest because you know every little thing about yourself, warts and all” (Deborah). However, by embracing common humanity (i.e. the notion that we are all connected, flawed beings), participants developed an acceptance of themselves and others which assisted in the cultivation of compassion: “As I'm more able to accept my own faults, well not necessarily faults, but I'm more able to accept how other people are...it's probably the same, similar techniques to developing compassion to myself” (Sophie). Deborah described how the development of this perspective contributed to her recovery:

If you know everything [about yourself] and can still say ‘I’m worth a second chance, I’m worth a bit of self-care, I’m a human being and I make mistakes and I deserve to still have some nice things’, then I think you can pretty much get better and move forward.

Discussion

The current study explored experiences of compassion in people with a diagnosis of BPD. The findings suggest that participants understood genuine compassion as containing three main components: emotional connection to suffering, empathic understanding and the prioritisation of needs. Participants discussed the impact of incompassion (a lack of compassionate experiences) and the presence of non-compassionate acts, such as trauma and abuse, upon their sense of self. All participants described viewing themselves as flawed and undeserving of compassion. For some participants, this feeling was consolidated by receiving a diagnosis of BPD. Participants experienced difficulty in receiving compassion from others and being compassionate to themselves. Nevertheless, by experiencing genuine compassion, participants alluded to a process of developing a healthy model of compassion that assisted them in offering compassion to themselves and others. This also led to a process of recovery underpinned by self-acceptance and the development of self-worth. A diagrammatic representation of this recovery process is illustrated in Figure 1.

The Three Elements of Compassion

Compassion contained three elements in relation to self or other: emotional connection to suffering, empathic understanding and prioritisation of needs. This is in line with Harrington's (2002) definition that compassion "brings us into a felt relationship with the pain and needs of some other" (p. 21). The elements of emotional connection to suffering and empathic understanding resemble the concept of emotional validation, which has been suggested is missing in the early life experiences of many individuals with a diagnosis of BPD (Westphal et al., 2016). The definition of compassion in the current study also

corresponds with Gilbert's (2010) key attributes of compassion including the recognition of sympathy and empathy towards emotion.

One aspect that was identified in the current study which has not been described in compassion literature is that of the prioritisation of needs. That is, offering compassion to others involves selflessness, while being self-compassionate involves prioritising one's own needs. Findings suggest that there is a cost involved in providing compassion unilaterally due to the prolonged subjugation of one's own needs. Participants described becoming burnt out, resentful and experiencing a deterioration in their own mental wellbeing. This may be reflective of submissive, appeasing behaviour in which compassion is displayed in order to enhance social credentials and acceptance while avoiding rejection (Catarino, Gilbert, McEwan & Baiao, 2014). I would argue that this is not genuine compassion, but resembles the displays of false or feigned compassion described by participants.

Participants in the current study described difficulty in emotionally connecting to their own suffering while over-identifying with the suffering of others. This may explain why participants experienced difficulty practising self-compassion, yet experienced 'over the top compassion' for others. Moreover, it may account for participants vicariously attempting to 'repair' themselves through offering compassion to the suffering of others. Some participants described a reluctance to express their vulnerability to others. This may inhibit the opportunity for others to emotionally connect to their suffering and so obstruct the receipt of compassion.

An empathic understanding from others and towards themselves facilitated compassion in participants. In particular, this related to understanding the impact that abusive experiences had had upon the development of their difficulties. For some participants empathic understanding was impeded by the diagnostic label by circumventing this

connection. This aligns with increasing evidence suggesting that the BPD label can have a detrimental impact upon people due to individualising difficulties and neglecting the wider relational context (Horn et al., 2007).

Shame: The Impact of Incompassion and Cruelty

The antithesis of compassion is considered to be cruelty (i.e. an indifference to, or pleasure derived from, another's suffering; Gilbert, 2005). Some researchers believe that it is the presence of abuse that results in the development of difficulties associated with the diagnosis of BPD (Holm & Severinsson, 2008). Although a high percentage of individuals with a diagnosis of BPD report having experienced abuse in childhood, this does not apply to everyone. The current study may account for this by making a distinction between the absence of compassion (incompassion) and the presence of cruelty. Perhaps it is not the presence of cruelty that leads to difficulties associated with BPD, but the absence of compassion (present also in cruelty). Some of the experiences described by participants such as emotional invalidation and the subjugation of needs involved in being a young carer align with this notion. Further research is required to investigate the impact of incompassion upon the development of difficulties associated with BPD.

Participants perceived themselves as unworthy, inadequate and undeserving of compassion. This resembles Brown's (2006) definition of shame: an intensely painful feeling related to a belief that one is flawed and unworthy of love and connection. This supports findings from previous studies regarding the negative perception that people with a diagnosis of BPD have of themselves in relation to aversive early experiences in relationships (Finzi-Dottan, 2006; Horn, Johnstone & Brooke, 2007; Holm et al., 2009; Krawitz, 2012a; Schanche, Stiles, McCullough, Svartberg & Nielsen, 2011; Warren, 2015). Findings of the

current study suggest that shame and negative self-perception arise not only as a consequence of direct cruelty in early life, but are the result of a lack of compassion.

Developing a Model of Genuine Compassion: Self-worth and Recovery

The current study suggests that participants' experiences of compassion, particularly in childhood, impacted upon their ability to develop a model of genuine compassion. This relates to the assertion that self-compassion and empathy are developed through the attachment relationship with a caregiver in early childhood (Neff & McGehee, 2010). Similarly, difficulties with self-compassion are associated with high levels of parental rejection (Pepping et al., 2015) and emotional invalidation in childhood (Westphal et al., 2016); findings supported by the current research.

The current study suggests that there are some barriers to receiving compassion and developing self-compassion (summarised in Table 3). These findings align with findings from the development of a fear of compassion scale including feelings of shame and unworthiness and concerns that self-compassion is selfish or self-indulgent (Gilbert, McEwan, Matos & Rivis, 2011). However, if barriers are addressed, compassion can play an important role in recovery. Through receiving compassion from others, participants described a process of internalising compassion and developing a model of genuine compassion. This assisted them in being more compassionate to others and to themselves. Moreover, it enabled them to develop a sense of worthiness. This process contrasts with the description of incompassion and cruelty in which a false model of compassion is developed alongside a sense of unworthiness. This aligns with literature of BPD and recovery in which recovery is facilitated by reducing shame and developing a sense of worth and self-acceptance (Katsakou et al., 2012). Moreover, participants suggested that self-compassion was facilitated by learning to forgive themselves, accept themselves and allow themselves to be human. This is the same

process of change that is written about in the compassion-focused intervention literature (Krawitz, 2012b; Warren, 2015).

Clinical Implications

Findings from the current study suggest that compassion has implications for recovery for individuals with a diagnosis of BPD. Although compassion-focused approaches are primarily offered as direct or group therapies, the current study suggests that compassionate relationships with mental health professionals can be therapeutic in their own right. Therefore, therapeutic relationships focusing on providing the conditions necessary for compassion can be expanded as an intervention. In considering this, mental health professionals working with people with a diagnosis of BPD experience high levels of ‘burn out’ and compassion fatigue (Woollaston & Hixenbaugh, 2008). Findings from the current study suggest that this may be due to continually prioritising the needs of another in the absence of compassion from others. Therefore, it is essential that mental health professionals are supported in this work.

A barrier to self-compassion identified in the current study is that of an intolerance of one’s emotional experiences. Some interventions such as distress tolerance, emotion regulation, mindfulness and acceptance-based strategies have been shown to be effective for individuals with a diagnosis of BPD (National Institute for Health and Care Excellence, 2009) and so may be usefully incorporated with compassion-focused approaches.

Strengths and Limitations

The current study demonstrated promising initial findings in terms of enhancing the theoretical understanding of how experiences of compassion, including experiences of incompassion and cruelty, are involved in the development of difficulties associated with

BPD. Moreover it demonstrated that compassion has implications for recovery and identified barriers to this process alongside conditions which support it.

Accessing a population who considered themselves stable and who were very reflective and insightful about their experiences was both a strength and limitation of the study. It enabled exploration of the facilitative nature of compassion towards recovery that may not have been otherwise acknowledged. However, an exploration of the life experiences of individuals who would not consider themselves stable or in recovery might provide further insight into experiences of compassion.

Future Research

Findings from the current study reinforce the notion that the reductionist, individualising narrative that accompanies BPD impacts upon individuals' sense of self. In addition, the diagnosis can impede the understanding of how experiences of incompassion and cruelty have influenced difficulties associated with BPD. Therefore, it is essential to incorporate a relational, trauma-focused understanding into the BPD narrative in order to circumvent the impact of self-blame that arises within some individuals in response to perceiving the diagnosis as individualising. It would be useful to conduct research that explores the distinction between incompassion and cruelty and their role in difficulties experienced by individuals with a diagnosis of BPD to incorporate this understanding of compassion into an understanding of the difficulties associated with BPD.

To further the theoretical development of compassion as a clinical construct, it would be useful to ascertain the role of the prioritisation and subjugation of needs in compassion and how this relates to early experiences such as being a young carer as described by the study participants. It would also be useful to explore the relationship between compassion

and emotional validation and attachment theory given the links identified in the current study and the fact that these are research areas which have been gathering evidence in regards to the diagnosis of BPD. Finally, given the potential for the involvement of compassion in recovery, it would be beneficial to explore how to overcome the barriers to receiving compassion and practising self-compassion that were outlined in the current study as well as how to promote feelings of safety, trust and security.

In conclusion, compassion has a significant role to play in the development of difficulties associated with BPD and has implications for recovery. This reinforces the fundamental importance of a relational understanding and approach. Barriers to compassion and factors which facilitate the development of compassion emerged from the analysis which have implications for clinical practice.

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Tables

Table 1

Summary of participants

Participant ^a	Gender	Ethnicity	Age	Recruited From
1 Natalie	Female	White	57	Advocacy Group
2 Laylie	Female	White	51	Advocacy Group
3 Catherine	Female	White	47	Twitter
4 Deborah	Female	White	31	Twitter
5 Alice	Female	White	28	Twitter
6 Sophie	Female	White	32	Twitter

^apseudonyms used to preserve anonymity

Table 2

Description of the Stages of IPA Analysis

Stage of IPA Analysis	Description
1: Reading and Re-reading	I read and re-read the transcripts to immerse myself in the data. Researcher notes were recorded in a reflective field diary.
2: Initial Notations	Transcripts were copied to an Excel spreadsheet and adjacent columns used to record annotations. Descriptive and linguistic elements (i.e. key phrases, direct quotes) and conceptual elements (i.e. exploratory comments, researcher's interpretation) were recorded in Column 1 (See Appendix C). My supervisor checked some of the early analysis and offered suggestions which helped to inform the analysis. I then re-read the transcripts focusing directly upon the descriptive and linguistic elements. The reflective diary was then revisited and further used to contribute to the annotations.
3: Developing Emergent Themes	Emergent themes were developed from the annotations and recorded in Column 2. This required a shift from focusing upon the transcript to the exploratory comments, holding in mind connections and patterns that emerged from the previous stages.
4: Searching for Connections across Participants	This stage involved developing superordinate themes for each participant in turn. See Appendix D for an example. Excel's filter function was used to group the data constituting related emergent themes and so enable the possibility of referring back retrospectively to the annotations and original transcripts. This was conducted to ensure rigour and sensitivity to context during theme-development. Superordinate themes were developed from contrasting and comparing emergent themes; developed through abstraction, subsumption and polarisation as described by Smith et al. (2009). They were then named and recorded in Column 3. The superordinate themes were taken to the six participants for consultation to enquire whether the themes reflected their accounts of compassion and whether they were meaningful. Participants felt that the themes captured their experiences of compassion.
5: Developing Higher Order Interpretations	Patterns were explored across all participants by juxtaposing superordinate themes from Step 4 using Excel's filter function (see Appendix E). This resulted in a relabelling process and integration of superordinate themes. Individual transcripts were then compared to develop overarching themes for the whole data set which were recorded in Column 5 and named.

