

**RECOVERY IN PEOPLE WITH A DIAGNOSIS OF BORDERLINE
PERSONALITY DISORDER**

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List of Contents

List of Appendices	6
List of Tables.....	7
List of Figures.	7
Thesis Abstract.....	8
Declaration.....	9
Copyright Statement	10
Acknowledgments.....	11
Chapter 1 Introduction.....	12
1.1 Introduction Overview.....	12
1.2 Personality Disorder	12
1.2.1 What is Personality Disorder?	12
1.3 Borderline Personality Disorder	13
1.5 Prevalence and Course of Borderline Personality Disorder	15
1.5.1 Gender	16
1.5. Ethnicity	17
1.5.3 Borderline Personality Disorder in Young People	17
1.6 Problems with Diagnosis and Alternatives.....	19
1.7 Complexity of Borderline Personality Disorder.....	20
1.8 Causes.....	21
1.8.1 Neurobiological Theories	21
1.8.2 Genetics	22
1.8.3 Attachment Theory	22
1.8.4 Object Relations Theory.....	24
1.8.5 Mentalization	24
1.8.6 Emotional Dysregulation.....	25
1.8.7 Cognitive Theories	26
1.8.8 Summary of Causes	27
1.9 Psychological Treatment	27
1.9.1 Transference Focused Psychotherapy	28
1.9.2 Mentalization Based Therapy	28
1.9.3 Dialectical Behaviour Therapy	29
1.9.4 Cognitive Analytic Therapy	29
1.9.5 Schema Therapy	30

1.9.6	Therapeutic Communities	31
1.9.7	Common Features.....	31
1.10	Service Provision.....	32
1.10.1	Staff Attitudes and Understanding	33
1.11	Borderline Personality Disorder Summary	34
1.12	Recovery.....	34
1.12.1	Components of Recovery	36
1.13	Problems with Lack of Definition	39
1.14	Criticisms of Recovery	39
1.15	Measures.....	41
1.16	Recovery Summary	42
1.17	Personality Disorder and Recovery	42
1.18	Recovery: Same or Different?	43
1.19	What is Known About Recovery in Borderline Personality Disorder?....	44
1.20	Personality Disorder and Recovery Summary	48
1.21	Aims and Hypotheses.....	49
1.22	About Q Method.....	49
1.23	Rationale for Using Q Methodology.....	50
Chapter 2 Method		52
Part 1.....		
2.1	Method Overview	52
2.2	Ethical Approval.....	52
2.3	Study Design.....	52
2.3.1	Overview of Q Methodology.....	52
2.4	Exploration of the Q Concourse	53
2.5	Source of Items: Review of Literature	55
2.6	Development of the Q Set	55
2.6.1	Theme Extraction	55
2.6.2	Q Sampling.....	57
2.6.3	Preparation of Statements for Q Sorting Process	59
2.6.4	Pilot Testing.....	59
2.7	Materials	60
2.7.1	The Q Sort Pack.....	60

2.7.2	58-item Q Set.....	60
2.7.3	Guide Bar and Distribution Grid	60
2.7.4	Narrative Instruction Sheet.....	61
2.7.5	Scoring Sheet.....	61
Part 2		
2.8	Participants	62
2.8.1	Identification and Recruitment of Participants.....	62
2.8.2	Recruitment Procedure.....	62
2.9	Inclusion and Exclusion Criteria	63
2.9.1	People with a Diagnosis of Borderline Personality Disorder	63
2.9.2	Staff Members	63
2.10	Sample Size.....	64
2.11	Conducting Q Sorts	64
2.11.1	Place and Environment.....	64
2.11.2	Consent	65
2.11.3	Demographic Information	65
2.12	Instructions for Q Sort	65
2.12.1	Initial Sort.....	65
2.12.2	Main Sort	66
2.12.3	Brief Feedback Interviews.....	66
2.12.4	Payment	67
2.13	Reflexivity	67
2.14	Data Handling and Confidentiality.....	67
2.15	Data Analyses	68
Chapter 3	Results.....	69
3.1	Participant Information.....	69
3.2.	Factor Analysis	70
3.2.1	Factor Loadings	72
3.2.2	Factor Arrays	73
3.3	Distinguishing Statements and Consensus Statements.....	76
3.3.1	Factors Ranked Important to Recovery	77
3.3.2	Factors Ranked Not Important to Recovery	78
3.4	Factor Descriptions and Interpretation	79
3.4.1	Factor 1: Difficulties Associated with Borderline Personality Disorder ..	80

3.4.2	Factor 2: Universality of Recovery	83
3.4.3	Factor 3: Relationship with Self and Others.....	85
3.4.4	Additional Feedback.....	87
Chapter 4	Discussion	90
4.2	Summary and Interpretation of Findings.....	90
4.3	Findings in Light of Previous Research	91
4.4	Summary.....	99
4.5	Study Limitations and Strengths	100
4.5.1	Study Strengths.....	100
4.5.2	Study Limitations	102
4.6	Clinical Implications	107
4.7	Recommendations for Further Research	109
4.8	Personal Reflections	110
4.9	Conclusions	112
	References.....	113

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List of Appendices

Appendix A. Personality Disorder Subtypes According to the DSM-5 Classification.....	140
Appendix B. The International Classification of Mental and Behavioural Disorders (10 th revision) Criteria for Emotionally Unstable Personality Disorder, Borderline Type..	141
Appendix C. List of Sources used to Sample the Q Set.....	142
Appendix D. List of Statements (Q Set).....	143
Appendix E. Study Information Sheets.....	145
Appendix F. Example Consent Forms.....	153
Appendix G. Six Factor Solution.....	157
Appendix H. Scree Plot.....	158
Appendix I. Interpretation Sheets.....	159
Appendix J. Visual Representation of Factor 1 Array. List of Exemplary Statements and Distinguishing Statements for Factor 1.	165
Appendix K. Visual Representation of Factor 2 Array. List of Exemplary Statements and Distinguishing Statements for Factor 2.	167
Appendix L. Visual Representation of Factor 3 Array. List of Exemplary Statements and Distinguishing Statements for Factor 3.....	169

List of Tables

Table 1. DSM-5 Diagnostic Criteria for Borderline Personality Disorder.....	14
Table 2. Participant Demographics.....	69
Table 3. Breakdown of Staff Members by Profession and Service Type.....	70
Table 4. Final Extracted Factors with Eigenvalues and Explained Variance.....	71
Table 5. Correlations Between Factors.....	71
Table 6. Rotated Factor Matrix with Loadings for each Q Sort.....	72
Table 7. Factor Arrays for Factors 1, 2, and 3	73
Table 8. Consensus Statements and Ranking for Each Factor.....	77
Table 9. Factor 1 Participants.....	83
Table 10. Factor 2 Participants.....	85
Table 11. Factor 3 Participants.....	87

List of Figures

Figure 1. Flowchart of stages in Q methodology.....	54
Figure 2. Quasi-normal distribution grid.....	61

Thesis Abstract

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Title: Recovery in people with a diagnosis of borderline personality disorder

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Aims. Understandings of recovery in borderline personality disorder are limited. Research has suggested that people with borderline personality disorder may not identify with some general mental health recovery principals. It is also not clear if there are differences in perceptions of recovery between people with borderline personality disorder and staff members. The study set out to explore and understand perceptions of recovery in borderline personality disorder and identify which factors are most important.

Design and Method. A Q methodology design was used, incorporating 58 statements on recovery that participants were required to sort, in order of how important they felt they were to recovery. An opportunity sample ($N= 22$) was recruited, consisting of 6 people with a diagnosis of borderline personality disorder and 16 staff members, from various services within the North West of England.

Results. Principal component factor analysis with a varimax rotation revealed three factors, representing distinct viewpoints from 19 participants. The dominant viewpoint placed importance on reducing features and symptoms specific to borderline personality disorder. The second viewpoint was concerned with universal, humanistic recovery principals and the third viewpoint saw relationships, both with the self and with others as most important to recovery.

Conclusions. Views on recovery in personality disorder are similar to general mental health recovery principals but there also may be recovery views which are more specific to the borderline personality disorder diagnosis. Areas for further research include the extent to which recovery is a transdiagnostic concept and the extent to which recovery values are influenced by therapy models and service requirements.

Keywords: recovery, borderline personality disorder, staff views, Q methodology.

Declaration

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Chapter 1 Introduction

1.1 Introduction Overview

This chapter will outline what is meant by borderline personality disorder, the history of this term, some explanations of its origins and potential psychological treatments. The following sections in the chapter will outline the concept of recovery in mental health and discuss this in relation to borderline personality disorder. The chapter will also give an overview of Q methodology and the rationale for use in the current study.

1.2 Personality Disorder

Personality disorder, in particular borderline personality disorder is associated with negative attitudes. People often refer to personality disorder as:

significant impairment....emotional instability....manipulative....pervasive and inflexible....dramatic and irrational.....severe personality pathology....burden to services....difficult to treat....

Until recently, personality disorder was viewed as an untreatable condition (Bateman & Tyrer, 2004; Paris, 2012). Developments in treatment models and the expansion in advocacy services have begun to shift this view (Friedel, 2006). Nevertheless, the title of personality disorder still carries great stigma, arguably to a greater degree than other mental health disorders. Negative attitudes towards personality disorder are still prevalent amongst professionals and in society (Pandya, 2014) and beliefs about untreatability remain (National Institute for Mental Health England [NIMHE], 2003a). Many healthcare professionals feel under-skilled in working with this client group (Cleary, Siegfried & Walter, 2002). Personality disorder is costly to health services (Bateman & Fonagy, 2003).

1.2.1 What is Personality Disorder?

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013, p.646) defines personality disorder as: *'An enduring pattern of inner experience and behaviour that deviates markedly from the*

expectations of the individual's culture, is inflexible and pervasive, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment'. The DSM-5 (APA, 2013) lists ten specific personality disorder subtypes, categorised into three clusters, according to characteristic behaviours (Appendix A). Cluster A is characterised by odd or eccentric behaviour, Cluster B is characterised by dramatic or irrational behaviour and Cluster C is characterised by anxious or fearful behaviour.