Table 3

Barriers to, and conditions necessary for, receiving compassion and self-compassion

Barriers to compassion	Conditions that facilitate compassion
A distrust of others	A trusting relationship with another
Fears of being vulnerable with others	An ability to be vulnerable with others
The subjugation of one's own needs or feelings of guilt and concerns of being selfish associated with prioritising one's own needs	Recognition of the importance of prioritising one's needs
Emotional disconnection and difficulty in tolerating one's emotions	Emotional connection and the ability to tolerate one's emotions
A lack of empathic understanding towards oneself.	Empathic understanding of oneself, particularly in relation to the impact of trauma
	Safety and stability
No model of genuine compassion	
A view that the self is underserving of compassion	
Over-compassionate responses to others and a process of vicarious reparation which can lead to burn-out, resentment and deterioration in mental health	

Figures

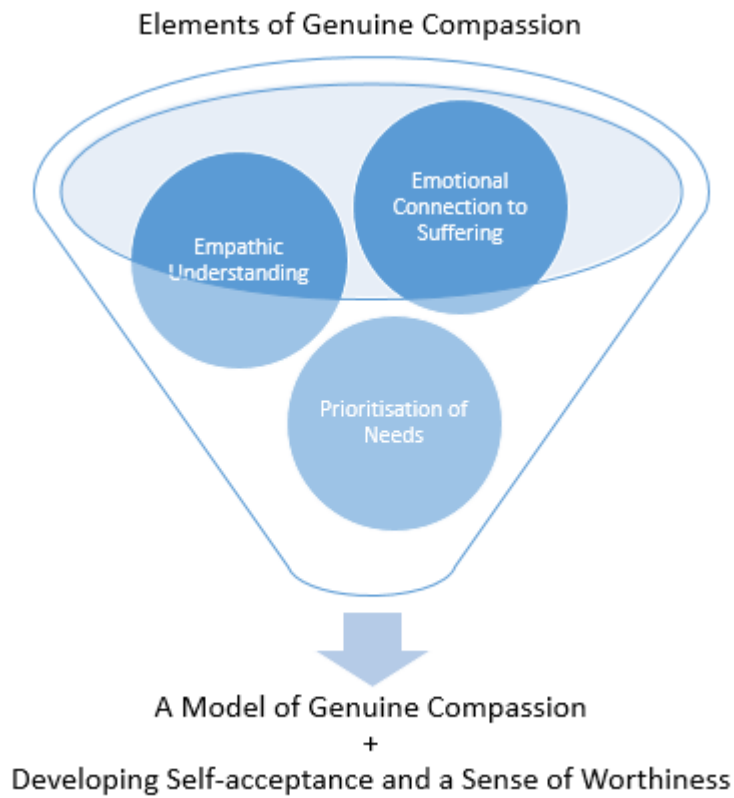


Figure. 1. Experiences of compassion in adults with a diagnosis of BPD: A recovery process.

Appendices

Appendix 2-A: Author Guidelines for the journal *Clinical Psychology & Psychotherapy*

Author Guidelines

[Manuscript Submission](#)

[Manuscript Style](#)

[Reference Style](#)

[Post Acceptance](#)

[Copyright and Permissions](#)

MANUSCRIPT SUBMISSION

Clinical Psychology & Psychotherapy operates an online submission and peer review system that allows authors to submit articles online and track their progress via a web interface. Please read the remainder of these instructions to authors and then visit <http://mc.manuscriptcentral.com/cpp> and navigate to the *Clinical Psychology & Psychotherapy* online submission site.

IMPORTANT: Please check whether you already have an account in the system before trying to create a new one. If you have reviewed or authored for the journal in the past year it is likely that you will have had an account created.

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All papers must be submitted via the online system.

File types. Preferred formats for the text and tables of your manuscript are .doc, .docx, .rtf, .ppt, .xls. **LaTeX** files may be submitted provided that an .eps or .pdf file is provided **in addition** to the source files. Figures may be provided in .tiff or .eps format.

New Manuscript

- **Non-LaTeX users.** Upload your manuscript files. At this stage, further source files do not need to be uploaded.
- **LaTeX users.** For reviewing purposes you should upload a single .pdf that you have generated from your source files. You must use the File Designation "Main Document" from the dropdown box.

Revised Manuscript

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- **LaTeX users.** When submitting your revision you must still upload a single .pdf that you have generated from your revised source files. You must use the File Designation "Main Document" from the dropdown box. In addition you must upload your TeX source files. For all your source files you must use the File Designation "Supplemental Material not for review". Previous versions of uploaded documents must be deleted. If your manuscript is accepted for publication we will use the files you upload to typeset your article within a totally digital workflow.

MANUSCRIPT STYLE

The language of the journal is English. 12-point type in one of the standard fonts: Times, Helvetica, or Courier is preferred. It is not necessary to double-line space your manuscript. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.

- During the submission process you must enter the full title, short title of up to 70 characters and names and affiliations of all authors. Give the full address, including email, telephone and fax, of the author who is to check the proofs.
- Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)**.
- Enter an **abstract** of up to 250 words for all articles [except book reviews]. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
- All articles should include a **Key Practitioner Message** — 3-5 bullet points summarizing the relevance of the article to practice.
- Include up to six **keywords** that describe your paper for indexing purposes.

Types of Articles

- **Research Articles:** Substantial articles making a significant theoretical or empirical contribution.
- **Reviews:** Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies.
- **Assessments:** Articles reporting useful information and data about new or existing measures.
- **Practitioner Reports:** Shorter articles (a maximum of 1200 words) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

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The PDF will appear on the *Wiley Online Library* site.

REFERENCE STYLE

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Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.
2. **If the author is named in the text, only the year is cited .**
Example: According to Irene Taylor (1990), the personalities of Charlotte. .
3. **If both the name of the author and the date are used in the text, parenthetical reference is not necessary.**
Example: In a 1989 article, Gould explains Darwin's most successful. . .

4. **Specific citations of pages or chapters follow the year .**
Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).
5. **When the reference is to a work by two authors, cite both names each time the reference appears .**
Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .
6. **When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al* . (meaning "and others") .**
Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al* ., 1997) When the reference is to a work by six or more authors, use only the first author's name followed by *et al* . in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.
7. **When the reference is to a work by a corporate author, use the name of the organization as the author.**
Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).
8. **Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text .**
Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .
9. **Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows .**
Examples:
 - List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
 - Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
 - List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

Reference List

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References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

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Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, 159, 483–486. doi:10.1176/appi.ajp.159.3.483.

Book edition

Bradley-Johnson, S. (1994). Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school (2nd ed.). Austin, TX: Pro-ed.

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Appendix 2-B: Interview Schedule

The following schedule for the interviews provides a general outline including prompt questions. However, if the participants bring other ideas that are relevant to the topic area, it will be okay to deviate to capture this wide range of ideas.

General Topic

What are the experiences of compassion in adults with a diagnosis of BPD in relation to self and other?

Introduction to terms

An introduction to the terms used in the study by discussing the terms ‘emotionally unstable (EU) or borderline personality disorder (BPD)’ and ‘compassion’ and exploring the personal meaning of these terms for each participant:

- What does the diagnosis EU/BPD mean for you?

Provide information about the definition of compassion according to the research base (i.e. kindness, care, strength, wisdom and courage applied to the relief of suffering)

- Does this align with your definition of compassion? What is your meaning of this term in your own words? And are there any other terms that you would prefer to use to describe this experience?
 - Is compassion a feeling, a behaviour, an idea? Where does it come from? What does it relate to? Does it extend to all people or is it reserved for specific people in a person's life? Are there other words that you would use in place of ‘compassion’?

Feelings of compassion for others

- What have been your experiences of feeling compassion towards others?
 - Did you feel compassionate towards others as a child?
 - Do you feel compassionate towards others now?

- Do you feel compassion to family, friends, partners, or others more widely?
- What does it mean to you to feel compassion for another person?
- Have these experiences changed across your life?
 - What has influenced these changes?
- What helps, or does not help, you to feel compassion for others?
- Do you feel that there are any barriers to feeling compassion for others?
- Do you think that there is a relationship between your experiences of feeling compassion towards others and the experience of EU/BPD?
 - In what way are these experiences related?
 - Are there ways in which these experiences are not related?

Experiences of receiving compassion

- What have been your experience of receiving compassion across your life?
 - Are there particular memories that you associate with compassion?
 - Do you have early experiences of receiving compassion?
 - What are your experiences of receiving compassion in adulthood?
 - Do these experiences relate to parents, friends, teachers, partners or others?
 - Have these experiences changed across your life?
 - What has influenced these changes?
 - What helps, or does not help, you to receive compassion from others?
 - Do you feel that there are any barriers to receiving compassion from others?
- Do you feel that there is a relationship between your experiences of receiving compassion and the experience of EU/BPD?
 - In what way are these experiences related?
 - Are there ways in which these experiences are not related?

Experiences of self-compassion

- What have been your experiences of feeling compassion towards yourself?

- Did you feel compassion towards yourself as a child?
- Do you feel compassion towards yourself now?
- What does it mean to you to feel compassionate towards yourself?
- Have these experiences changed across your life?
 - What has influenced these changes?
- What helps or does not help you to feel compassion towards yourself?
- Do you feel that there are any barriers to feeling compassion towards yourself?
- Do you feel that there is a relationship between your experiences self-compassion and the experience of EU/BPD?
 - In what way are these experiences related?
 - Are there ways in which these experiences are not related?

Comparison

- Is there any comparison between receiving compassion, feeling compassion towards others and self-compassion?
- Is there any comparison between these experiences of compassion and the experience of EU/BPD?
 - Do experiences of compassion impact upon the potential for receiving a diagnosis of EU/BPD or experiencing the difficulties described by EU/BPD?
 - Do experiences of compassion impact upon any of your day-to-day experiences that you relate to EU/BPD?
 - Are there any specific aspects of the experiences of compassion that impact upon specific aspects of EU/BPD?
- Would you identify any other common themes throughout this discussion?

Final Thoughts

- Do you have any other observations, thoughts or comments that we have not covered so far?

Appendix 2-C: Example of Transcription, Annotations and Emergent Themes for Deborah

Annotations	Transcription	Emergent Themes
	Q: What is your understanding of compassion, how would you describe it?	
Compassion as <i>empathy</i> ; can't <i>feel something</i> for someone without an understanding of them <u>Perspective-taking important for empathy</u>	I think compassion has an element of empathy I think it is very difficult to feel something for someone if you can't understand where they are coming from	Perspective Taking Required to Empathise
Compassion as <i>selflessness</i> Selflessness a component of giving compassion to others? <i>Prioritising them above you</i>	there's an element of selflessness and you know it might be really hard to show compassion to someone but sometimes you do sort of prioritise them above you	Selflessness and Prioritising Another to Give Compassion
Being <i>non judgemental</i>	and being non-judgemental as well	Non-Judgemental
Difficulty in seeing things from other people's <i>perspectives</i> which makes compassion difficult <u>Difficulty with perspective-taking and perspective-taking necessary for compassion?</u>	Q: empathy and if you don't understand someone you can't... Yeah, I would struggle to give someone compassion if I didn't understand it's a personal flaw in that I'm not terribly great at seeing things from others perspectives so I try and do that as much as possible	Personal Difficulty in Perspective-Taking: A Barrier to Compassion
Easier to feel compassion if it's something I can relate to; <i>understand the pain of</i> <u>Emotional connection to suffering?</u>	but to me if it's something that I can understand and relate to you've stubbed your toe, I get that, I remember when I was in pain and I think that's awful, when my kid cry and hurt themselves I get up but when people have very strong views on something or are upset	Compassion Facilitated by Understanding of Emotion / Empathy

<p>Not acting compassionately due to seeing it too much from own perspective <u>Difficulty perspective-taking is a barrier to giving compassion to others</u></p>	<p>I don't always act in the most compassionate way because I'm too much seeing it from my perspective</p>	<p>Letting Go of Own Perspective to Perspective-Take that of Another</p>
<p>Not understanding importance of event/situation to another <u>Perspective-taking and understanding the reason for the emotional response of another?</u></p>	<p>so for example my partner was really upset about the brexit vote because he had too much compassion for all the people he thought it would have a negative effect on and I didn't give him the patience that I should have done I was just stop being so silly about it it's just politics, instead of understanding that to him it's really important</p>	<p>Perspective-Taking to Understand Another's Emotional Response</p>
<p>Impact of <i>imposing own feelings</i> on a situation; expectations of how others should respond; full of compassion, but sometimes showing it in the right way can be hard <u>Understanding another's emotion? Heightened emotional connection, but difficulty conveying compassion in the right way for another?</u></p>	<p>Q: So you need to have that understanding of why someone is feeling a certain way</p> <p>yeah because otherwise I kind of impose my own feelings of a situation and it's sort of like they're not following the right script, they're not acting in the right way and I find it very difficult unless I take a moment to stop and recognise but that is something that I have noticed about myself generally whether it's borderline or it's just personality flaw but I do, I want to care and I've noticed a lot of people with Borderline are the same, they're absolutely desperate to care for other people, overwhelmingly full of compassion but sometimes showing it in the right way can be hard</p>	<p>Heightened Emotional Connection and Compassion</p>
<p>DBT and mindfulness skills = being more reflective aids compassion <u>Mindfulness and reflection</u></p>	<p>Q: so you need that understanding then to know what is the right way to show it. Do you think that has changed over time?</p> <p>Em, since I did the DBT and I studied a lot of mindfulness, and sort of became more reflective more about the moment</p>	<p>Mindfulness and Reflection</p>

Not about why they're suffering but <i>trying</i> to make someone feel better <u>Compassion as a choice / an effort to care for the wellbeing of another</u>	so it's not really about why they're suffering or why they're upset it's just really about trying to make them feel a little better and everything else can come later and sort of	Compassion as a Choice
Being compassionate by focusing on the individual and their <i>feelings</i> <u>Person centred / about other and focus on emotions</u>	trying to separate things out just to focus on the individual and their feelings	Person-Centred Focus on Emotions
Learning compassion by seeing things from other people's perspectives <u>Perspective taking</u>	and the DBT covered a lot of the interpersonal stuff about trying to see things for other people's perspective	Perspective-Taking to Learn Compassion
<i>Detaching</i> from own emotions and embracing others feelings <u>Separating and acknowledging validity of another's emotions</u>	and just detach a moment and recognise that they've got valid feelings just because they're not my feelings so stuff like that	Separate from Own Emotions to Perspective-Take
Acknowledging validity of others feelings making it easier to give compassion that want to give <u>Acknowledging validity of others feelings</u>	I know it sounds kind of cold but when I do stop and look at it that way it makes it easier to then give them the compassion that I know I want to	Acknowledge Another's Emotions
Barrier to compassion: <i>judgemental feelings</i> and a lack of understanding	but I would maybe let judgemental feelings or lack of understanding get in the way	Barrier to Compassion: Not Perspective-Taking / Understanding

Appendix 2-D: The Development of Superordinate Themes for Natalie

Superordinate Theme	Description
Theme 1: 'Your personality is wrong, who you are is wrong': The impact of abuse and diagnostic labelling and the healing power of compassion	Natalie described the impact of abuse, invalidation and disregard on her perception of herself as flawed and inadequate. Natalie described how this negative perception of herself was further impacted by receiving a diagnosis of BPD. She described how by receiving compassion from a psychiatrist; someone who showed genuine regard for her wellbeing, who respected her and advocated for her, she developed a sense of herself as 'worth fighting for'. This helped her in developing feelings of acceptance towards herself and increased self-belief.
Theme 2: 'Making a decision in my interest and taking responsibility for that': Compassion as selflessness and genuine concern	Natalie described a consultant psychiatrist who advocated for her to be discharged rather than placed in a secure mental health unit. She described the selflessness involved in this decision as the consultant believed that this was in Natalie's best interests, but had to take on responsibility and anxiety himself as a result of this decision. Similarly, Natalie described the actions taken by other clients on an inpatient unit who demonstrated selflessness to offer compassion to her. For example, she recalled one client standing up for during mistreatment by professionals despite the personal risk to themselves. She also contrasted these encounters with her experiences of the behaviour of other professionals. For example, she described that a barrier to compassion was that some professionals focused on themselves and their own needs

	rather than focusing upon her.
Theme 3: 'A real deep emotional bond': Empathy, Communication and Connection	Natalie described the importance of others recognising her subjective distress in order to provide compassion. This related to the trauma she had experienced and the impact of this upon her sense of self and emotions. By hiding her inner pain and keeping the trauma she had experienced a secret, misunderstandings occurred and this acted as a barrier to others being able to empathise and offer compassion. This was due to fears of speaking out in case of not being believed or being punished in response to this. Therefore, she described the importance of a trusting connection between herself and another as a way of facilitating her to share experiences of abuse. Also contained within this theme was Natalie's descriptions of her own heightened empathy towards the distress of others and how this enabled her to connect deeply and offer compassion to others.
Theme 4: 'I also related as a survivor of abuse': Empowerment through self-understanding	Natalie described the importance of understanding the impact of abuse in order to offer compassion. She described a process of connecting her experiences of abuse with her personality development in order to understand herself better. This led her to become less blaming of herself and reduced the negative perception that she held of herself. She also connected with others who were survivors of abuse which led to a shared understanding, the mutual giving of compassion and empowerment. She described a lack of understanding as a barrier to compassion.

Appendix 2-E: The Development of Theme 4: A Model of Genuine Compassion

Theme 4: A Model of Genuine Compassion

This theme reflects the way in which participants' experiences of care from others contributed to the development of their models of compassion. Through having not received compassion from others, or experiencing feigned displays of compassion, participants did not develop a model of genuine compassion. This also led to a reluctance to receive compassion from others. However, participants described that, by embracing compassion offered to them, they were able to develop a model of compassion which they could use to be compassionate towards themselves and provide compassion to others in a healthy way. This ability to embrace compassion was facilitated by feelings of safety and trust.

Participant	Superordinate Theme	Summary
Laylie	'If somebody is kinda nice to me, I automatically think what are you after': Fear, suspicion and mistrust of compassion due to previous experiences	Laylie described feeling suspicious when compassion is offered to her due to difficulty trusting others and questioning their motives. She related this to having received feigned compassion from men in the past who appeared extremely compassionate before 'turning' and becoming abusive towards her. She also described the impact of chronic addiction having led to a reluctance to trust others as well as experiencing difficulty in trusting herself.
Catherine	'I was never taught kindness': Learning compassion	Catherine said that she was 'never taught kindness' in her early years and did not know what human rights, basic human needs, respect, love, kindness and compassion were. She described

		learning what compassion was through developing a trusting relationship with a social worker when she was a teenager.
Alice	‘Compassion as a form of power’: Manipulation, control and ulterior motives	Alice described ‘false compassion’ being offered as a way of controlling another person by manipulating them. She witnessed this in a domestic abuse situation between her mother and step-father. She also experienced ‘false compassion’ displayed disingenuously for self-validation by some individuals. This led her to feel suspicious of compassion offered by others and she did not believe that ‘true, genuine compassion’ existed and so did not wish to receive it from others.
Sophie	‘I never had a model for compassion’: Controlled, dismissed and invalidated	Sophie described a lack of compassion being shown to her when she experienced distress as a child and so did not feel that she developed a ‘model for compassion’. However, through embracing ‘healthy relationships’ in which her needs and feelings were taken into consideration by another, she learned what compassion was. This enabled her to offer compassion to others and to herself.

Appendix 2-F: Overarching Themes and their constituent Superordinate Themes

Overarching Theme	Superordinate Themes
Theme 1: Emotional Connection to Suffering	<p>'A real deep emotional bond': Compassion as empathy and genuine connection (Natalie)</p> <p>'I'm scared of uncomfortable feelings': Disliking and pushing away emotion (Laylie)</p> <p>'Compassion is in the holding': Hiding vulnerability and being there with pain (Catherine)</p> <p>'I keep my very tumultuous emotions suppressed': Emotional saturation, suppression and acknowledgement (Alice)</p> <p>'I can't bear to feel that way so they shouldn't have to': Emotional intensity and over the top compassion (Deborah)</p> <p>'I think it takes a lot to be able to kind of look more inside yourself': Connecting with and tolerating extreme emotions (Sophie)</p>
Theme 2: Empathic Understanding	<p>'I also related as a survivor of abuse': Empowerment through self-understanding (Natalie)</p> <p>'That's compassion: I get it': Thoughtful consideration and understanding the impact of trauma (Catherine)</p> <p>'Being known': Listening, curiosity and understanding (Alice)</p> <p>'I would struggle to give someone compassion if I didn't understand': Person-centred compassion through perspective-taking and understanding (Deborah)</p> <p>'If you can see from someone's perspective you're much more likely to feel compassion': Knowledge and understanding (Sophie)</p>
Theme 3: Prioritisation of Needs	<p>'Making a decision in my interest and taking responsibility for that': Compassion as selflessness and genuine concern (Natalie)</p>

	<p>‘I think some people are just too focused on themselves, I’ve worked really hard not to be like that’: Conflating self-compassion with selfishness (Laylie)</p> <p>‘Focusing entirely on somebody else and what they need’: A sense of duty and being overly compassionate (Alice)</p> <p>‘I think people are like a bottle of water you’ve only got so much to give and then you are empty’: Selflessness, Guilt and Resentment (Deborah)</p>
<p>Theme 4: A Model of Genuine Compassion</p>	<p>‘If somebody is kinda nice to me, I automatically think what are you after’: Fear, suspicion and mistrust of compassion due to interpersonal trauma (Laylie)</p> <p>‘I was never taught kindness’: Learning compassion (Catherine)</p> <p>‘Compassion as a form of power’: Manipulation, control and ulterior motives (Alice)</p> <p>‘I never had a model for compassion’: Controlled, dismissed and invalidated (Sophie)</p>
<p>Theme 5: Developing Self-acceptance and a Sense of Worthiness</p>	<p>‘Your personality is wrong, who you are is wrong’: The impact of abuse and diagnostic labelling and the healing power of compassion (Natalie)</p> <p>‘I had internalised the message that it’s not okay to be you...if other people are kind to me then I must be okay’: Receiving compassion and its role in developing worth and acceptance (Laylie).</p> <p>‘People with mental health problems don’t have the same equality’: Feeling Unworthy and Unequal (Catherine)</p> <p>‘Not Worth Anyone’s Time’: Feeling unimportant and developing self-acceptance through genuine compassion (Alice)</p>

'I can still at the end of that say I'm worth a second chance': Developing self-esteem, acceptance and hope (Deborah)

'I'm gonna help you, it doesn't matter that you've got that weakness, you're still a good person': Compassion and self-acceptance (Sophie)

Chapter 3: Critical Appraisal

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Abstract

In this critical appraisal, I outlined the rationale for the research and compared findings from chapters 1 and 2 in order to consider how a compassionate and relational understanding can be integrated into the BPD narrative to challenge stigma and inform positive therapeutic relationships.

Project Summary

In this critical appraisal, I will summarise the findings from the project and discuss how they challenge stigma associated with Borderline Personality Disorder (BPD) by developing a compassionate and relational understanding. Due to the controversy of the diagnosis and the argument that stigma is elicited as a result of diagnostic labelling (Gambrill, 2013), I will discuss why I chose to conduct the research with adults with a formal diagnosis of BPD. I will then compare findings from the literature review and research paper to consider how a compassionate and relational understanding can be integrated into the BPD narrative to challenge stigma and inform positive therapeutic relationships.

The aim of the research was to challenge the individualistic paradigm and associated stigma by exploring a relational understanding of BPD. Chapter 1 reports the findings of a metasynthesis which explored the relational dynamics between adults with a diagnosis of BPD and mental health professionals and, through the application of psychological theory, provided a compassionate reframing of these dynamics. Twenty-four themes that described relational dynamics emerged. These dynamics were reconceptualised by applying psychological theory to develop 12 third order interpretation themes. During this process, compassionate terminology based upon psychological theory was integrated into the understanding. For example, terms such as ‘manipulative’ and ‘threatening’ were reconceptualised as *Attempts to Control Overwhelming Emotions*, while attention-seeking was reframed as *Care-seeking*. In addition, four cycles of relational dynamics were identified between adults with a diagnosis of BPD and mental health professionals based upon these third order interpretations.

Chapter 2 reports the findings of a qualitative study which explored experiences of compassion in adults with a diagnosis of BPD. The aim was to explicitly utilise the construct

of compassion to develop an understanding of relationships to others and the self in order to further the development of the construct of compassion in relation to BPD. Five themes emerged: *Emotional Connection to Suffering, Empathic Understanding, Prioritisation of Needs, A Model of Genuine Compassion and Developing Self-acceptance and a Sense of Worthiness*. The themes were integrated into a recovery model that highlighted the process of recovery through therapeutic relationships that model genuine compassion. In addition, barriers to compassion and factors which facilitate the development of compassion emerged from the analysis.