The International Classification of Mental and Behavioural Disorders 10th revision (ICD-10; World Health Organisation, 1992, p.222) defines personality disorder as: '*Severe disturbances in the characterological condition and behavioural tendencies of the individual, usually involving several areas of personality, and nearly always associated with considerable personal distress and social disruption*'. ICD criteria list nine categories of personality disorder.

1.3 Borderline Personality Disorder

The DSM-5 (APA, 2013, p.663) defines borderline personality disorder as: '*A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning in early adulthood*'. This pattern should be present over a variety of contexts, indicated by five or more criteria (listed in Table 1).

Table 1: DSM-5 diagnostic criteria for borderline personality disorder (APA, 2013, p. 663)

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

Borderline personality disorder is classed within cluster B of the personality disorders. The category of borderline personality disorder does not exist within the ICD classification system (World Health Organisation, 1992). There is a disorder named *Emotionally unstable personality disorder, borderline type*, which is thought to be the equivalent (diagnostic criteria are listed in Appendix B). This disorder category does not include the psychotic like experiences described in DSM-5 (criterion 9). Diagnosis in Britain tends to be according to ICD criteria, but DSM criteria are generally used for research purposes.

1.4 History

The construct of borderline personality has had multiple meanings, and has been used to describe a personality organisation, a syndrome and is now known as a disorder (Gunderson & Links, 2008). The term 'borderline' was first used by the psychoanalyst Adolph Stern (1938) to describe people who did not fit neatly into the categories of psychotic or neurotic, and did not respond well to psychotherapy. Later, borderline was used to describe a particular pattern of personality organisation (Kernberg, 1967), rather than a specific disorder. Difficulties in identity integration are a feature of this type of personality organisation. Kernberg was the first to suggest that this group of people could be treated successfully with psychotherapy (Gunderson & Links, 2008). The formal diagnosis of borderline personality disorder appeared in DSM-III (APA, 1980). This was following an influential paper defining the major characteristics of borderline personality disorder (Gunderson & Singer, 1975). Prior to publication of DSM-III, people with borderline personality disorder were often diagnosed as having schizophrenia (Gabbard, 1994). The current diagnostic criteria have changed very little since the DSM-III descriptions.

1.5 Prevalence and Course of Borderline Personality Disorder

Personality disorders are common (NIMHE, 2003a; Pedersen & Simonsen, 2014). The prevalence of personality disorder within the general population in Britain is approximately 4.4 percent (Coid, Yang, Tyrer, Roberts & Ulrich, 2006). In the same study, the prevalence of borderline personality disorder was 0.7 percent. A similar prevalence has been reported in Europe (e.g., Pedersen & Simonsen, 2014). Borderline personality disorder has been more frequently reported in Western cultures such as Europe and North America (Bjorklund, 2006) but has also been reported in non-Western cultures, for example in India (Gupta & Mattoo, 2010). The prevalence of borderline personality disorder in primary care settings (i.e., G.P surgeries and health centres) is six percent (APA, 2013). The difficulties in diagnostic methods make it problematic to make an accurate estimate (NIMHE, 2003a).

Borderline personality disorder is not as enduring as was first hypothesised. Studies have found that personality disorder improves over time, in terms of improved

functioning on self-report measures and no longer meeting diagnostic criteria (e.g., Gunderson et al., 2011; Paris, 2012; Sanislow, Marcus & Reagan, 2012). Remission rates (i.e., no longer meeting diagnostic criteria) of up to 78 percent at eight years follow up have been reported (Zanarini, Frankenburg, Reich & Fitzmaurice, 2012). Remission rates and overall functioning are lower in people with a diagnosis of borderline personality disorder in comparison to people with other personality disorders (Zanarini et al., 2012). The remission and clinical recovery data in borderline personality disorder have been compared to people with Axis 1 disorders (e.g., anxiety disorders), where improvement seems to be much quicker, but recurrence is more common in Axis 1 disorders (Bateman & Fonagy, 2006).

1.5.1 Gender

The prevalence of personality disorder is thought to be similar in males and females; however, a gender bias has been found with regard to specific personality disorders. A diagnosis of antisocial personality disorder is more common amongst males and borderline personality disorder diagnoses are more common in females (NIMHE, 2003a). Approximately 75 percent of borderline personality disorder diagnoses are in females (APA, 2013). The difference in prevalence may reflect real gender differences. However, this also may be due to diagnosis bias or bias in assessment tools (British Psychological Society [BPS], 2006). Sexual abuse is more common in females than males (Jonas et al., 2011) and given that borderline personality disorder is associated with sexual abuse, this may partly explain the higher incidence. Males and females may use different coping behaviours. Women may be more likely to use internalising behaviours (e.g., food, self-harm) and men may be more likely to use externalising behaviours (e.g., aggression, use of alcohol or drugs) (Johnson et al, 2003; Paris, Chenard-Poirier, & Biskin, 2013; Zanarini et al., 1998). However, DSM-5 (APA, 2013) does warn against the dangers of over/under diagnosing particular personality disorders due to gender stereotypes. From a feminist and social construction perspective (e.g., Bjorklund, 2006; Shaw & Proctor, 2005; Warner & Wilkins, 2004) borderline personality disorder may be created around gender roles and cultural and societal expectations, which locate pathology ‘inside’ an individual, therefore ignoring causal

systems, such as oppression and power inequalities. In borderline personality disorder, females may be seen as not living up to their gender role, by showing aggression or anger and can be viewed as 'irrational'. There may be less tolerance in society for females engaging in certain behaviours (e.g., risky behaviours, sexual promiscuity). Males may also be less likely to seek out psychological help. Not all research has found evidence towards a gender bias (e.g., Torgersen, Kringlen & Cramer, 2001) and it is likely that males are under diagnosed and more likely to end up in the criminal justice system (Bateman & Krawitz, 2013). The prevalence of borderline personality disorder in mental health settings is thought to be 20 percent, but higher in prison populations (APA, 2013).

1.5.2 Ethnicity

Cultural and ethnic differences have been reported in the occurrence of personality disorder. White people are more likely than black people to have a personality disorder diagnosis (Byrne, Henagulph, McIvor, Ramsey & Carson, 2014; National Collaborating Centre for Mental Health [NCCMH], 2009). This is in contrast to other mental health disorders, such as schizophrenia, where black people are more likely to receive this diagnosis. There is little research on this and the differing diagnosis of personality disorder amongst cultural groups is unexplained (McGilloway, Hall, Lee & Bhui, 2010). It is unclear if this is a 'true' difference. Similar to the gender hypothesis, black (American) females may be more likely to use externalising behaviours, such as aggression or drug abuse in comparison to white females (De Genna & Feske, 2013). Alternatively, with personality disorder from minority ethnic groups may have less access to services, or may seek help through different ways (Byrne, et al., 2014). There may be differences amongst cultural groups in terms of affluence, spirituality and psychological awareness, which can impact upon the way borderline personality disorder is regarded.

1.5.3 Borderline Personality Disorder in Young People

Despite agreement that personality disorder is a developmental disorder (e.g., Cicchetti, 2014) diagnosis in young people is controversial (NCCMH, 2009). There is a reluctance

to diagnose before age 18 (Miller, Muehlenkamp & Jacobson, 2008; Schmeck, Schluter-Muller, Foelsch & Doering 2013). This may be due to possible negative consequences of the personality disorder label (Gask, Evans & Kessler, 2013), uncertainty about whether young people can be given this diagnosis and the appropriateness of this diagnosis at a time of developmental change (Chanen, Jovev, McCutcheon, Jackson, & McGorry, 2008).

DSM-5 allows borderline personality disorder to be diagnosed in young people where personality traits are ‘pervasive, persistent, and unlikely to be limited to a particular developmental stage or another mental disorder’ (APA, 2013, p.647). The features must be present for over one year. The criteria for diagnosing borderline personality disorder in young people are the same as the adult criteria. DSM-5 emphasises the onset of personality disorder often being traced back to adolescence, suggesting that borderline personality disorder can be detected relatively early (APA, 2013).

It can be difficult to distinguish between signs of typical adolescent development and the diagnostic criteria for borderline personality disorder (Miller et al., 2008). Adolescence is a period of major developmental change. Young people often experience distress related to difficulties in establishing a sense of identity and interpersonal relationships (NCCMH, 2009). For this reason, more tentative terms such as ‘emerging personality disorder’ are used with young people. Symptoms of borderline personality disorder are thought to be more chronic, pervasive and severe. Misdiagnosing or failing to diagnose borderline personality disorder may lead to a young person receiving inappropriate treatment (BPS, 2006) or being denied access to services, both which can lead to worsening of difficulties (Miller et al., 2008). As a result, early detection and intervention programmes are being developed (e.g., Chanen & McCutcheon, 2013). Researchers have emphasised the variability in behaviours and symptoms across young people diagnosed with borderline personality disorder. For this reason, a dimensional approach to diagnosis may be more helpful. As with many mental health difficulties, formulation, in addition to diagnosis is more likely to be beneficial, particularly with young people (BPS, 2006).

1.6 Problems with Diagnosis and Alternatives

Diagnosis is far from satisfactory and many controversies remain (Livesley, 2008). The reliability and validity of borderline diagnostic criteria have been criticised (Livesley, 2001; NCCMH, 2009; Skodol, Morey, Bender & Oldham, 2013). Even though effort has been made to make the two diagnostic systems (DSM and ICD) similar (Ekselius, Tillfors, Furmark & Fredrikson, 2001) research has shown that there is little agreement between the two (Ottosson, Ekselius, Grann, & Kullgren, 2002) and both the DSM and ICD definitions of borderline personality disorder have been subject to debate. People often meet the criteria for more than one personality disorder (NIMHE, 2003a). For example, approximately twenty-five percent of people diagnosed with borderline personality disorder also meet the criteria for antisocial personality disorder (Zanarini et al., 1998). There is also much heterogeneity in symptoms amongst people with the same personality disorder diagnosis subtype (Sanislow, Marcus, & Reagan, 2012). It has been reported that there are 256 possible combinations of criteria to make a DSM-IV diagnosis of borderline personality disorder (Critchfield, Levy, & Clarkin, 2007).