Diagnostic Labelling and Stigma

One limitation of the current project which will be described here is the use of the BPD label. BPD is a controversial diagnosis. There are concerns regarding its validity and reliability including particularly high rates of co-morbidity (Alwin et al., 2006). Moreover, the majority of individuals diagnosed with BPD are women, with research suggesting that approximately 75% of whom have experienced sexual abuse in childhood (McFetridge, Milner, Gavin & Levita, 2015). There is, therefore, a risk that the label pathologises difficulties which have arisen as a result of interpersonal trauma (Shaw & Proctor, 2005).

Some researchers argue that stigma associated with mental health difficulties arises due to applying the medical model of physical health problems to mental health difficulties (e.g. Gambrill, 2013). Therefore, to challenge stigma, some argue that diagnostic labelling should not be used (Timimi, 2014) and that the study of transdiagnostic factors would be more useful (Krueger & Eaton, 2015). Moreover, guidelines on language in relation to functional psychiatric diagnosis outlined by the Division of Clinical Psychology (DCP, 2014) suggest that, rather than using the label 'personality disorder', alternative terms should be

used (e.g. complex trauma, relationship or attachment difficulties). Nonetheless, despite recognition by healthcare services that the BPD label is problematic and stigmatising (e.g. Department of Health, 2003), the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013) makes no call to abandon the label.

Due to the prevalence of the BPD label within mental health services and within the wider community, rather than avoiding it, I chose to adopt the category and challenge the stigma associated with it by integrating a relational, compassionate understanding into a new understanding of it. This was reflected in the choice of inclusion and exclusion criteria; namely, that a formal diagnosis was required for participation. I will further outline my position and the reason for this decision below.

Position Statement

I adopted a critical realist perspective in relation to the interpersonal dynamics described within Chapter 1. It is my position that the interpersonal dynamics described by the synthesised studies reflect real phenomena and that many different interpretations have been offered to explain the phenomena. This was the epistemological basis for offering an interpretation which compassionately reframed these dynamics.

In Chapter 2, I adopted the position that the diagnosis of BPD outlined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) is a social construction which serves to categorise a variety of commonly co-occurring difficulties (i.e. identity disturbance, emotion dysregulation and interpersonal difficulties; Cheavens, Strunk & Chriki, 2012). These difficulties have arisen as a result of multiple factors including biological and

psychological contributors. Relational experiences, including interpersonal trauma, have been identified as a key factor in the development of these difficulties (Giffin, 2008). I believe that the high levels of heterogeneity evident across individuals diagnosed with BPD (Asnaani, Chelminski, Young & Zimmerman, 2007) arise as a result of the idiosyncrasy of individual experience and the differing developmental pathways of difficulties. Therefore, I believe that the diagnosis cannot comprehensively or exclusively represent individuals' difficulties and that a person-centred perspective (e.g. individual psychological formulation) is most helpful. However, the DSM categorisation provides a useful basis for conducting research with groups of individuals who have similar difficulties to further our understanding of these difficulties. It also enables us to develop heuristic frameworks and explore useful therapeutic interventions, develop treatment pathways and navigate the welfare system. Moreover, some individuals feel positively about the diagnosis, believing that it gives them a sense of relief, hope and understanding (Horn, Johnstone & Brooke, 2007) as well as helping them connect to a community of others who have similar life experiences and difficulties.

The drawbacks of using the BPD label are that heuristic frameworks are imperfect and can result in stereotyping and misunderstandings. This can lead to stigma and negative attitudes which have an adverse impact upon individuals' self-esteem (Horn et al., 2007). I do not believe that this is a reason to abandon the use of the label, particularly in light of evidence which suggest that there are positive aspects of receiving a diagnosis (Horn et al., 2007). Nonetheless, it suggests that there is a need to be considered in our use of the label and challenge stigma and stereotyping that arises from its use. As such, I will outline three key factors in the current conceptualisation of BPD which perpetuate stigma and discuss how the current project addresses these concerns:

1) The absence of an explanatory framework. Mental health diagnoses are descriptive conceptualisations based upon consensus of clinical experience and do not provide an explanatory framework. Miller (1994) analysed the narratives of people with a diagnosis of BPD and found prominent similarities signifying that a common experience is shared. However, these narratives differed substantially from the clinical description of BPD as described in the DSM. Although the conceptualisation of BPD is being continually updated and revised within the DSM, there remains a focus upon difficulties and lack of explanatory framework. Stroud and Parsons (2013) found that, when there was a framework to explain the behaviour of people with a diagnosis of BPD, community psychiatric nurses were more likely to express positive attitudes; whereas without a framework, clients were viewed more pejoratively. Some psychological theories contribute to an explanatory framework of BPD (e.g. attachment theory; Fonagy, 2000); however, they are not used routinely alongside the descriptive framework provided by the DSM within services, nor do such frameworks exist in public discourse.

2) The individualistic paradigm. The classification system of mental health difficulties overlooks the wider context of human suffering including relational and societal factors (DCP, 2013; Gambrill, 2013). This individualistic paradigm and the lack of conceptualisation regarding relational contexts can serve to perpetuate the stigma associated with BPD (Bonnington & Rose, 2014). The importance of a relational approach in BPD diagnoses is described by Giffin (2008) who discusses the interpersonal nature of the difficulties experienced by people with a diagnosis of BPD. Giffin describes how the emotional and behavioural difficulties referred to within the DSM criteria are often elicited and perpetuated by interpersonal dynamics.

3) The use of clinical language. Not only can clinical language contribute to the intrapersonal conceptualisation of BPD described above, but the language used (e.g. ‘disorder’) can negatively impact upon a person’s identity and self-esteem (DCP, 2013). Furthermore, it can stigmatise people and have dehumanising effects (Gambrill, 2013). This dehumanisation can impact upon compassionate feelings by both affecting compassion towards a person and a person’s compassion towards themselves (Gambrill, 2013). Therefore the use of clinical language has the potential to detach compassion from the BPD narrative. This seems particularly pertinent in the cases of people with a diagnosis of BPD where it has been suggested that there is a lack of compassion towards the self (Horn et al., 2007) and where stigmatising language exists. The terms “attention-seeking” and “manipulative” are often used in relation to people with a diagnosis of BPD (Kling, 2014).

I believe that the current project challenged pejorative labelling and provided a richer understanding of BPD through addressing the three problematic factors described above by developing: 1) an explanatory framework; 2) based upon a relational understanding; 3) which incorporated compassionate language.

Integrating Relational Dynamics and Experiences of Compassion

I will now apply the theory of compassion from Chapter 2 to the relational dynamics described in Chapter 1 to form a cohesive relational understanding based upon compassion.

Compassion Fatigue and Compassionate Leadership

Compassion fatigue is a concept that is used within healthcare to describe the work-related stress response that results in a loss of compassion (Sinclair, Raffin-Bouchal,

Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017). Compassion fatigue was described within both chapters. Chapter 2 discussed the cost of selflessness for the individuals I interviewed, in which continually offering compassion to others and subjugating their own needs led to resentment and burn-out. This occurred, in particular, in situations in which there was an absence of compassion from others. This resembles the process described in Chapter 1 in which staff feel *Frightened, Trapped and Overwhelmed* in response to clients' *Care-seeking* alongside a lack of support from the wider service. The synthesis described the impact of these feelings upon *Establishing a Therapeutic Relationship and Calibrating Emotional Involvement*. During this process, professionals described emotionally withdrawing from clients to protect themselves from vicarious traumatisation and personal harm.

However, a key function of giving compassion is to form an emotional connection to suffering. In order for staff to give compassion to clients while looking after their own mental health, they must receive compassion and adequate support from their organisations. This view is supported by guidelines on the importance of facilitating compassionate working environments through compassionate leadership (NHS England, 2014). The findings from Chapter 2 suggest that this can be facilitated by healthcare organisations: 1) emotionally connecting to the suffering of staff; 2) having an empathic understanding of their difficulties in working with clients; and 3) giving time to prioritise the needs of professionals. Moreover, applying this model to professionals can assist them in internalising a model of genuine compassion. This has implications for offering compassion to clients as well as developing their own skills in self-compassion. This resembles the suggestions made by Dutton, Frost, Worline, Lilius and Kanov (2002) who propose that compassionate leaders create an environment in which people can express their emotions and take action to alleviate the suffering of themselves and others.

Integrating Compassion into the Therapeutic Relationship

In Chapter 1, *Establishing a Therapeutic Relationship and Calibrating Emotional Involvement* appeared to lie at the heart of relational dynamics between professionals and clients with a diagnosis of BPD. Boundaries and emotional involvement shifted in response to feelings and actions taken by both professionals and clients. Chapter 2 identified the importance of building safety and trust within therapeutic relationships in order for compassion to be received. Moreover, compassionate relationships were implicated in recovery by enabling the development of *A Model of Genuine Compassion and Developing Self-acceptance and a Sense of Worthiness*. Therefore, in establishing a therapeutic relationship, it would be useful to consider how the three aspects of compassion that emerged from Chapter 2 (*Emotional Connection to Suffering, Empathic Understanding, Prioritisation of Needs*) can be integrated.

Firstly, safety and trust must be built within the relationship. Structured Clinical Management is a useful model for this as it is based upon building secure attachment relationships between individuals with a diagnosis of BPD and mental health professionals (Bateman & Fonagy, 2009). It aims to build reliable, consistent relationships with clients, and positive team working as well as integrating support and supervision for professionals.

Secondly, forming an emotional connection to suffering emerged as one of the aspects of compassion. Mental health professionals described that, in calibrating their emotional involvement, they disconnected from their own emotions and the emotions of clients at times. Sabo (2006) suggested that this detachment is a result of unprocessed emotions within professionals due to witnessing the distress of clients. It is important to consider this process as emotional disconnection can act as a barrier to compassion; while emotional connection to suffering has been implicated in compassion fatigue and vicarious traumatisation for

professionals. This reinforces the importance of support and supervision for mental health professionals that is focused upon acknowledging and processing their own emotions.

Moreover, the same interventions that have been implicated as helpful for individuals with a diagnosis of BPD to connect to their emotions may also be usefully applied within staff teams. For example, mindfulness interventions for mental health professionals have been shown to reduce stress, enhance self-compassion and increase clinical care (Raab, 2014).

Compassion also includes developing an empathic understanding of one's difficulties. Therefore, enhancing empathic understanding can facilitate compassion within the therapeutic relationship. This is reflected in the theme *Attempts to Understand* in Chapter 1 in which professionals attempt to understand clients' experiences. This process was hindered by *Inconsistency and Conflict* within services in which there is a lack of shared understanding. However, a shared outlook can be facilitated through training. This would help professionals feel more confident and able in their approach and so benefit the therapeutic relationship and result in less splitting and conflict in teams. Empathic understanding entails the identification of an emotion and the behavioural response it engenders. For many participants within the research, this understanding was facilitated through an understanding of their trauma background. Trauma-informed care is a service delivery model that seeks to train staff to recognise the impact of trauma upon individuals and seeks to support them using a trauma-informed approach (Muskett, 2013). In addition, reconceptualising BPD based upon an understanding of the impact of trauma will encourage a more compassionate approach to self and from others.

Overall Reflection

My position has changed considerably as a result of this research project. My reason for conducting the study was as a result of working in services and hearing stigmatising language in relation to people with a diagnosis of BPD. I felt that there was something ‘real’ occurring in the dynamics between mental health professionals and clients and wanted to explore these dynamics and offer a compassionate and psychological interpretation. I was also interested in studying compassion as I believed that individuals with a diagnosis of BPD had had adverse experiences and received limited expressions of compassion in their lives. I anticipated that participants would express having encountered a lack of compassion during their contact with services. However, I was surprised at the descriptions of recovery through compassion, many of which were in the context of relationships with mental health professionals. I believe that this is reflective of the individuals who wished to participate in the study. Indeed, two participants remarked that they were aware of the negative narrative surrounding mental health service provision for individuals with a diagnosis of BPD. They informed me that they wanted to share their story due to the gratitude they felt for the support they had received and its impact on their recovery.

I believe that this was a particular strength of the study as it offered the telling of what is a subjugated narrative on this topic. This was similarly reflected in Chapter 1 through the use of interpretative methodology as I believe that the compassionate reframing of difficult interpersonal dynamics is also a subjugated narrative. As described in Chapter 1, terms such as ‘attention-seeking’ and ‘manipulative’ are regularly used pejoratively towards clients with a diagnosis of BPD. The review allowed for another narrative to develop which utilises compassionate language and an alternative, psychological framework for understanding these dynamics. I also believe that a major strength of the current research is the novel findings regarding a lack of compassion in early life experiences in the role of the development of

difficulties associated with BPD which has implications for theoretical development of the construct.

Limitations of the project includes the heterogeneity of professional groups represented in the synthesis as this excludes additional context from the understanding. Moreover, due to the lack of studies exploring experiences of interpersonal dynamics from the perspective of clients, I was unable to integrate their perspective into the study findings. It is important that future research explores interpersonal phenomena from the perspective of clients.

In conclusion, the BPD label is used within mental health services as a heuristic framework for offering interventions to clients. However, stigma and stereotyping has developed around this framework of understanding. Therefore, it is important to integrate a relational, compassionate understanding into the BPD narrative to challenge this stigma. The current research proposed that reflecting upon the relational dynamics between professionals and individuals with a diagnosis of BPD and integrating the construct of compassion into the development of the therapeutic relationship can be a useful way of challenging this stigma. This can be facilitated by replacing negative, stigmatising language with terms developed from a psychological understanding. Moreover, professionals must be supported to emotionally connect to the suffering of clients and develop an empathic understanding of clients' difficulties and the trauma background that gave rise to their suffering. Due to the impact of this difficult work and the personal risk to professionals (e.g. compassion fatigue, vicarious traumatisation), professionals must be adequately supported emotionally by the services in which they work through compassionate leadership. In addition, trauma-informed training and models of care based upon attachment theory (e.g. SCM) would assist professionals in developing an empathic understanding of clients as well as facilitating safety and trust within the therapeutic relationship.

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Chapter 4: Ethics Section

Ethics Application for Research Paper:

Experiences of Compassion in Adults with a Diagnosis of Borderline Personality Disorder: An Interpretative Phenomenological Analysis

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Word Count: 2707 (Max 6000 excluding references, appendices, tables and figures)

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**Faculty of Health & Medicine Research Ethics Committee (FHMREC)
– Application Form**



**Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University**

**Application for Ethical Approval for Research involving
direct contact with human participants**

Instructions [*for additional advice on completing this form, hover PC mouse over 'guidance'*]

1. Apply to the committee by submitting:
 - a. A **hard copy** of the University's **Stage 1 Self Assessment (part A only)** and **Project Questionnaire**. These are available on the Research Support Office website: [LU Ethics](#)
 - b. The completed application **FHMREC form**
 - c. Your full research proposal (background, literature review, methodology/methods, ethical considerations)
 - d. All accompanying research materials such as, but not limited to,
 - 1) Advertising materials (posters, e-mails)
 - 2) Letters/emails of invitation to participate
 - 3) Participant information sheets
 - 4) Consent forms
 - 5) Questionnaires, surveys, demographic sheets
 - 6) Interview schedules, interview question guides, focus group scripts
 - 7) Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing handbooks or measures which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submit the FHMREC form and all materials listed under (d) by email as a **SINGLE attachment in PDF format** by the **deadline date**. **Before converting to PDF ensure all comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line*.**
3. Submit one **collated** and **signed** paper copy of the full application materials **in time for the FHMREC meeting**. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the [FHMREC website](#). Applications must be submitted by the deadline date, to:

Dr Diane Hopkins
B14, Furness College
Lancaster University,
LA1 4YG
d.hopkins@lancaster.ac.uk
5. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application.

6. Attend the committee meeting on the day that the application is considered, if required to do so.

1. **Title of Project:** Experiences of compassion in adults with a diagnosis of borderline personality disorder: an interpretative phenomenological analysis.

2. **Name of applicant/researcher:** Stephanie Fagan

3. Type of study

Includes *direct* involvement by human subjects.

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. Please complete the University Stage 1 Self Assessment part B. This is available on the Research Support Office website: [LU Ethics](#). Submit this, along with all project documentation, to Diane Hopkins.

4. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught PG projects should complete **FHMREC form UG-tPG**, following the procedures set out on the [FHMREC website](#))

PG Diploma Masters dissertation PhD Thesis PhD Pall. Care

PhD Pub. Health PhD Org. Health & Well Being PhD Mental Health MD

DClinPsy SRP [if SRP Service Evaluation, please also indicate here:] DClinPsy Thesis

Applicant Information

5. **Appointment/position held by applicant and Division within FHM** Stephanie Fagan, Trainee Clinical Psychologist

6. Contact information for applicant:

E-mail: s.fagan@lancaster.ac.uk

Telephone: [REDACTED] (please give a number on which you can be contacted at short notice)

Address: DClinPsy Department, Lancaster University

7. Project supervisor(s), if different from applicant: Suzanne Hodge

8. Appointment held by supervisor(s) and institution(s) where based (if applicable): Lecturer in Health Research, Lancaster Uni.

9. Names and appointments of all members of the research team (including degree where applicable)

Charlotte Morris, Clinical Psychologist, North CMHT, Greater Manchester West Mental Health NHS Foundation Trust

The Project

NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials.

10. Summary of research protocol in lay terms (indicative maximum length 150 words):

Borderline Personality Disorder (BPD) is contentious diagnosis with criticism questioning the social narrative that surrounds it which includes pejorative labelling by mental health staff and the wider community. The stigma associated with the diagnosis of BPD is perpetuated by the individualisation of mental health difficulties and lack of relational focus. The aim of the current study is to explore the experiences of compassion in people with a diagnosis of borderline personality (BPD) through qualitative interviews to develop a compassionate, relational approach to explain some of the difficulties experienced by people with a diagnosis of BPD. Compassion was chosen due to its capacity to be relational. Moreover, there are recent studies suggesting the effectiveness of compassion-focused therapeutic approaches for people with a diagnosis of BPD. The study will take a qualitative design, interviewing 6 to 12 people with a diagnosis of BPD on the topic of compassion.

11. Anticipated project dates (month and year only)

Start date: August 2016

End date: May 2017

12. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

Six to Twelve adults (18+) with a diagnosis of BPD will be recruited from a UK population.

Inclusion criteria: adults (18+); diagnosis of BPD; English speakers; resident in the UK.

Exclusion criteria: unable to consent to take part; where taking part is deemed to be detrimental to the wellbeing of the individual or is self-reported as such.

13. How will participants be recruited and from where? Be as specific as possible.

During phase 1 of the recruitment strategy, I will contact service user groups (e.g. peer support groups, advocacy groups) within Central/Southern Scotland and Northern England. I will attend meetings within these settings to discuss the study, provide information and answer any questions. I will also advertise the research by displaying a poster at the location of the community support groups, hand out information leaflets and provide participant information sheets. The leaflet and poster will request that people who are interested complete an expression of interest form and return it to the researcher.

During phase 2 of the recruitment strategy, I will open up to a UK-wide population by advertising the research on social media, internet-based support groups, community / peer support groups and advocacy groups in the UK. The research poster will be disseminated via social media through the creation of a Twitter account. During this phase, telephone interviews will be offered.

14. What procedure is proposed for obtaining consent?

The contact details (name, telephone number, email / postal address) of those who express an interest in participating in the research will be provided in the expression of interest form. I will have a telephone conversation to further discuss the research and clarify what would be required from taking part. If an individual appears unable to consent to take part or appears distressed, they will be informed that they will be contacted following a discussion between the research team. A discussion will be held between the research team. If it is unclear whether an individual has capacity to consent or if there is concern that taking part in the research might be detrimental to their wellbeing, the individual will be excluded from taking part in the research. They will be contacted and informed of this decision. If the potential participant meets the inclusion criteria and would like to continue to take part, a date and time to conduct the interview will be arranged. When the individual attends for interview, we will discuss the information from the participant information sheet and answer any questions before signing a consent form.

15. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

If a participant becomes distressed during the interview, we will take a break from the interview. The participant will then be offered the opportunity to continue or end the interview. If a participant

wishes to end the interview, they will be debriefed. They will be given a debriefing sheet with a list of helplines and websites and we will discuss the distress caused and how the participant will manage this. I will also discuss with the individual whether or not they would like to withdraw their data from the study and remind them that they can withdraw their data up to 14 days after the interview. If I am affected by any aspect of an interview, I will discuss my feelings with the supervisory team. Other measures that will be taken to ensure that people feel safe and able to contribute, include the following:

- Prior to consenting to participate, individuals will be given an information sheet which will include information about research interviews, confidentiality and other relevant information so that they know what to expect if they choose to participate. There will also be an opportunity for people to speak with the researcher to ask further questions about any queries they have
- If it was felt that taking part in the interview would be detrimental to the mental health of a person (or lead to vulnerability), then they would be excluded by the researchers.
- During the initial screening conversation, potential participants will be asked whether they have support systems in place in case of any distress following the interview. This information will be used to inform the decision of whether they should participate or not. It will also be used if a person becomes distressed during or after the interview.
- Literature on conducting research interviews has been consulted and will be followed while conducting the research (Dongre & Sankaran, 2016; Eyseback & Till, 2001).
- Before commencing an interview, participants will be reminded that this is one-off interview and that they may want to consider this in deciding what to disclose so that they can take best care of themselves.

16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

Lancaster University's Lone Worker Guidance has been consulted due to the study requiring face-to-face interviews in the community. All research interviews will be conducted during daytime hours at a community location (e.g. community centre, service location of advocacy group / community support group). Each interview will be recorded in a diary: participants name, location and time of interview as part of a 'buddy system' with a colleague. A telephone call will be made to the 'buddy' after the completion of an interview.

17. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

Some people may find that they enjoy taking part in the research and having the opportunity to talk about their experiences and ideas. It can also be a positive experience to contribute to research and it is hoped that this information can be used to improve service provision for people in the future.

18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

Travel expenses will be reimbursed up to £20. However, interviews will take place at a location near to the participants and this will be discussed and agreed upon with each participant in advance.

19. Briefly describe your data collection and analysis methods, and the rationale for their use. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

The data will be collected via one-to-one interviews using a semi-structured interview schedule. These interviews will take place at community locations including third sector organisations and community centres. The interviews are anticipated to last between 30 and 90 minutes. The data will be analysed using Interpretative Phenomenological Analysis (IPA) to retain individuals' stories and contexts. In addition, developing a unified definition of compassion is difficult; IPA allows for the exploration of participants' personal perceptions of their experiences.

Research supervisors and a service user expert will provide consultation on the transcripts, codes and themes generated from the data. During the analysis, an audit trail and a reflective diary will be kept by the researcher which will note observations and justification for analysing the data in a certain way. Participants will be asked to provide feedback on the themes generated by the researcher.

At the beginning of the interviews, the researcher will discuss confidentiality and the anonymisation of information. It will be reiterated that any quotes that are used in the write-up of the study will be anonymised. The participants will be told that the researchers will adhere to confidentiality guidelines which includes the duty to disclose safeguarding concerns should any arise (i.e. harm to self or others). If a potential participant is discussed with the research team regarding the inclusion / exclusion criteria, names will not be mentioned to retain confidentiality (unless there is a safeguarding concern).

20. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

██ has been consulted and have provided feedback on the study design and research materials.

21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.

All personal information including contact details, consent forms and demographic data will be scanned into a computer and stored on Lancaster University's secure encrypted server in password-protected files. Hardcopies will be shredded as soon as possible after this time. The server will be accessed from the university or via a VPN on my personal computer. Personal data will be kept separately from the anonymised study data. Personal data will be destroyed after the thesis is assessed and the study data will be destroyed by a member of the DClinPsy programme staff at Lancaster University after 10 years.

Participants have the option to withdraw their data from the study up to 14 days after the interview. In this event, all personal information and study data will be deleted by myself, the researcher, as soon as possible after I have been notified.

22. Will audio or video recording take place? no audio video

If yes, what arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

As the dictafone is not encrypted, the audio recordings of the discussions will be moved to Lancaster University's secure encrypted server and stored in password-protected files. This will take place as soon as possible following the interview at which time the dictafone recording will be deleted. The original recordings will be stored on Lancaster University server until after the thesis has been assessed, at which time the recordings will be deleted. I will transcribe the audio recordings and store them in password-protected files on Lancaster University secure encrypted server. These will only be accessible by the researchers. This information will be destroyed by a member of the DCLinPsy programme staff at Lancaster University after 10 years.

23. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

An information sheet and/or video presentation which summarises the generalised, anonymised main findings will be created and made available to the participants and the groups in which recruitment takes place. A presentation will also be held at Lancaster University, the research sponsors. The research will also be submitted to an academic journal for publication.

24. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

The main ethical considerations are: informed consent, confidentiality and the potential for interviews to elicit distress. All of these matters are discussed full within the protocol.