An alternative diagnostic model of personality disorder was proposed for inclusion in the recently published Diagnostic and Statistical Manual of Mental Disorders –Fifth Edition (APA, 2013). This model has been placed in a section entitled *Emerging Measures and Models*, and is currently not in use. This model takes a more dimensional approach than the traditional, currently used categorical approach. This is termed a ‘hybrid dimensional categorical’ model, as it has dimensional elements, but still keeps categorical constructs which are thought to be useful (Trull, & Distel & Carpenter, 2011). The dimensional approach views personality disorder as being on the extreme end of a continuum of personality traits rather than being completely absent or present. Diagnosis would be according to the severity of impairment in self and interpersonal functioning (APA, 2013). Many researchers and clinicians have advocated for this change (e.g., Skodol, Morey, Bender & Oldham, 2013; Tyrer & Garralda, 2005) for diagnosis in the future, highlighting the problems of using a categorical approach. The new system will be a radical change towards the diagnosis of personality disorder. The current DSM-5 criteria have been retained, and it was argued that further research

into the revised diagnostic system was needed before proper use (e.g., Anderson, Snider, Sellbom, Krueger & Hopwood, 2014).

1.7 Complexity of Borderline Personality Disorder

It has been suggested that clinical diagnoses do not adequately convey the experiences of people with personality disorder (Horn, Johnstone & Brooke, 2007; Ramon, Castillo & Morant, 2001). The difficulties experienced by people with borderline personality disorder include intense and rapidly changing emotions, such as bursts of rage, which tend to be concerned with fear of abandonment or rejection (Levy, Beeney & Temes, 2010). People with borderline personality disorder are extremely sensitive to environmental or interpersonal change (Linehan, 1993). This often leads to great difficulties in relating to other people and developing close, stable and meaningful interpersonal relationships (Gunderson, 2007). Lack of self-concept (NCCMH, 2009) and feelings of emptiness are also commonly reported by people with borderline personality disorder (Kernberg, 1967; Schmeck, et al., 2013). Psychotic symptoms such as delusions and hallucinations are sometimes reported (NCCMH, 2009), but tend to be more transient than those experienced by people with psychosis (Zanarini, Gunderson & Frankenburg, 1990). People with borderline personality disorder commonly (but not always) engage in recurrent deliberate self-harm (NIMHE, 2003a) and often experience thoughts of suicide or engage in suicidal/para suicidal behaviours (James & Taylor, 2008). Reasons for self-harm include self –punishment, a means of relief from extreme emotions (Morris, Simpson, Sampson & Beesley, 2013) but also to feel more alive (Barr, Hodge, & Kirkaldy, 2008). This is in line with the chronic feelings of emptiness reported by some people with borderline personality disorder (Brown, Comtois & Linehan, 2002). Other destructive behaviours such as gambling, binge eating or dangerous driving are often reported in people with borderline personality disorder (APA, 2013).

Personality disorder is considered a risk factor for the presence of other psychiatric disorders (Kendall, 2002). The most frequent disorders associated with borderline personality disorder are depression, substance misuse and anxiety disorders (Nysaeter & Nordahl, 2012). The substance misuse reported in individuals with

borderline personality disorder may be an attempt to manage their extreme emotions (Trull, Sher, Minks-Brown, Durbin & Burr, 2000).

1.8 Causes

The aetiology of borderline personality disorder is not fully understood. Some genetic and neurobiological explanations have been put forth. As with many mental health difficulties, the role of environment and early life experiences are thought to be significant and a bio-psychosocial model of understanding is likely to be the most informative, particularly given the heterogeneous nature of the disorder (Cicchetti, 2014; Wingefeld, Spitzer, Rullkotter & Lowe, 2010).

1.8.1 Neurobiological Theories

Neuroimaging studies have shown possible structural differences in brain regions of people with borderline personality disorder, in comparison with matched controls. Hippocampal and amygdala volume loss has commonly been reported (e.g., O'Neill & Frodl, 2012). The amygdala is relevant to borderline personality disorder as this area of the brain is thought to be involved in emotional processing (Krause-Utz, Winter, Niedtfeld & Schmahl, 2014). The hippocampus is sensitive to the effects of stress via cortisol production (Brambilla et al., 2004). A slower return to baseline levels following activation of the amygdala has been found in people with borderline personality disorder (Krause-Utz et al., 2014).

However, these findings are not specific to borderline personality disorder and have been found in other mental health difficulties (e.g., schizophrenia and depression) (van Elst et al., 2003) and in people who have experienced trauma (O'Neill & Frodl, 2012). People with borderline personality disorder have often experienced early trauma and early adverse experiences. This has led to the hypothesis that early adverse experiences, resulting in stress can have a damaging effect on these brain regions. However, it has been difficult to interpret such results due to other possible confounds, such as the effects of psychotropic medication and the effects of ageing on the brain.

1.8.2 Genetics

No specific gene has been identified as causative of borderline personality disorder (Chanen & McCutcheon, 2013). It is likely that certain personality traits (e.g., impulsivity) have a genetic component, rather than borderline personality disorder itself (Calati, Gressier, Balestri & Serretti, 2013). The heterogeneity in borderline personality disorder has led researchers to believe that multiple genes are involved (Amad, Ramoz, Thomas, Jardri & Gorwood, 2014).

The gene-environment interaction theory is becoming widely accepted as the most likely explanation for the development of borderline personality disorder (Calati et al., 2013; Chanen & McCutcheon, 2013). According to this theory, people with sensitive genotypes and a predisposing environment are thought to be at greater risk of developing borderline personality disorder. The quality of primary attachment relationships may influence the expression or inhibition of certain genes in developing infants. Genes that have been implicated in borderline personality disorder are related to emotional sensitivity and impulsivity (Liotti, 2014). The idea that genes can be altered by the environment (e.g., through attachment patterns) is known as epigenetics and provides a new way of viewing the impact of nature and nurture and the transaction between the two (e.g., Champagne, 2008 for a review).

1.8.3 Attachment Theory

Childhood emotional abuse and neglect have been associated with later personality pathology (Cohen et al., 2013; Johnson, Cohen, Brown, Smailes & Bernstein, 1999). A history of childhood maltreatment is more common in people with a diagnosis of borderline personality disorder compared to people with other types of personality disorder (Battle et al., 2004). Not surprisingly, a dose response relationship has been found: where the greater the level of reported abuse (physical, sexual emotional abuse and neglect), the greater the level of personality disturbance (Cohen et al., 2013).

More specifically, the role of primary attachment relationships have been put forth as predictors of later personality disturbance (Bowlby, 1977; Crittenden & Newman, 2010; Diamond et al., 1999; Diamond, Clarkin, Levy, Levine & Foelsch, 2002; Diamond, Yeomans, Clarkin, Levy & Kernberg, 2008). Attachment is thought to

be crucial in the formation of personality, as well as contributing towards understandings of personality disorder. Attachment theory describes the quality and security of relationships between infants and their caregivers (Bowlby, 1977; Ainsworth, Blehar, Waters & Wall, 1978) and proposes that this can be a predictor of subsequent cognitive and social development. Through early interactions with caregivers, infants form 'internal working models' which are mental representations about the self and others, and serve as a template for later relationships. For example, infants who have consistent and responsive care giving are hypothesised to develop secure attachments and to go on to develop further healthy relationships and adequate self-esteem. Various insecure attachment styles have been proposed (Ainsworth et al., 1978; Crittenden, 2005). Infants who are not overly distressed on separation from their caregiver and show little interest when they are re-united are classed as insecure avoidant. Infants who show limited exploration, become highly distressed on separation with their caregiver and are not easily comforted when reunited, are classed as insecure ambivalent. A fourth attachment classification was later added, known as disorganised/disorientated attachment (Main & Solomon, 1990). Infants with disorganised attachment show odd or ambivalent behaviour towards their caregiver, such as running to them and then changing direction. As the name suggests, these children have no organised solution for receiving care. In disorganised attachment, it is thought that the infant is fearful of the caregiver (Fonagy & Target, 2003).

There is a theory that personality disorders are disorders of attachment (e.g., Fonagy, Target, Gergely, Allen & Bateman, 2003). The fear of abandonment and intense emotions experienced in interpersonal relationships in people with borderline personality disorder are suggestive of attachment difficulties (Morse et al, 2009). Borderline personality disorder has been associated with disorganised attachment (Liotti, 2014) and unresolved attachment (Levy, 2005). Disorganised attachment patterns in infants correspond with unresolved attachment styles in adults. Preoccupied adult attachment styles have also been associated with borderline personality disorder (Scott et al., 2013). Adults with pre-occupied attachment patterns have a desire for closeness with fear of abandonment, which is very similar to that reported by people with borderline personality disorder.

1.8.4 Object Relations Theory

Object relations theory (Bion, 1962; Klein, 1932) is an extension of Freudian psychoanalytic theory. Object relations theory is a developmental theory of personality and emotional and cognitive development. According to this theory, infants make sense of their early experiences by splitting them into satisfying and frustrating experiences as a survival strategy. Infants are thought to project out their unmanageable feelings which are experienced as overwhelming (e.g., anxiety, pain, hunger) into another mind (e.g., the caregiver's mind) where they can be contained, processed, and given back to the child in manageable amounts (a process known as projection and introjection). In doing so, the caregiver is showing his or her understanding of the infant's internal state (e.g., Winnicott, 1956) and letting the infant know that internal states can be managed by another; containment (Bion, 1962). If containment is 'good enough' (Winnicott, 1956), the infant can develop the capacity to manage their own emotional states (e.g., tolerate frustration) and develop thought (i.e., mentalization).