Signatures: Applicant:

Date:

*Project Supervisor (if applicable):

Date:

*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review.

Appendices

Appendix 4-A: Research Paper Protocol

Experiences of compassion in adults with a diagnosis of borderline personality disorder: an interpretative phenomenological analysis.

Chief Investigator: Stephanie Fagan, Trainee Clinical Psychologist, Lancaster University

Academic Supervisor: Suzanne Hodge, Lecturer in Health Research, Lancaster University

Field Supervisor: Charlotte Morris, Clinical Psychologist, North CMHT, Bolton

Introduction

The Construct of Borderline Personality Disorder

Borderline Personality Disorder (BPD) is a diagnostic label described in the Diagnostic and Statistical Manual for Mental Disorders (DSM). The DSM was originally produced by the American Psychiatric Association as a tool to categorise and understand the array of experiences of people accessing support from psychiatrists (Cooper, 2014). The scope and influence of the DSM has grown since its first publication (Cooper, 2014) and diagnosis is often accompanied by a reductionist narrative of “dysfunction in biological or ‘underlying’ psychological processes” (Moncrieff, 2014). The current study takes a critical realist stance which is the philosophical position that “entities exist independently of being perceived, or independently of our theories about them” (Phillips, 1987, p. 205). From this perspective, the construct of BPD is considered to *exist* as an entity, but questions the current framework used to describe it.

The most recent definition of BPD in the fifth edition of the diagnostic manual describes “impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits” (American Psychiatric Association, 2013). Three main areas of difficulty for people with a diagnosis of BPD have been identified: the regulation of emotions, non-integrated self-concept and problematic interpersonal functioning (Cheavens, Strunk & Chriki, 2012). Relational theories such as attachment theory provide an explanatory framework for understanding these difficulties (Fonagy, 2000). However, the classification system of mental health difficulties overlooks the wider context of human suffering including relational and societal factors (Division of Clinical Psychology (DCP), 2013; Gambrell, 2014). This individualistic paradigm and the lack of conceptualisation regarding relational contexts can serve to perpetuate the stigma associated with BPD (Bonnington & Rose, 2014). The importance of a relational approach in BPD diagnoses is described by Giffin (2008) who discusses the interpersonal nature of the difficulties experienced by people with a diagnosis of BPD. Giffin describes how the emotional and behavioural difficulties referred to within the DSM criteria are often elicited and perpetuated by interpersonal dynamics. Moreover, the DSM framework lacks explanatory power regarding the construct of BPD (DCP, 2013).

‘Living With A Sense of Guilt and Shame’

One theory addresses these concerns by suggesting that aversive early experiences in relationships leads to low self-esteem and shame in people with a diagnosis of BPD (Finzi-Dottan, 2006; Horn, Johnstone & Brooke, 2007; Krawitz, 2012a; Schanche, Stiles, McCullough, Svartberg & Nielsen, 2011; Warren, 2015). In a quantitative study, Rusch et al. (2007) found that women with a diagnosis of BPD reported higher levels of guilt and shame than other people; and that levels of shame correlated with tendencies towards self-criticism. Similarly, Holm et al. (2009) conducted a qualitative study investigating the impact of trauma in early life and how it influenced the daily lives of women with BPD diagnoses. One of the themes was named ‘living with a sense of guilt and shame’ in which participants described feelings of shame and self-loathing.

Compassionate mind training (CMT) has been found to be effective for people with high levels of shame and self-criticism (Gilbert & Procter, 2006). This research has recently been applied to people with a diagnosis of BPD and compassion-focused approaches offered as a solution towards targeting feelings of shame and low self-esteem in this population (Feliu-Soler et al., 2016; Krawitz, 2012b; Lucre & Corten, 2013).

Compassion-Focused Approaches

Gilbert (2009) defines compassion as “a basic kindness, with deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it” (p.132). Recent psychological interventions have been developed utilising a compassion-focused approach; the most well-known of which is Compassion Focused Therapy (CFT; Gilbert and Procter, 2006). CFT is based upon evolutionary and neuroscientific models of emotion regulation. Gilbert proposes that there are three affect regulation systems which have evolved over millions of years: those that respond to threats, those that respond to rewards and those that detect safeness and give rise to feelings of contentment. This is known as the ‘three systems model’ within the CFT framework. CFT proposes that the system which gives rise to feelings of contentment can be activated and have beneficial effects upon emotion regulation. This has further implications for compassion-focused interventions with people with a diagnosis of BPD (where emotion dysregulation is proposed as a maintaining factor of life difficulties; Warren, 2015).

The effectiveness of compassion-focused interventions has been explored across a variety of populations, including people with high levels of self-criticism and shame; eating disorders; psychosis; personality disorders and addictions (Leaviss & Uttley, 2015). Two recent studies have been conducted to explore the effectiveness of compassion-focused approaches for people with a diagnosis of personality disorder. Lucre and Corten (2013) ran a 16-week CFT group and found a beneficial impact on a range of outcome measures which were maintained at 1-year follow-up. In addition, Feliu-Soler et al. (2016) conducted a study investigating the effectiveness of a 3-week training programme in loving kindness meditation (LKM) and compassion meditation (CM) for people with a diagnosis of BPD. LKM / CM

aims to foster positive emotions such as love for others and for oneself. Self-compassion is activated through imagery and focusing upon common humanity. Moderate to large effect sizes were found in the LKM/CM group for reductions in 'BPD severity' and self-criticism; and increases in mindfulness, self-kindness and acceptance.

Rationale

In summary, high levels of self-criticism and a lack of self-compassion have been implicated in some of the difficulties experienced by people with BPD diagnoses. The cultivating of self-compassion has been suggested as an effective intervention for both emotion regulation difficulties and high levels of shame and self-criticism in people with BPD diagnoses (Warren, 2015). Therefore, an exploration of the relationship between compassion, early experiences, emotion regulation and feelings of shame or self-criticism may provide more information on the lived experiences of people with BPD diagnoses. This has implications for working therapeutically with individuals using compassion-focused approaches.

Moreover, Gilbert et al. (2011) describes the flow of compassion in relation to self and other across three directions: compassion for others, compassion from others and compassion for the self. By exploring compassion across these domains, not only are relational experiences considered, but the impact of these experiences on the relationship to oneself. This appears important in light of qualitative research studies with people with a diagnosis of BPD linking negative interpersonal experiences in childhood to negative attitudes towards the self in adulthood (Finzi-Dottan & Karu, 2006; Horn, Johnstone & Brooke, 2007).

Research suggests that people with a diagnosis of BPD can experience difficult relationships with loved ones and professionals (Ekdahl, Idvall, Samuelsson & Perseus, 2011; Woollaston & Hixenbaugh, 2008) as well as pejorative labelling by mental health staff and the wider community (Nehls, 1999; Byrne, 2000; Furnham, Lee & Kolzeev, 2015). This stigma can lead to many difficulties for people with a diagnosis of BPD including social oppression and further impacting upon low self-esteem (Bonnington & Rose, 2014). By bringing an understanding, compassionate

narrative to the discourse around BPD, stigma can be challenged and used to inform care within mental health services.

Method:

Design

The primary aim of this research is to explore experiences of compassion. As this is theoretically-exploratory and requires an inductive approach, it is best-suited to qualitative research. In addition, the study aims to develop a compassionate and accessible narrative using colloquial language. Therefore, it was decided that a qualitative approach would be most suitable.

Participants

The participants will be adults with a diagnosis of borderline personality disorder.

The inclusion and exclusion criteria are as follows:

Inclusion Criteria

- Participant is willing and able to give informed consent for participation.
- Adult (age 18 +)
- Diagnosis of borderline personality disorder
- Resident in the United Kingdom
- Basic Level of English

Exclusion Criteria

The participant may not enter the study if ANY of the following apply:

- Unable to consent to take part.
- Where taking part is deemed to be detrimental to the wellbeing of the individual or self-reported as such. This will be decided in a discussion between myself, the researcher, and the supervisory team.

The aim will be to conduct six to twelve interviews as this range is indicated as sufficient for Interpretative Phenomenological Analysis (IPA).

Materials

A schedule for the interview has been developed which includes a structure, a list of open questions and prompts. The schedule focuses upon a discussion of experiences of compassion across the lifespan in relation to three broad aspects:

1. Experiences of receiving compassion from others
2. Experiences of feeling compassion towards others
3. Experiences of self-compassion

As this is an exploratory study, the interview schedule will be subject to change throughout the study where salient aspects of the experiences of compassion may be identified and focused upon in subsequent interviews.

Procedure

Recruitment Strategy. There will be a two-phase recruitment strategy. During the first phase, I will advertise the research via peer support networks, community support groups and advocacy groups within North England and Central/Southern Scotland. Groups that have already shown an interest in the project include [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. The research will be advertised by meeting with local groups to discuss the study, provide information and answer questions. I will also advertise the research by displaying a poster at the location of the groups, hand out information leaflets and participant information / expression of interest forms. Participants in phase 1 recruitment will be offered to attend a face-to-face interview at the location of the service or a local community service such as community centre or GP practice. Travel expenses up to £20 will be reimbursed by Lancaster University.

If required, phase 2 of the recruitment strategy will involve opening up the study to a UK-wide population. Groups outside of North England and Central/Southern

Scotland would be contacted. The research project will also be advertised online via social media (Twitter) and internet support groups ([REDACTED] [REDACTED]) where the research poster will be circulated. Due to the potential travel costs involved in recruiting beyond North England and Central/Southern Scotland, this phase of recruitment would offer telephone interviews to participants.

Expression of Interest. Across both phases of the study individuals who are interested in taking part will be asked to complete an expression of interest form. My contact details will be supplied and potential participants can contact me via a university email account or a telephone number supplied by Lancaster University. These contact details will be specified on the leaflet and poster. I will take the contact details (name, telephone number, email / postal address) of those who express an interest in participating in the research. This information will be stored in a password-protected file on Lancaster University's secure server. I will have a discussion via telephone to further discuss the research and clarify what would be required from taking part. A participant information sheet will be sent via email / post for those who have not received one by this point. A stamped-addressed envelope (SAE) will be included for postal correspondence.

Screening. The initial telephone conversation will provide the opportunity to discuss the exclusion criteria with the interested individual. Specific questions have been devised alongside conversations with a service user-led organisation to screen for eligibility to participate.

Diagnosis

The following questions will be asked to provide information to assess the validity of an individual's diagnosis:

- Do you have a diagnosis of emotionally unstable or borderline personality disorder?

- Who diagnosed you?
- How did you get the diagnosis?
- What are the difficulties that led you to seeking or being given a diagnosis?

Ethical Concerns

The following questions will be asked to provide information to assess an individual's ability to consent to participate and if taking part may be considered to be detrimental to their wellbeing:

- Do you feel that attending a research interview and discussing the topic of compassion would be detrimental to your wellbeing?
- If you did become distressed or upset following the interview, do you have strategies or support systems in place to manage these feelings?

Through an open discussion with the participant, I will assess whether the individual has concerns regarding their participation. I will also assess whether I have concerns about an individual's ability to consent to participate or the potential for participation to have a negative outcome. If I have any concerns, I will discuss these with the research team and a decision will be made between myself and my supervisors regarding the individual's eligibility to participate. If a person appears unable to consent to take part or appears distressed during this initial telephone conversation, they will be contacted subsequently and informed of this decision. In this event, individuals will be offered information regarding who to contact for support (as per the guidance in the ethical concerns section below). If an individual is assessed to be at immediate risk, immediate action will be taken (as per the guidance in the ethical concerns section below). If the potential participant meets the inclusion criteria and would like to continue to take part, a date and time to conduct the interview will be arranged.

Interview. A face-to-face interview will be conducted with the researcher during phase 1 of the recruitment strategy. The interviews will be held at the location of the community service that they were recruited from. If this is not possible, a room at a local community centre or GP practice will be booked. The interviews will be conducted during daytime hours when staff members are in the building. Lancaster University Lone Worker Policy will be consulted and a 'buddy system' will be in operation with a colleague. If phase 2 of the recruitment strategy is required, a telephone interview will be arranged.

Before commencing the interviews, the participant information sheet will be revisited and the participant will be asked to sign a consent form, complete a demographic information sheet and choose a pseudonym. During phase 1, this will be completed together in person; during phase 2, this will be completed over the telephone and individuals will be required to post the information to Lancaster University in the SAE that was provided.