Borderline personality organisation is thought to develop where there is inadequate containment, and a lack of introjection on the caregiver's part, leaving an infant with no capacity for self-soothing and lack of integration between good and bad experiences and subsequently, a lack of integration within self-identity. Additionally, people with borderline personality disorder are thought to continue to use primitive coping strategies, such as splitting and projection, as a result of insufficient early containment (Zanarini, Frankenburg, & Fitzmaurice, 2013) in order to manage overwhelming emotions. Attachment theory is closely linked with object relations theory, as they both focus upon internalised relationships (Yeomans & Levy, 2002).

1.8.5 Mentalization

Some theorists view difficulties in the capacity to mentalize as a key feature of borderline personality disorder (Bateman & Fonagy, 2006; Fonagy & Bateman, 2007). Mentalization refers to the ability to understand one's behaviour in terms of states of mind (e.g., beliefs, needs, feelings and reasons). Mentalization has been called 'thinking about thinking' (Fonagy, 1991). It has been described as the ability to see one's self from the outside and others from the inside. This concept is very similar to Theory of

Mind (Premack & Woodruff, 1978). Some cognitive psychologists have proposed that mentalizing ability forms naturally as part of neuro-typical development. Other researchers have argued that mentalization ability is dependent upon and facilitated by the quality of primary attachment relationships (e.g., Fonagy, 1991). It has been suggested that in order to develop an awareness of one's own mind, an infant first needs to feel understood and to feel held in mind by another (e.g., their caretaker), in the context of a secure attachment relationship. Attachment related-experiences, such as the caretaker's attunement to the infant's emotions and mirroring of the infant's emotions by the caretaker through facial and vocal expressions facilitate awareness of mind. Difficulties in mentalization ability have been found in people with personality disorder (Chiesa & Fonagy, 2014). Mentalization is closely linked with attachment and object relations theory.

1.8.6 Emotional Dysregulation

Borderline personality disorder is thought to be primarily a disorder of emotional regulation (Carpenter & Trull, 2013; Linehan, 1993). A model has been proposed, which attempts to explain the emotional regulation difficulties in people with borderline personality disorder (Linehan, 1993). Linehan's (1993) model is a bio-social model, and views emotional regulation difficulties as a result of a transaction between biological vulnerabilities and environmental influences (termed invalidating environments).

The model states that certain individuals can be biologically predetermined towards emotional sensitivity. Features of this include heightened emotional sensitivity, high levels of arousal and delayed recovery to baseline levels. An invalidating environment is one where emotional experiences, particularly negative experiences are disregarded by the caregiver, and punished or trivialised. Emotions are seen as invalid and incorrect responses to events, and attributed to unacceptable character traits, such as over-sensitivity, or a failure on the child's part to view events more positively. Additionally, an invalidating environment places value on control of emotions and self-reliance.

As a result of the invalidating environment, a child does not learn to label or regulate their emotions or view them as valid reactions. Children are taught to control

their emotions but do not possess the necessary skills to tolerate distress (e.g., self-soothing). Children resort to extreme behaviours in order to have their emotions recognised. For example emotional outbursts become adaptive within an invalidating environment. As a result of this, the child swings between attempting to hide and inhibit their emotions and extreme emotional outbursts.

In addition, people with borderline personality disorder are thought to use unhelpful coping strategies in response to heightened emotions (e.g., self-harm). Such behaviours are thought to be simpler to use than more adaptive coping strategies and have more immediate effects (Carpenter & Trull, 2013).

1.8.7 Cognitive Theories

According to cognitive theory, personality disorders are characterised and maintained by rigid dysfunctional cognitions and behaviours (Beck et al., 2001; Pretzer & Beck, 1996). Each personality disorder has been thought to have a distinct set of core beliefs and corresponding behaviours. It has been suggested that that borderline personality disorder is the only personality disorder without a particular set of beliefs (Beck, 1990). Multiple maladaptive beliefs are held by people with borderline personality disorder, and at clinically higher levels than controls (Lawrence, Allen & Chanen, 2011). This may be due to the variation of presentations in borderline personality disorder (Asnani, Chelminski, Young & Zimmerman, 2007). However, beliefs about other people and the world being dangerous, and the self as powerless and vulnerable are thought to be important in borderline personality disorder (Arntz, 1994). The core belief of being bad and unacceptable also plays a role (Pretzer & Beck, 1996).

Core beliefs result in automatic thoughts, which are a stream of thoughts which arise in daily situations. People with personality disorder are thought to misinterpret situations through 'thinking errors'. A thinking error characteristic in borderline personality disorder is dichotomous thinking (Bateman, Karterud & Van Den Bosch, 2005). This is the tendency to view experiences in terms of absolute categories, such as good or bad, with little ability to think in the middle ground (Pretzer & Beck, 1996).

Further models of borderline personality disorder arising from cognitive theories have been developed. A fourth level of cognitive structure, termed early maladaptive

schemas has been added (Young, 1994). Maladaptive schemas are broad and enduring patterns of thinking about the self and others. They are developed during childhood as a result of unmet emotional needs. A schema consists of cognitions, emotions, memories and bodily sensations. Behavioural responses are reactions to schemas. Four schema modes have been identified as particularly relevant to borderline personality disorder (abandoned and abused child, angry and impulsive child, detached protector and punitive parent) (Davidson, 2008). Themes of abandonment and distrust/ abuse are prominent maladaptive schemas within people with borderline personality disorder (Lawrence et al., 2011).

1.8.8 Summary of Causes

The notion of ‘equifinality’ is important in considering the development of borderline personality disorder (Cicchetti, 2014). This means that a number of pathways, rather than a single trajectory can lead to borderline personality disorder. Similarly, individuals with the same risk factors may not all go on to develop borderline personality disorder. Developmental experiences can have moderating effects on outcome. Genetic vulnerability may begin to explain the development of borderline personality disorder, but must be considered with early experiences and processes along different developmental time points. Difficulties in cognitions, emotions, behaviours and interpersonal relationships have been highlighted in borderline personality disorder, but these cannot be considered as exclusive from one another (Cicchetti, 2014).

1.9 Psychological Treatment

Historically, personality disorder was thought to be untreatable (Paris, 2012). There has been much less research into treatment efficacy in personality disorders than in other mental health difficulties. The first evidence of effective treatment published was in 1991 (Linehan, Armstrong, Suarez, Allmon & Heard, 1991). Despite a growing number of studies, the evidence base for treatment of borderline personality disorder is still underdeveloped (Levy, Yeomans, Denning & Fertuck, 2010). Most studies are uncontrolled (Bateman & Fonagy, 2000), study numbers are often small (NCCMH, 2009) and typically include more women than men. Dropout rates in therapy are high,

making it difficult to generalise the results of treatment trials (Yeomans et al., 1994). One suggestion has been that longer follow up data are needed in this group to make any valid judgments on treatment efficacy. Due to the fluctuating and long standing patterns of symptoms in people with borderline personality disorder, improvements tend to be gradual, rather than sudden (Perry & Bond, 2009).

1.9.1 Transference Focused Psychotherapy

Transference focused psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 2006) is a modified manualised form of psychodynamic psychotherapy based on Kernberg's (1984) object relations model of borderline personality disorder. Clear boundaries and a treatment contract are developed at the beginning of therapy. Therapy lasts for at least one year and is twice weekly. The aim of treatment is to help a person examine and integrate their internal object relations (patterns of relating to self and others) through the use of transference and interpretation.

In a randomised controlled trial comparing TFP, dialectical behaviour therapy (DBT) and supportive treatment, both TFP and DBT were associated with improvement in suicidality and TFP and supportive treatment were associated with a reaction of angry feelings. TFP has also been found to be predictive of improvement in impulsivity and aggressive behaviour (Clarkin, Levy, Lenzenweger & Kernberg, 2007).

1.9.2 Mentalization Based Therapy

Mentalization based therapy (MBT; Bateman & Fonagy, 2006; Fonagy & Bateman, 2007) has been developed through the developmental theory of mentalization, psychodynamic theory and attachment theory. The therapist adopts a 'mentalizing stance' which involves being curious about a person's thought, beliefs and intentions. The aim of therapy is to increase reflective capacity (mentalizing ability) of an individual, therefore leading to better emotional regulation, improved interpersonal relationships and more control over behaviour (e.g., better ability to think, rather than immediately act).

A randomized controlled trial with 134 outpatients, comparing MBT and structured clinical management found that MBT resulted in less suicide attempts, less

incidents of self-harm and higher levels of self-reported functioning, although both groups showed improvements (Bateman & Fonagy, 2009). It was found that self-harm improved more slowly in MBT. This may be used as evidence that longer-term follow-ups are needed to assess meaningful change within this client group.

1.9.3 Dialectical Behaviour Therapy

Dialectical behaviour therapy (DBT; Linehan, 1993) is a structured, manualised therapy, consisting of group and individual therapy and was originally developed for women who self-harmed. DBT is the most explicit application of cognitive behaviour therapy to personality disorders (Linehan, 1993). DBT combines behavioural approaches (e.g., behavioural chain analysis) to reduce problematic behaviours and teach more functional coping strategies, but also uses acceptance based approaches (e.g., mindfulness). The main components of treatment are: skills training, individual therapy and telephone coaching. The aims of DBT are to increase distress tolerance, balance emotional regulation and reduce impulsive behaviours.

DBT was the first psychological treatment for borderline personality disorder to be tested in a clinical trial (Paris, 2010) and has been argued to have the most evidence for treatment of borderline personality disorder (Paris, 2012). A meta-analysis of 16 studies investigating DBT for borderline personality disorder found a moderate effect size for DBT in comparison with other treatments (e.g., treatment as usual, validation treatment, community therapy by exerts) on self-harm and suicidal behaviour. However, the same study did not find evidence for the efficacy of DBT in comparison with other 'borderline specific treatments' (e.g., transference focused psychotherapy) (Kliem, Kröger & Kosfelder, 2010). It has been suggested that further research is needed to explore specifically which components of DBT are effective (Scheel, 2000).

1.9.4 Cognitive Analytic Therapy

Cognitive analytic therapy (CAT; Ryle, 1997) is an integrative, relational therapy combining psychoanalytic and cognitive models and was developed to deliver a time limited treatment, whilst retaining meaning and depth. CAT aims to achieve insight into difficult patterns of interactions with others, known as 'reciprocal roles'. These are

thought to develop in early childhood, and used in attempt to elicit reciprocal responses in relationships with others and can be enacted through the therapeutic relationship. Around 16-24 individual sessions are usually offered. These include the use of diagrams and letters to help people recognise patterns and states of mind (Gask et al., 2013).

The evidence base for CAT is scarce in comparison to other therapies for borderline personality disorder (Margison, 2000). The first (reported) randomised controlled trial (Clarke, Thomas & James, 2013) for personality disorder reported that post therapy, a significantly higher number of people no longer met criteria for personality disorder (measured by the Structured clinical interview for DSM-IV). Sixty-eight percent of the sample had borderline personality disorder. However, results were only compared with treatment as usual, and the sample did not include people with high levels of self-harm.

1.9.5 Schema Therapy

Schema therapy (ST; Young, 1994) is an integrative therapy including elements of cognitive behavioural theory, object relations, and gestalt theory. ST explores the way an individual relates to themselves and others and looks at the various ‘maladaptive’ schemas (self-defeating, pervasive themes or patterns) that an individual holds. The aim of therapy is to provide insight into an individual’s various schemas and to adapt and integrate these. The four techniques used in ST are re-parenting, experiential imagery, cognitive restructuring and behavioural pattern breaking.

A recent review (Sempértegui, Karreman, Arntz, & Bekker, 2013) investigating the effectiveness of schema therapy evaluated four studies (two were randomised controlled trials and two were single case studies). The review concluded that both group and individual schema therapy were effective for some difficulties associated with borderline personality disorder, as compared to treatment as usual and compared to other treatments for borderline personality disorder (e.g., transference-focused psychotherapy).

1.9.6 Therapeutic Communities

Therapeutic communities have been used for treatment of personality disorders but are not exclusive for this group. They draw from a range of approaches (e.g., sociotherapy) but are psychoanalytically informed (e.g., Bateman & Fonagy, 1999; Behr & Hearst, 2005). Therapeutic communities range in intensity from one day per week to residential facilities. The main principals of therapeutic communities are attachment, containment, communication, involvement and agency (Haigh, 2013). The development of therapeutic communities in the 1940s reflected a move from psychiatric treatment to a more democratic way of working (Hellin, 2006). Group members are involved in the running of the community and therapeutic work. Democratic principles apply to almost everything. Therapeutic change is brought about through interactions with group members, providing a safe environment where interpersonal difficulties can be explored.

The lack of randomised controlled trials has made it difficult to draw any conclusions on the effectiveness of therapeutic communities (NCCMH, 2009). However, one randomised controlled trial reported a reduction in suicide and self-harm attempts, improvements in self-reported anxiety, depression and interpersonal functioning (Bateman & Fonagy, 1999). Therapeutic communities can improve interpersonal relationships (Hodge, Barr, Gopfert, Hellin, Horne & Kirkcaldy, 2010) and improvements in social functioning have been reported (Barr, Kirkcaldy, Horne, Hodge, Hellin & Gopfert, 2010).

1.9.7 Common Features

Attempts have been made to find common features of effective treatments. A review of treatments from 1990 to 2010 identified the following the following similarities between therapy treatments: clear treatment framework, close attention to emotions, emphasis on the therapeutic relationship, active role by the therapist, emphasis on exploratory nature, and promotion of change (Weinberg, Ronningstam, Goldblatt, Schechter & Maltzberger, 2011). Clear structure and focus are thought to be an essential element of treatment for people with borderline personality disorder (Bateman & Fonagy, 2000). It has also been argued that validation and empathy are more important for this client group due to their

high levels of emotional sensitivity (Paris, 2010). It has been recognised that longer term therapy is needed to make meaningful change.

National clinical guidelines do not recommend any specific treatment for borderline personality disorder but state that ‘an explicit and integrated theoretical approach’ should be used (NCCMH, 2009, p.207). Brief interventions (lasting less than 3 months) are not recommended and twice-weekly therapy has been suggested. Clinical supervision is recommended for therapists. There is little evidence for the efficacy of medication for borderline personality disorder (Gask et al., 2013). Medication is not recommended for treatment of borderline personality disorder or for individual symptoms (e.g., transient psychotic symptoms) or associated behaviours.

1.10 Service Provision

There is a lack of specialist personality disorder services, although they do exist within the National Health Service. A survey of all adult mental health trusts in England found that seventeen percent of trusts provided a personality disorder service (Moran, 2002). Changes to the Mental Health Act (Mental Health Act, 2007) have meant that personality disorders are now viewed as being within mainstream mental health services; however, this has led to a reduction in specialist services. The provision of services is still thought to be inadequate (Fanaian, Lewis & Grenyer, 2013) and inconsistent (Cleary, Siegfried & Walter, 2002). This may be one reason why recovery is underdeveloped within this client group.

People with a diagnosis of personality disorder have expressed their preference for specialist services, rather than being treated within generic mainstream mental health services (Haigh, 2002). This may be due to negative experiences from mainstream mental health services who may not be properly equipped to deliver appropriate treatments and interventions. People with borderline personality disorder are often seen in A&E departments during crisis, leading to inappropriate hospital admissions, often with no follow up, which can lead them becoming ‘revolving door patients’ (NIMHE, 2003a). People with personality disorder use services for longer than people without this disorder (Zanarini, 2009). Recent research investigating service usage within a community mental health team found that people with a personality disorder diagnosis

were less likely to have a care-coordinator and made more duty calls, compared to people without this diagnosis (Byrne et al. 2014). The same study also found that people with a diagnosis of personality disorder were less likely to engage with professionals consistently. These findings highlight the need for specialist services. Specialist services may be able to provide more lengthy and targeted treatments (BPS, 2006) which can lead to more successful outcomes (Bateman & Tyrer, 2004).

National policy guidelines state that specialist personality disorder services should be developed (DH, 2009; NIMHE, 2003b) and have prescribed the way that these services should operate. The proposed model is one where people with a personality disorder diagnosis have access to mainstream services, with specialist services providing consultation and supervision (DH, 2009). Clinicians have advocated the need for further training and education, support through supervision and leadership, clearer guidelines and a shift in attitudes towards personality disorder as means of improving services (Fanaian et al., 2013).

1.10.1 Staff Attitudes and Understanding

The lack of specialist services has led to people with personality disorder using mainstream mental health services; often community mental health teams with high caseloads who can find it difficult to meet their needs (DH, 2009). Staff working with people with a diagnosis of borderline personality disorder have reported feeling under skilled (Cleary et al., 2002; McCarthy, Carter & Grenyer, 2013) and as a result, some staff are reluctant to work with people with this diagnosis (DH, 2009).

Historically, people with a personality disorder diagnosis have been termed ‘the patients that psychiatrists dislike’ (Lewis & Appelby, 1988). The self-destructive behaviours expressed by people with borderline personality disorder can lead to feelings of inadequacy and incompetence in staff and services (Cleary et al, 2002). Similarly, the chronic suicidal feelings and behaviours expressed by people with borderline personality disorder can mean that they feel very risky to work with (Paris, 2012), evoking high levels of anxiety in staff. People with borderline personality disorder who describe constantly fluctuating emotions can leave staff feeling that they are being ‘manipulated’, or thinking that people are simply ‘seeking attention’ (Nehls, 1999) leaving staff feeling

frustrated and angry (Gabbard & Wilkinson, 1994). When staff do not have appropriate training or expertise, they may then respond to their patients in punitive, unhelpful ways, which in turn are likely to reinforce people's feelings of hopelessness and destructive behaviours (Liebman & Burnette, 2013). Such counter-transference reactions are more likely to occur between people with borderline personality disorder and staff in comparison to people with other Axis I and Axis II disorders (Lewis & Appelby, 1988; Rossberg, Karterud, Pedersen, & Friis, 2007). Similarly, mental health staff are more likely to view people with a diagnosis of borderline personality disorder as 'in control' of their behaviour in comparison to people with other mental health difficulties (Markham & Trower, 2003).

1.11 Borderline Personality Disorder Summary

Borderline personality disorder is a contested mental health disorder and there are difficulties with diagnosis and treatment. Causes and aetiology are still being understood. The whole area of personality disorder including borderline personality disorder is under development. National clinical guidelines only exist for antisocial and borderline personality disorder at present (NCCMH, 2009). Over the last fourteen years, changes are being made into the way personality disorder is viewed and treated. These changes can be seen in the way services have been commissioned and developed (for example Haigh, 2002; NIME, 2003b). The changes are increasingly being informed by people with personal experience of personality disorder.

1.12 Recovery

Recovery has been described as an idea, a philosophy, a paradigm and a principal for change (Turner-Crowson & Wallcraft, 2002). There is no unitary definition of recovery within mental health.

However, a widely used definition of recovery within mental health settings is:

'....a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves

the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness'. (Anthony, 1993, p.15).

The concept of recovery has grown dramatically over the last ten years. There has been an emphasis on promoting recovery within government and national policy documents (e.g., BPS, 2009; DH, 2001; Royal College of Psychiatrists, 2009). Due to this drive, recovery principals are now becoming the norm in the design and organisation of mental health services (Davidson & White, 2007). Recovery perspectives offer alternative ways of thinking about mental health disorders, in contrast with clinical models of recovery, which focus upon symptom reduction and 'cure' or improvement in functioning (Deegan, 1996). Personal recovery has a broader meaning and describes being able to live a meaningful and happy life, despite the existence of mental health difficulties or symptoms (Yates, Holmes & Priest, 2012). This way of thinking has been developed from the stories and voices of people with personal experience of mental health difficulties (Slade, Williams, Bird, Leamy & Le Boutillier., 2012). The concept of recovery has been compared to adaptation to chronic physical illness, such as diabetes (Davidson, 2010), where successful management of the illness has been shown to lessen a person's distress and improve their quality of life.