All personal information including contact details, consent forms and demographic data will be scanned into a computer and stored on Lancaster University's secure encrypted server in password-protected files. Hardcopies will be shredded as soon as possible after this time. The server will be accessed from the university or via a VPN on my personal computer. Personal data will be kept separately from the anonymised study data. Personal data will be destroyed after the thesis is assessed and the study data will be destroyed by a member of the DClinPsy programme staff at Lancaster University after ten years.

The interviews are expected to last between 30 and 90 minutes, but this will be flexible depending on the participant and how much they wish to contribute. The researcher will record the interviews on an encrypted dictaphone supplied by Lancaster University. If phase 2 of the recruitment strategy is carried out, telephone interviews will be conducted using speakerphone and recorded on the dictaphone.

At the end of the interview, participants will be thanked for taking part in the study and debriefed. The researcher will ask the participant about their experience of the discussion and how they feel. They will be given a debriefing sheet which will inform them what to do if the conversation has caused any difficult feelings. If the interview is conducted via telephone, the debriefing sheet will be discussed and

emailed/mailed to the participant. Participants will also be asked whether they wish to provide feedback on the themes that are generated from the analysis or whether they would like to receive an information sheet following the completion of the study.

As the dictafone is not encrypted, the audio recordings of the discussions will be moved to Lancaster University's secure encrypted server and stored in password-protected files. This will take place as soon as possible following the interview at which time the dictafone recording will be deleted. The original recordings will be stored on Lancaster University server until after the thesis has been assessed, at which time the recordings will be deleted. I will transcribe the audio recordings and store them in password-protected files on Lancaster University secure encrypted server. These will only be accessible by the researchers. This information will be destroyed by a member of the DClinPsy programme staff at Lancaster University after 10 years.

Proposed analysis

The data will be analysed using Interpretative Phenomenological Analysis (IPA) to retain individuals' stories and contexts. In addition, IPA allows for the exploration of participants' personal perceptions of their experiences (Smith, 2004) which is important as developing a unified definition of compassion is difficult (Kneafsey, Brown, Sein, Chamley & Parsons, 2016).

Research supervisors and a service user expert will provide consultation on the transcripts, codes and themes generated from the data. During the analysis, an audit trail and a reflective diary will be kept by the researcher which will note observations and justification for analysing the data in a particular way. Participants will also be asked to provide feedback on the themes generated by the researcher to ensure that it is representative of the ideas that they shared.

Dissemination

Information which summarises the generalised, anonymised main findings will be created and made available within the participating third sector services. This will be in the form of an information sheet and/or a video presentation. Participants will have the option if they want to receive this information by email or post. A presentation will be held at Lancaster University, the research sponsors. The research will also be

submitted to an academic journal for publication. The proposed journal is Clinical Psychology & Psychotherapy.

Practical issues

Practical issues that may hinder the project include low recruitment, dependence on another individual for access to potential participants and poor data collection (i.e. lack of engagement or poor discussion schedule). Therefore, recruitment will begin as soon as ethical approval is granted. This will allow for the possibility of reaching different cohorts over time if there is low uptake or drop-out. I will make links with as many individuals within the local community services as possible and inform them of the research project. To ensure good quality data, the discussion schedule for the interviews will adopt open questions with prompts. In addition, a service user representative has been consulted as to the design of this schedule. The schedule will also be subject to revision over time depending upon the outcomes of the analysis throughout data collection. The researcher will meet with potential participants or have a telephone conversation before the interviews to make introductions and built rapport.

Rooms will be booked for the interviews in advance across the service locations. Any small costs such as printing and stamped-addressed envelopes will be paid for by the university. A dictaphone will be provided by Lancaster University. The storage of the data has been carefully considered and will be stored on an encrypted and password-protected device before being saved onto Lancaster University's secure server.

Ethical concerns

The main ethical concerns regarding the study are in relation to any distress associated with participation in the interviews, informed consent and confidentiality of taking part. These issues will be discussed in detail below.

Informed Consent. Potential participants will be included if they have other diagnosed mental health difficulties. This decision was made to ensure that the participant group is representative and to not unfairly exclude people from participating. However, a

person will be excluded if deemed unable to consent to take part of if taking part might be considered detrimental to their wellbeing. Every potential participant will be spoken to via telephone or face-to-face (if through a local community group). This will provide an opportunity to get to know the individual, discuss the research and answer any questions. There will also be a discussion regarding exclusion criteria. Individuals will be asked whether they feel able to consent to participate and whether they feel that taking part might cause them any difficult emotions. Specific questions to ask at this stage were devised alongside a service user expert as outlined in the procedure section above. If there are concerns at this stage, the individual will be informed that a discussion will be held between the research team and a decision made based upon whether the participant meets the inclusion criteria. If there are no concerns, then the participant will be invited for interview. If the researcher has concerns, a discussion will be held between the research team and then the potential participant contacted with the outcome. If a participant is deemed not to be eligible for participation, these concerns will be discussed with them and they will be advised to contact a relevant party such as their GP or another professional. If there are immediate concerns, relevant safeguarding procedures will be followed.

Distress during the interviews. If a participant becomes distressed during the interview, we will take a break from the interview. The participant will then be offered the opportunity to continue or end the interview. If a participant wishes to end the interview, they will be debriefed. They will be given a debriefing sheet with a list of helplines and websites and we will discuss the distress caused and how the participant will manage this. I will also discuss with the individual whether or not they would like to withdraw their data from the study and remind them that they can withdraw their data up to 14 days after the interview. If I am affected by any aspect of an interview, I will discuss my feelings with the supervisory team.

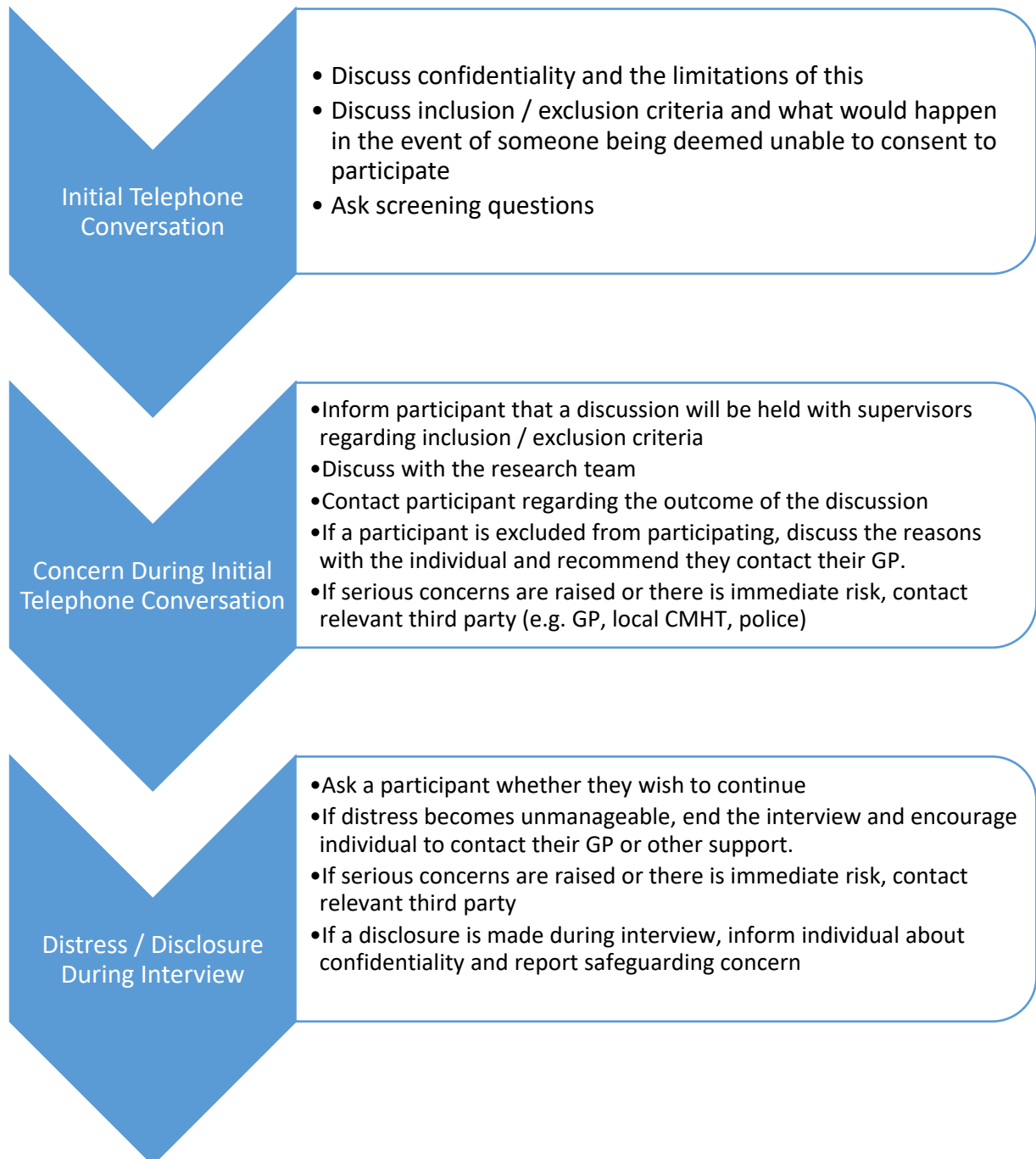
Other measures that will be taken to ensure that people feel safe and able to contribute, include the following:

- Prior to consenting to participate, individuals will be given an information sheet which will include information about research interviews, confidentiality and

other relevant information so that they know what to expect if they choose to participate. There will also be an opportunity for people to speak with the researcher to ask further questions about any queries they have.

- If it was felt that taking part in the interview would be detrimental to the mental health of a person (or lead to vulnerability), then they would be excluded by the researchers.
- During the initial screening conversation, potential participants will be asked whether they have strategies and/or support systems in place in case of any distress following the interview. This information will be used to inform the decision of whether an individual meets the inclusion criteria. It will also be used if a person becomes distressed during or after the interview.
- Literature on conducting research interviews has been consulted and will be followed while conducting the research (Dongre & Sankaran, 2016; Eyseback & Till, 2001).
- Before commencing an interview, participants will be reminded that this is one-off interview and that they may want to consider this in deciding what to disclose so that they can take best care of themselves.

Confidentiality within the interviews. At the beginning of the interviews, the researcher will discuss confidentiality and the anonymisation of information. It will be reiterated that any quotes that are used in the write-up of the study will be anonymised. The participants will be told that the researchers will adhere to confidentiality guidelines which includes the duty to disclose safeguarding concerns should any arise. If a potential participant is discussed with the research team regarding the inclusion / exclusion criteria, names will not be mentioned to retain confidentiality (unless there is a safeguarding concern).

Risk Flow Chart

Timescale

Overall time frame: February 2016 – May 2017

End June 2016: Submission of Ethics Application.

July 2016 – December 2016: Write-up of introduction and method

September - October 2016: Advertisement and recruitment (after ethical approval received).

October 2016 – December 2016: Collection and transcription of data.

January 2017 – March 2017: Analysis of data; write-up of results and discussions.

April 2017: Draft submission.

May 2017: Final submission.

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Appendix 4-B: Interview Schedule

**Interview Schedule**

The following schedule for the interviews provides a general outline including prompt questions. However, if the participants bring other ideas that are relevant to the topic area, it will be okay to deviate to capture this wide range of ideas.

General Topic

What are the experiences of compassion in adults with a diagnosis of BPD in relation to self and other?

Introduction to terms

An introduction to the terms used in the study by discussing the terms ‘emotionally unstable (EU) or borderline personality disorder (BPD)’ and ‘compassion’ and exploring the personal meaning of these terms for each participant:

- What does the diagnosis EU/BPD mean for you?

Provide information about the definition of compassion according to the research base (i.e. kindness, care, strength, wisdom and courage applied to the relief of suffering)

- Does this align with your definition of compassion? What is your meaning of this term in your own words? And are there any other terms that you would prefer to use to describe this experience?
 - Is compassion a feeling, a behaviour, an idea? Where does it come from? What does it relate to? Does it extend to all people or is it reserved for specific people in a person’s life? Are there other words that you would use in place of ‘compassion’?

Feelings of compassion for others

- What have been your experiences of feeling compassion towards others?
 - Did you feel compassionate towards others as a child?