The UK government paper *No Health without Mental Health* has proposed recovery as an important objective, highlighting self-management, social relationships, sense of purpose, development of skills, access to employment and education and housing as part of this (HMG/DH, 2012). The Department of Health paper *Journey to Recovery* states that services in future will talk as much about recovery as they do about symptoms and illness (DH, 2001).

There has been a general shift in mental health which attempts to move away from a dominant medical model perspective; for example, a focus on symptoms and illness and towards a focus on health, wellness and strengths (Shepherd, Boardman & Slade, 2008). This shift includes greater collaboration between clients and professionals (Lipczynska, 2011) in choice and treatment options, recognition of clients as having expert knowledge about themselves and their difficulties (DH, 2012), the development of roles such as Experts by Experience (D'Sa & Rigby, 2011; Rose, 2011) and service

user researchers (e.g., Pitt, Kilbride, Nothard, Welford & Morrison, 2007). Recovery principals seem to sit particularly well within this paradigm shift.

There has been discussion over the use of the word ‘recovery’ and whether this is the most appropriate language for use within mental health (Ralph, 2000).

‘Transformation’ has been suggested as a more meaningful term (Deegan, 2002), whilst others have suggested that ‘healing’ better encapsulates the recovery process:

‘Healing is seen as broader than recovery. Healing often emphasises the healing from an injury or trauma or hurt in life..... Healing implies that the self has a role in the process’ (Jeanne Dumont, quoted in Fisher & Deegan, 1998, p. 6).

Others have warned against recovery becoming confused with quality of life (e.g., Green, 2011), arguing that recovery involves hope, opportunity and control, which can lead to improved quality of life, but does not mean the same thing (Repper & Perkins, 2003). Recovery is viewed as an ongoing process, rather than an end result (Deegan, 2002; Pitt et al., 2007), leading some to discuss the journey of recovery (e.g., Castillo, Ramon & Morant, 2013).

1.12.1 Components of Recovery

Recovery is best understood as a multi-dimensional concept encompassing various components. There is an abundance of literature, which has attempted to describe the various aspects of recovery and a number of researchers have identified common features (e.g., Anthony, 1993; Bonney & Stickley, 2008; Leamy, Bird, Le Boutillier, Williams & Slade, 2011). Four principal components, developed from accounts of people with personal experience of mental health difficulties, have been suggested (Andreson, Caputi & Oades, 2006; Andresen, Oades & Caputi, 2003), consisting of hope, identity, meaning and responsibility. These components have been used to develop the personal recovery framework (Slade, 2009). The following section will briefly discuss each of these processes with regard to their meanings and the existing literature.

1.12.1.1 Hope

The recovery process is ‘fuelled by hope’ (Perkins, 2006). A number of documents have included hope as key to recovery (Pitt et al., 2007; South London & Maudsley NHS

Foundation Trust & South West London & St Georges Mental Health NHS Trust [SLAM & SWLSTG], 2010; Mental Health Network, 2012). The presence of hope implies that it can be possible to pursue one's goals and ambitions (Mental Health Network, 2012). A distinction between hope and optimism has been made (Deegan, 1996), highlighting hope as more enduring and involving a belief in one's self. Hope has been associated with a belief in recovery (Leamy et al., 2011), positive thinking and motivation to change. It has been suggested that mental health professionals often can communicate a sense of pessimism, which clients can internalise (Rose, 2011), which makes hope very important in the recovery process.

1.12.1.2 Redefining Identity

Identity is central to recovery (Bonney & Stickley, 2008; Repper & Perkins, 2003). The experience of having mental health difficulties can challenge and fragment one's self concept and can also contribute towards loss of identity (Henderson, 2010) and feelings of incapacity and worthlessness (Warner, 2010) leading to a disabled role, in which symptoms persist or become the focus. Iatrogenic effects of mental health services such as not feeling listened to and detainment in secure institutions can further contribute to a negative sense of self (Andresen, Caputi & Oades, 2006) or identity as a 'mental patient'. Identity is closely related to other aspects in one's life, such as vocation and family relationships (Davidson & Strauss, 1992). A key aspect of recovery involves developing, re-defining or maintaining a positive identity apart from a person with a mental illness (Slade, 2009). Aspects of this in recovery include a focus on the person, rather than the disorder and of personal meaning opposed to diagnosis (Slade, 2009). Such ideas may involve 're-discovery' of the self and may include accepting illness and integrating this into one's identity (BPS, 2009; Davidson & Strauss, 1992). This may include positive beliefs about the experience of having a mental illness, such as being more creative or feeling mentally stronger (Bonney & Stickley, 2008).

1.12.1.3 Finding Meaning in Life

Recovery involves having a sense of purpose and meaning in life. This contributes towards a positive sense of self. Activities such as employment, voluntary work and

education have been identified as a way of maintaining a sense of purpose and meaning (Repper & Perkins, 2003). Employment can enhance social inclusion and bring financial benefits, preventing further social drift. People with mental health difficulties often report employment as a goal (Shrivastava, Johnston, Shah & Bureau, 2010). However, there is a lack of opportunity for people with mental health problems in gaining access to such employment and education activities (SLAM/SWLSTG], 2010, 2010). Barriers include stigma, discrimination (BPS, 2009) and lack of assistance (Shrivastava et al., 2010). Many recovery activists have pushed for supported employment schemes within mental health Trusts (Repper & Perkins, 2003). The National Health Service is now setting an example by promoting the employment of people with mental health difficulties.

Employment can be important, but it is not the only way of finding meaning. Meaning and purpose can be gained through a host of things including through one's role in society and within family, friends and social groups. Spirituality, goals, aspirations and achievements are also important within this idea.

1.12.1.4 Responsibility for Recovery

Empowerment (Bonney & Stickley, 2008; Warner, 2010), control over one's life (SLAM & SWLSTG, 2010), self-management, choice, and participation are related to this concept (Davidson, 2010; Sugarman, Ikkos & Bailey, 2010). Within clinical practice, there has been a shift away from professional 'expert knowledge' to individuals' personal priorities (SLMT & SLGMT, 2010) and recognition that this can lead to better outcomes. The government white paper *No decision about me without me* (DH, 2012) sets out to ensure that people with mental health difficulties are fully involved in decisions about their care and has made shared decision making an important principal. This involves a more collaborative way of working such as individuals being involved in their care plans and promoting individualised approaches to care.

1.12.1.5 Recovery as an Integrated Concept

These components are interlinked and interdependent. Meaning is closely related to other components of recovery, as having meaning maintains hope and contributes to the development of personal identity (Repper & Perkins, 2003). Relationships are key to all the above-mentioned components of recovery. People do not recover in isolation (Shepherd, Boardman & Slade, 2008). Social inclusion, and having meaningful roles are dependent upon the quality of an individual's relationships. Connectedness and sense of belonging are related to the idea of relationships (Leamy et al., 2011). It has been found that people with more supportive networks report higher recovery scores.

1.13 Problems with Lack of Definition

There is no consensus concerning how recovery is defined and measured in mental health services (Slade, 2009). Some theorists are against attempts to develop a unitary definition of recovery, arguing that this may detract from the nature of recovery as being a unique and individual process (Anthony, 1993). However, the lack of definition in recovery means that there is no prescribed method for how services should be operationalised to enhance and promote recovery. Despite the assertion that recovery is not something services can do to a person (Slade, Williams, Bird, Leamy & Le Boutillier, 2012), it can be difficult for mental health professionals to implement recovery principals into clinical practice (Craig, 2008). It has been suggested that the varying interpretations of recovery also leaves potential for misunderstanding and even misuse (Jacobson & Greenley, 2001). Furthermore, use of the term without understanding of its meaning could lead it to becoming meaningless (Davidson, O'Connell, Tondora, Styron & Kangas, 2005). The lack of clarity also makes recovery a difficult process to measure (Slade, 2009).

1.14 Criticisms of Recovery

Views on recovery, including client perspectives, have included the limitations of this concept. It has been argued that the drive for recovery can place undue pressure on individuals (Castillo, Ramon & Morant, 2013) with overly high expectations and can create a split between people who consider themselves to be in recovery, and those who

do not (Rose, 2011). As services are increasingly set up with a recovery-orientation, there may be implications in the future for ‘in recovery’ individuals accessing services.

It has been argued that the emphasis on the individual and internal processes in recovery (such as hope and determination), have led to overlooking the importance of environment (Yates, Holmes & Priest, 2012) and political, economic and social processes (Kirmayer, Simpson & Cargo, 2003) which impact upon recovery. Taking this argument further, some researchers have pointed out the potential difficulties in one’s wider environment which can impact upon recovery, such as social inequality, stigma and discrimination (Deegan, 1996), which can be difficult for an individual to change.

It has been argued that within the recovery literature there has been little consideration of ethnicity and culture (Ralph, Kidder & Phillips, 2000; Roberts & Wolfson, 2004) and recovery drivers have acknowledged this (e.g., DH, 2001). Similar concerns have been raised regarding the applicability of existing recovery measures to groups of people from culturally different backgrounds (Burgess, Pirkis, Coombs & Rosen, 2011). There has been international interest in recovery and much of the recovery literature has come from Australia and New Zealand; however, the recovery model is more dominant in English speaking countries (Slade, Leamy et al., 2012). An investigation into recovery in black and ethnic minority people identified a greater importance upon spirituality, stigma and collectivist ideas concerning identity (Leamy, et al., 2011). Qualitative interviews with Maori people of New Zealand identified that in addition to established features of recovery, culturally specific factors were identified that were unique to that population (Lapsley, Nikora & Black, 2002).

Gender differences in perceptions of mental health difficulties and coping styles have been well documented within the literature. A qualitative study exploring gender differences in recovery found that in line with previous research, recovery was a highly individual process. However, this study found that female participants were more able to express their emotions and seek help for mental health issues, where males were more inclined to deal with their difficulties themselves (Schon, 2013). This research raised questions of whether there may be marked gender differences in recovery processes.

1.15 Measures

Recovery measures have been developed, such as the Recovery Star (Mental Health Providers Forum, 2008). The lack of definition in the concept of recovery means that measurement tools are varied (Burgess et al., 2011) and can lack construct validity (Ralph et al., 2000). This has led to some researchers questioning the value of attempting to measure this construct. Others have argued that recovery measures are needed in order to progress towards more recovery orientated services and systems (Andresen, Caputi & Oades, 2006). In comparison to instruments measuring other areas of mental health, such as symptoms or quality of life, there are few existing recovery measures (Ralph et al., 2000). A criticism of recovery measures has been that items tend to weigh on the positive aspects of recovery (Ralph et al., 2000). Perhaps more research into barriers to recovery is needed.

A recent systematic review (Sklar, Groessl, O'Connell, Davidson & Aarons, 2013) identified thirteen (quantitative) recovery measures. These included measures of recovery outcomes, recovery dimensions and recovery stages. In six of the measures, psychometric properties had not been evaluated, other than during their initial development. The measures varied according to the input from clients in their development (this was deemed involvement which was more than pilot testing, e.g., development of items). Client involvement is important in the development of recovery measures, as this is in line with recovery principals. The *Illness Management and Recovery Scale* (Mueser et al., 2006) and the *Maryland Assessment of Recovery in People with Serious Mental Illness* (Drapalski et al., 2012) were found to have the most client involvement in their development. Some of the measures reviewed focused strongly on managing illness and symptoms (e.g., the *Consumer Recovery Outcomes System*, Bloom & Miller, 2004). The review also reported that the *Milestones to Recovery Scale* (Doyle, 2012) had 'minimal correspondence' with recovery as a concept (Sklar et al., 2013). The review concluded that there was variation in the extent to which each measure was consistent with common definitions of recovery.

Similarly, an Australian systematic review of recovery measures identified thirty-three recovery measures (Burgess, Pirkis, Coombs & Rosen, 2011), both for individual and service use (the extent to which services are recovery orientated). Only

four measures were identified as suitable for use according to the study criteria (four measures for individual recovery and four for service use). The researchers found that psychometric properties of service measures were less validated than individual measures. This review highlighted the differing aspects of recovery that measures focused upon and the need to decide what was important. For example, some instruments took both a client and staff perspective on an individual's recovery (e.g., *The Illness Management and Recovery Scale*) and other measures were designed to measure progress through stages of recovery (*Stages of Recovery Instrument*, Andresen et al., 2006). The review concluded that there is a need for further testing of measures to determine their validity and reliability and sensitivity to change.

1.16 Recovery Summary

Recovery can mean different things to different people, although there are some overarching prevalent themes, which encapsulate its meaning. One of the main debates in the area of recovery concerns its varying definitions and how this makes measurement of recovery problematic. Recovery needs to be taken into account from the individual's perspective and on a service level. Little is known about the stages or process of recovery. Language, culture and gender appear to influence recovery. There are some existing recovery measures but these are not satisfactory.

1.17 Personality Disorder and Recovery

Recovery is a particularly important area of study in personality disorder, as personality disorder has historically been viewed as an untreatable condition (Paris, 2012). This view still prevails in mental health settings (Rogers & Acton, 2012), implying that recovery may not be possible for this group of people. Personality disorder carries more stigma than other mental health difficulties (Nehls, 1999). People with borderline personality disorder have reported experiencing negative attitudes from mental health staff (Rogers & Dunne, 2011). It has been reported that people with borderline personality disorder often feel hopeless about recovery (Rogers & Acton, 2012). Additionally, having a diagnosis of borderline personality disorder is associated with greater unmet needs and more psychological distress (Hayward, Slade & Moran, 2006).

Personality disorder is associated with having co-morbid mental health difficulties, and therefore more complexity (Rogers & Acton, 2012). Finally, from a health economics perspective, personality disorder is costly to health services (Bateman & Fonagy, 2003) and people with personality disorder use services for longer than people without this diagnosis (Zanarini, 2009). Findings such as these highlight the need for a greater understanding and focus on recovery within borderline personality disorder.

Little research has been carried out in the area of recovery in personality disorder and understandings of this are limited (Turner, Neffgen & Gillard, 2011). It has been argued that this lack of knowledge about recovery extends to specialist services in general (where personality disorder may more prevalent), such as eating disorder and forensic settings (Turton et al., 2011). The Department of Health white paper *Journey to Recovery* (DH, 2001) makes reference to recovery in personality disorder but specifically to people with ‘severe personality disorder’. Although their mission statement acknowledges that further development in the area is needed, they discuss risk, additional spaces in high secure hospitals and provision of specialist secure units. These proposals do not lend themselves well to recovery ideas. The knowledge gap in personality disorder may be due to research being focused upon other areas; for example, treatment efficacy (Turton et al., 2011; Zanarini, 2012). Some have argued that within personality disorder there is too much emphasis on symptom reduction and have called for more recovery related studies such as a greater focus on social outcomes (Zanarini et al., 2014). With a growing body of promising evidence on clinical treatments, the focus is now turning to recovery.

1.18 Recovery: Same or Different?

Recovery principals taken from mainstream mental health are being applied to the area of personality disorder. This has been criticised by some researchers and people with personality disorder, as they feel that such recovery ideas do not fit well (Turner, Lovell & Brooker, 2011; Green, Batson & Gudjonsson, 2011; Gudjonsson et al., 2010) with the enduring course and ego-syntonic nature of personality disorder. It has been suggested that recovery in personality disorder is a more complex and time-consuming process than recovery in other mental health difficulties (Repper & Perkins, 2003). For

example, a study validating a recovery measure for use in secure services found that people with a diagnosis of personality disorder reported lower levels of recovery than those without a diagnosis (Green et al., 2011).

Research in the area has highlighted both sides of the debate, concerning the applicability of recovery to personality disorder. Previous research exploring recovery views in people with a diagnosis of personality disorder found that some people's recovery views were very similar to mainstream recovery literature, whilst others people's views were in contrary with recovery values (e.g., Turner, Neffgen & Gillard, 2011). Similarly, some people with personality disorder agreed with the concept of recovery but did not always agree with recovery language (Katsakou et al., 2012). Within mental health and particularly within the area of personality disorder, alternative terminology has started to be used; for example, 'discovery', rather than recovery and 'emerged', rather than recovered (Turner, Lovell & Brooker, 2011).

1.19 What is Known About Recovery in Borderline Personality Disorder?

In light of these findings, it seems important to explore and examine what recovery means for people with a diagnosis of borderline personality disorder. There has been much research conducted into the personal experience of borderline personality disorder within different contexts, such as the label of personality disorder (Stalker, Ferguson & Barclay, 2005), experience of using medication (Rogers & Acton, 2012), being on an inpatient unit (Rogers & Dunne, 2011) and unmet needs in this client group (Hayward, Slade & Moran, 2006). Less research has been undertaken to establish the meaning of recovery from the perspective of people with a diagnosis of personality disorder. To date, only three pieces of research specifically exploring this have been identified. This research has been concerned with how recovery is defined by people with personality disorder, and what aids and hinders the recovery process. Some of the research methods and main findings are discussed.

A piece of participatory action research, carried out by people using a personality disorder service identified recovery views using interviews and focus groups (Castillo, Ramon & Morant, 2013). Data were analysed using thematic analysis. The opinions of sixty-six people (people with personality disorder and family members) were used. The

arising themes were presented within a hierarchy diagram, similar to Maslow's hierarchy of needs (Maslow, 1943). The recovery process was highlighted as a series of stages. The themes within each stage included: safety and trust, feeling cared for, feeling a sense of community and belonging, boundaries, containing experiences and developing skills, hopes, dreams and goals, achievements and transitional recovery.

This study only looked at the views of participants who were connected to a particular service (a therapeutic community). Even though the service was a personality disorder service, the study did not state what sub-types of personality disorder participants had, and it was unclear whether personality disorder was the primary diagnosis for all participants (the study did list participants' reason for referral, which included a number of difficulties such as aggression, eating disorders and gender issues).

The first author of the research paper was Chief Executive of the service and the research team was made up of people using the service. This may have introduced an element of bias in the research process, in particular concerning data analyses; for example, negative aspects of the service may have been overlooked within the thematic analysis. Even though the researchers stated that a 'reflexive and collaborative approach to data analysis' was taken, details of this were not made clear in the study. Even though the study endeavoured to gain views from participants who had not found the service helpful, the views of the study may reflect those who found the service beneficial, and therefore may not represent a full reflection of recovery views. The study does acknowledge this limitation.

A second piece of qualitative research (Katsakou et al., 2012) interviewed forty-eight participants with a diagnosis of borderline personality disorder, recruited from a range of specialist and generic mental health services, thus reflecting diverse views. This study used grounded theory and thematic analysis. This research highlighted that self-understanding was a recovery goal for participants. Self-understanding was seen as precursor to other goals, such as greater self-acceptance and self-esteem. Participants reported wanting to gain more control over their emotions and thoughts and be able to tolerate these without engaging in harmful behaviours (e.g., alcohol, self-harm). In addition, participants wanted to reduce self-harm, suicidality, drug and alcohol intake and address eating difficulties. Improving relationships was also important; this

included socialising more, being better able to tolerate conflict and ending unsupportive relationships. Having meaningful activities, completing practical achievements, and for some, employment were important goals.

Within this study, half of the sample did not agree with the word recovery. It was suggested that the word 'recovered' could reflect an 'all or nothing' way of thinking about one's difficulties (e.g., recovered or not) and might reflect the dichotomous thinking style which is often found to be problematic in personality disorder.

Participants described recovery as a 'dynamic process' and something which fluctuated (e.g., times of feeling better and at times feeling that things were not going well). The study described that full recovery seemed over-realistic, but participants described feeling hopeful about being able to deal with their difficulties better and the possibility of being able to make helpful changes to their lives. The study concluded that some of the recovery goals reported by participants were in line with wider recovery values, such as relationships, activities and employment. However, the study reported that other recovery goals reported by participants seemed more specific to borderline personality disorder, such as gaining control over emotions and reducing self-harm.