- Do you feel compassionate towards others now?
- Do you feel compassion to family, friends, partners, or others more widely?
- What does it mean to you to feel compassion for another person?
- Have these experiences changed across your life?
 - What has influenced these changes?
- What helps, or does not help, you to feel compassion for others?
- Do you feel that there are any barriers to feeling compassion for others?
- Do you think that there is a relationship between your experiences of feeling compassion towards others and the experience of EU/BPD?
 - In what way are these experiences related?
 - Are there ways in which these experiences are not related?

Experiences of receiving compassion

- What have been your experience of receiving compassion across your life?
 - Are there particular memories that you associate with compassion?
 - Do you have early experiences of receiving compassion?
 - What are your experiences of receiving compassion in adulthood?
 - Do these experiences relate to parents, friends, teachers, partners or others?
 - Have these experiences changed across your life?
 - What has influenced these changes?
 - What helps, or does not help, you to receive compassion from others?
 - Do you feel that there are any barriers to receiving compassion from others?
- Do you feel that there is a relationship between your experiences of receiving compassion and the experience of EU/BPD?
 - In what way are these experiences related?
 - Are there ways in which these experiences are not related?

Experiences of self-compassion

- What have been your experiences of feeling compassion towards yourself?

- Did you feel compassion towards yourself as a child?
- Do you feel compassion towards yourself now?
- What does it mean to you to feel compassionate towards yourself?
- Have these experiences changed across your life?
 - What has influenced these changes?
- What helps or does not help you to feel compassion towards yourself?
- Do you feel that there are any barriers to feeling compassion towards yourself?
- Do you feel that there is a relationship between your experiences self-compassion and the experience of EU/BPD?
 - In what way are these experiences related?
 - Are there ways in which these experiences are not related?

Comparison

- Is there any comparison between receiving compassion, feeling compassion towards others and self-compassion?
- Is there any comparison between these experiences of compassion and the experience of EU/BPD?
 - Do experiences of compassion impact upon the potential for receiving a diagnosis of EU/BPD or experiencing the difficulties described by EU/BPD?
 - Do experiences of compassion impact upon any of your day-to-day experiences that you relate to EU/BPD?
 - Are there any specific aspects of the experiences of compassion that impact upon specific aspects of EU/BPD?
- Would you identify any other common themes throughout this discussion?

Final Thoughts

- Do you have any other observations, thoughts or comments that we have not covered so far?

Participant Information Sheet**Experiences of compassion in adults with a diagnosis of borderline personality disorder.**

My name is Stephanie Fagan and I am a trainee clinical psychologist at Lancaster University. I am carrying out a study and would like to invite you to take part. Before you decide, I would like you to understand why the research is being done and what you would need to do. Please take time to read the following information carefully. If anything is not clear or if you would like more information, please contact me. My contact details are listed at the end of this information sheet.

What is the study about?

This study involves exploring the experiences of compassion in your life. Compassion is a word with different meanings for different people. It can include kindness, care, strength, wisdom and courage applied to the relief of suffering. We would like to explore how experiences of compassion might relate to day-to-day experiences of living with emotionally unstable/borderline personality disorder or how they might have an influence on shaping what it means to have this diagnosis.

Why have I been invited?

You have been invited to participate because you meet the inclusion criteria for the study: you are an adult (age 18+) who has received a diagnosis of emotionally unstable/borderline personality disorder and you live in the UK.

Do I have to take part?

It is up to you to decide if you want to take part. You can read this information sheet and take it away and discuss it with others. You can contact me if you have any further questions about the study. If you wish to take part, I will ask you to sign a consent form to show you agree to take part. You are free to withdraw at any time, without giving a reason and there will be no negative consequences.

What will happen to me if I take part?

You will be invited to attend an interview. If you live in the North of England or the South/Central belt of Scotland, I will arrange to meet with you at a location in the community. If you live in the UK, but outside of this region, we can arrange a telephone interview. The interview is expected to last between 30 and 90 minutes, though this is flexible depending upon how much or little you would like to contribute. I will ask you to sign a consent form and a form that asks for some information such as age, gender, ethnicity, etc and you will have the opportunity to ask any questions before we begin. I then have a few questions about your experiences of compassion.

The interviews will be audio-recorded so that the discussion can be typed up. This audio-recording will only be heard by me when I am typing up our discussion and will be deleted after the study has been assessed. I will then read back all the interviews from different participants and pull together common themes (i.e. thoughts or ideas that a selection of participants in the study have discussed). When writing up the study, I will use some examples of what you've said. These quotes will be made anonymous and we will ensure that no information is used that would identify you as having taken part in the study.

After the interview, you are not required to do anything else; however, I would like to contact participants with the initial themes that come from the study to check whether they align with what we discussed. Although, it would be helpful to have your input at this stage, it is not essential.

Expenses and payments?

The interviews will be held at a location local to you or via telephone. If you are required to travel to the interview, you will be reimbursed up to £20.

How do I take part?

If you decide to take part after reading this information sheet, you can complete the expression of interest form below and pass on your details to me via email or post. I will then contact you via telephone, at a time convenient to you, to introduce myself and have a chat about the research. There is no commitment to proceed at this point, but if you wish to, we can then arrange a time to conduct the interview.

What are the possible disadvantages of taking part?

The main disadvantage of taking part is the time to attend the interview. I would hope that this would not be upsetting for you and so ask you to only share information that you feel comfortable with. However, if you did become upset when discussing this topic, we can take a break or end the interview.

What are the possible benefits of taking part?

Some people may find that they enjoy taking part in the research and having the opportunity to talk about their experiences and ideas. It can also be a positive experience to contribute to research and it is hoped that this information can be used to improve experiences for people in the future.

What if there is a problem?

If you have a concern about any aspect of this study, you may contact the researchers who will do their best to answer your questions. The contact details are below. If you remain unhappy and wish to complain formally you can do this by contacting Professor Roger Pickup, Lancaster University Research Director, on 01524 593746 or by email to r.pickup@lancaster.ac.uk.

Will my taking part in the study be kept confidential?

The information you provide is confidential. That means that your personal information will not be shared with anyone outside the interview. Any quotes that are used in the write-up of the study will be made anonymous. You can choose a name that you would like to use to go beside the quote. I will not use any quotes that could potentially identify you as a participant in the study. There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to another professional about this. If possible, I will tell you if I have to do this.

What will happen to information about me collected during the study?

All data will be stored securely in accordance with the Data Protection Act (1998) and only the researchers will have access to this information. The interviews will be recorded on a password-protected dictaphone. The discussion will be typed up as soon as possible afterwards. This will contain only anonymous information. The audio recording will be destroyed after the study has been assessed. All personal data including signed consent forms, demographic information and the interview transcription will be scanned on to a computer and kept on Lancaster University server in an encrypted and password protected file that is only accessible to the researchers. This information will be deleted after 10 years.

What will happen to the results of the study?

When the study is completed, the results (overall ideas or 'themes' that have been pulled together from the interviews) will be submitted to a scientific journal for publication. Your identity and personal details will be kept confidential and no named information about you will be published in any reports. The results will also be provided in a summary information sheet and/or video presentation and you can choose whether or not you would like to receive copies.

What will happen if I don't carry on with the study?

You can withdraw from the study up to 14 days after the interview and all reasonable attempts will be made to remove your data from the study. However, if you withdraw from the study after the findings have been analysed, it will not be possible to withdraw your contribution. In this instance, we will ensure that no quotes that came from you will be included in the written-up study.

Who is supporting the research?

The research is supported by Lancaster University.

Who has reviewed the study?

The study has been approved by Lancaster University and reviewed by a university Research Ethics Committee to protect your safety, rights, wellbeing and dignity.

Further information and contact details:

If you have any questions about this research project or would like further information, please contact Stephanie Fagan. Detail given below.

Thank you for taking the time to read this information sheet. Please find attached the expression of interest form if you wish to participate.

Expression of Interest in Study

Experiences of compassion in adults with a diagnosis of borderline personality disorder.

I am interested in taking part in the above study. Please contact me to arrange a meeting.

Name _____

Please fill in your contact details below with your preferred method(s) of contact. You do not need to supply all of this information.

Telephone number _____

Is there a time that is best to call? _____

Email _____

Postal address _____

You can hand this form to the researcher or return using the email / postal address provided below:

Contact details

Stephanie Fagan

Researcher

Clinical Psychology

Division of Health Research

Lancaster University

Lancaster

LA1 4YG

Tel: 07852 516 812

Email: s.fagan@lancaster.ac.uk

Appendix 4-D: Consent Form

**Consent Form****Study Title: Experiences of compassion in adults with a diagnosis of borderline personality disorder.**

We are asking if you would like to take part in a research project exploring experiences of compassion in adults with a diagnosis of emotionally unstable / borderline personality disorder.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Stephanie Fagan.

Please initial
each statement

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study
2. I confirm that I have had the opportunity to ask any questions and to have them answered.
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript.
4. I understand that audio recordings will be kept until the research project has been examined.
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published

Please initial
each statement

8. I consent to information and quotations from my interview being used in reports, conferences and training events.
9. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with her research supervisor.
10. I understand that anonymised information will be shared and discussed with the investigator's research supervisors.
11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.
12. I consent to take part in the above study.

Name of Participant _____

Signature _____

Date _____

Name of Researcher _____

Signature _____

Date _____

Appendix 4-E: Debriefing Sheet

**Debriefing Sheet****Experiences of compassion in adults with a diagnosis of borderline personality disorder.****Researcher's name** Stephanie Fagan**Supervisor's name** Suzanne Hodge and Charlotte Morris

Thank you for taking part in this study. I will now explore themes from the discussion and write-up the project. Following this, I will prepare a summary information sheet and/or a video presentation with the findings from the study. You can provide me with your email address or a postal address and I can send this information out to you if you wish. The deadline for the project is May 2017 and so I would expect to bring information back soon after this time.

I hope that you found taking part in this study to be a good experience. However, if you became upset by the discussion and are feeling sad or worried, it is really important that you speak to someone. This could be your GP, a family member, friend or someone that you feel able to confide in. I have also included some helpline numbers and websites:

The Samaritans

Telephone: 08457 90 90 90

Email: jo@samaritans.orgWebsite: <http://www.samaritans.org/>

ReThink Mental Illness

Telephone: 0300 5000 927

Website: www.rethink.org

Thank you again for your participation.

Appendix 4-F: Demographic Information Sheet

**Demographic Information Sheet****Experiences of compassion in adults with a diagnosis of borderline personality disorder.****Researcher's name** Stephanie Fagan**Supervisor's name** Suzanne Hodge and Charlotte Morris

It would be helpful to have some details about the ages, gender and ethnicity of people taking part in the research. If you prefer not to let us know any part of this information, you can leave the line blank. The gender and ethnicity lines have been left open so you can use any term that you feel best describes you.

You can also choose a pseudonym (a made-up name). When the research is written up, all quotes will be made anonymous so that you are not identified. However, we can use the pseudonym you choose to write next to any quotes you made. Therefore, it is best to use a pseudonym that you feel will not identify you.

Age (years): _____

Gender: _____

Ethnicity: _____

Pseudonym: _____

Any other mental health diagnoses _____

Appendix 4-G: Future Contact



Future Contact

Experiences of compassion in adults with a diagnosis of borderline personality disorder.

Researcher's name Stephanie Fagan

Supervisor's name Suzanne Hodge and Charlotte Morris

- 1. Following the data analysis stage, would you like to provide feedback on the themes that are generated from the study?

Yes / No (please circle)

- 2. a) Once the project has been written up, would you like to receive a summary of the outcomes of the study?

Yes / No (please circle)

- b) If Yes, would you like to receive this information by email or post?

Email / Post (please circle)

Signed (research participant)

Print name

Date

Thank you.

Appendix 4-H: FHMREC Approval Letter



Applicant: Stephanie Fagan

Supervisor: Suzanne Hodge

Department: Health Research

FHMREC Reference: FHMREC15114

19 September 2016

Dear Stephanie

Re: Experiences of compassion in adults with a diagnosis of borderline personality disorder: an interpretative phenomenological analysis.

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

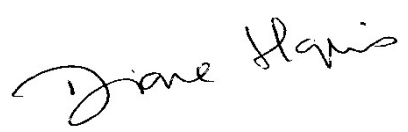
- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 592838

Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

A handwritten signature in black ink that reads "Diane Hopkins". The signature is written in a cursive style with a large, looping initial "D".

Dr Diane Hopkins

Research Integrity and Governance Officer, Secretary to FHMREC.