Participants in the study were required to have a history of self-harm (defined as 'self-injurious behaviour, overdosing or suicide attempts, performed as the intention to self-harm') and so did not include views of people who may have self-harmed in other ways (e.g., sexual behaviours, risky behaviours) and therefore only reflecting views of a subset of people with borderline personality disorder. Furthermore, the study stated that new participants were recruited on the basis of potential similarities and differences from the existing sample of participants, but did not clarify the details of how. This recruitment strategy may also suggest an element of bias in the study selection and recruitment methods.

The final piece of research, commissioned by a service user led organisation, interviewed six people (three males, three females) who were using a personality disorder service. Thematic analysis was used to analyse the data. Data collection and analyses were carried out by a clinical researcher and a service user researcher. This study highlighted seven recovery themes. These were: personal understandings of recovery, acceptance, positive feelings about recovery, relationships, society, obstacles

to recovery and goals. Recovery was found to be a meaningful concept but full recovery, or being without difficulties was felt to be unrealistic. Recovery was generally defined as coming to terms with one's shortcomings and learning to cope with difficulties. Changes in behaviours, thoughts and feelings were seen as signs of recovery, such as staying away from alcohol and responses towards difficult situations. Acceptance included awareness, understanding and insight about one's self, which led to participants reflecting more on their behaviours and unhelpful thought processes and also to having more realistic aims for one's self. Self-esteem, being valued by others and hope and belief in one's self was highlighted as important to recovery, as was self-confidence and determination. Within the theme of relationships, the research highlighted that participants recognised the impact of their behaviour on others and this was sometimes a trigger for recovery. Building trusting relationships was important and helped lead to changes in an individual's thoughts and feelings. Within the theme of society, participants felt ambivalent about how much they wanted to feel 'normal' and feel part of society. However, employment, education and volunteering were seen as important within this theme in order to feel more integrated within society and build confidence. Some aspects of society's systems such as housing and benefits were seen as difficult in recovery as participants had had negative experiences in relation to these. Obstacles to recovery included negative thoughts, extreme and fluctuating emotions and fear and anxiety. Self-destructive behaviours such as suicide attempts and self-neglect were seen as obstacles to recovery. Participants' recovery goals included living a healthier life and having more social time, improving relationships and gaining access to employment and educational opportunities. Other goals included having more control over emotions, and becoming more self-confident and assertive. In addition, the study reported that participants wanted to reduce their medication and mentioned the harmful effects but also for some, how medication was necessary for recovery.

This study did not acknowledge any limitations to the research process, although they did discuss their reflections on the interview process. The study was not clear about participants' diagnoses; for example, what type of personality disorder participants had, or how this was diagnosed, or what participants' primary difficulties were. The study was vague about how and where participants were recruited from. Even though the study

used equal numbers of males and females, they only interviewed six participants which is a small sample size, even for a qualitative study. The study did not discuss how the findings might translate to other contexts or look at previous recovery literature in their conclusions. The study produced clear guidelines as to how they went about the data analyses. The research project was commissioned and funded by a service user organisation and one of the authors was Chair of the organisation at the time, and so may reflect their views. The study did; however, include an independent researcher.

1.20 Personality Disorder and Recovery Summary

The literature on personality disorder and recovery is sparse and perceptions of recovery in people with borderline personality disorder are not fully understood. Existing studies appear to have conflict of interest or personal involvement, such as conducting research within their own services. Only one study identified so far has looked specifically at views with people with a diagnosis of borderline personality disorder. Only one study has looked at views from people with personality disorder from a range of services. None of the research has examined the way that different types of therapies and services may influence recovery views, although this has been highlighted as an area for further consideration. Even though some of the studies have looked for views from people not using services, it seems that data have mostly been taken from people who have found services to be helpful. Staff views on recovery have not been taken into account. Staff views on recovery in borderline personality disorder are also important in order to ascertain whether recovery training is required for mental health staff and how services can become more recovery orientated. Also, it is unclear if staff recovery views reflect the recovery values of people with borderline personality disorder. A study found that even following recovery training, staff from inpatient forensic services felt that the recovery approach would be beneficial to detained patients, but felt more uncertain about the benefits of recovery principals with people with personality disorder diagnoses (Gudjonsson, Webster & Green, 2010).

It is apparent in the existing literature that some people with personality disorder agree with general recovery concepts, whilst others find them less meaningful.

1.21 Aims and Hypotheses

The aim of the current study is to explore and understand perceptions of recovery in people with borderline personality disorder and staff members, using Q methodology. The study also aims to find out what factors are most important to recovery in people with borderline personality disorder and if these are in line with general recovery principals. As the study is exploratory, there are no formal hypotheses to be tested; Q methodology does not impose a *priori* meaning. However, in line with previous research on personality disorder and recovery, it is believed that there will be distinct, differing viewpoints on recovery amongst people with borderline personality disorder and staff members.

1.22 About Q Method

The Q technique was devised by William Stephenson (Stephenson, 1935). Stephenson was a psychologist and physicist. Stephenson was interested in the subjectivity of the mind; for example, an individual's attitudes, judgements, and perspectives (Brown, 1996). Q methodology has been described as capturing 'life as lived from the standpoint of the person living it' (Brown, 1996, p. 561). Stephenson felt that an individuals' subjectivity was communicable to others, and therefore able to be measured and researched (Amin, 2000). Stephenson was influenced by psychoanalysis (he was analysed by the psychoanalyst Melanie Klein) and also by his background training in physics. Stephenson also saw limitations with traditional R techniques where he felt participants' views were constrained within objective psychological tests and participants were reduced to traits and characteristics (Robbins & Krueger, 2000). Q methodology was designed to challenge the idea that people could be divided into a series of parts (Watts, 2005) and is more concerned with 'holism'.

Q methodology uses an 'inverted' form of factor analysis to identify groups of people who make sense of topics in similar ways (Watts & Stenner, 2005). Traditional factor analysis measures how variables are alike, but Q methodology measures how persons are alike. Q methodology is interesting because its method makes it neither a fully quantitative nor qualitative method. It has been described as 'qualiquantological', and sitting between the two paradigms (Watts & Stenner, 2005).

1.23 Rationale for Using Q Methodology

As the research literature is limited, and little is known about understandings of recovery in people with borderline personality disorder, an exploratory approach was necessary for the current study. The existing research is qualitative in nature, and it was deemed that further ‘pure’ qualitative techniques, such as grounded theory or thematic analysis would have supplemented the literature, yet perhaps not added anything new. As Q methodology makes use of existing viewpoints around a topic, it was decided that the use of Q methodology would provide a means of directly utilising the existing research and opinion.

It is clear from the literature that there are differing viewpoints concerning recovery in borderline personality disorder and some debate about the applicability of recovery principals for this group of people. Q methodology is useful to investigate ‘complex and socially contested concepts’ (Watts & Stenner, 2005) and is also an appropriate method to identify the diversity of viewpoints there may be concerning understandings of recovery. In addition, it was believed that Q methodology would highlight similarities between people on recovery views, in addition to difference.

Participants can be classed into meaningful groups in terms of shared opinion, rather than by demographic data (Schlinger, 1969). As Q methodology seeks to uncover differing points of view, participants who potentially have opposing or diverse viewpoints can be included. Q methodology therefore allows for mixed groups of participants to be included; in this case people with borderline personality disorder and staff members. Separate statistical analyses can be conducted if necessary, so factor arrays for different groups of participants can be produced. It is possible to later combine factor arrays from different groups (who have completed the same Q sort) to arrive at a set of ‘super factors’ which can identify similarities and differences between viewpoints of the original separate groups (e.g., people with borderline personality disorder and staff members). Thus, the flexibility of analyses in Q methodology makes it an appropriate method for exploring views of people with borderline personality disorder in addition to staff members.

Alternative research methodologies were considered to address the study aims; for example, the use of repertory grids (based upon Personal construct theory),

questionnaires or semi-structured interviews. Q methodology explores the significance of different opinions within an overall configuration (Watts & Stenner, 2005), in comparison to questionnaires, where participants consider each item separately. Given that recovery views are likely to be nuanced and complex within people with borderline personality disorder it was believed that Q methodology would be useful in this respect. Q methodology was considered advantageous over the use of repertory grids because Q methodology is more suitable for combining group responses (Durning & Brown, 2006) whereas repertory grids are more suited to examining individual responses. Q methodology can produce viewpoints that may not be considered using interviews (Vahey, 2013), because participants are required to consider various statements and this approach was considered advantageous for this reason. Additionally, more participants can be included using Q method than in an interview design, therefore, allowing more viewpoints to emerge. The use of Q methodology was considered advantageous to other research methodologies in addressing the study aims.

The use of Q methodology in the current study would reveal participants' subjectivity, and given that recovery is an individual concept with different meaning for individuals, it was decided that the use of Q methodology would allow for subtle differences in meaning to be reflected (Coogan & Herrington, 2011) and for participants to voice what is meaningful from their perspective. Q methodology does not impose a priori meanings, which fits in with the exploratory nature of the current study. It was deemed that the use of Q methodology would provide the detail captured by using a qualitative analysis, whilst providing structured statistical means of doing this (Schlinger, 1969).

Q methodology has been used to explore various areas of mental health, particularly in psychosis such as voice hearing (Jones, Guy & Ormrod, 2003), substance misuse in people with schizophrenia (Gregg, Haddock & Barrowclough, 2009), and recovery in psychosis (Wood, Price, Morrison & Haddock, 2012). Q methodology has not yet been applied to investigate understandings of recovery in people with borderline personality disorder.

Chapter 2 Method

Part 1

2.1 Method Overview

The following sections describe the stages of Q methodology. The section is separated into two parts. Section 1 describes the development of the Q set. Section 2 describes the study procedure.

2.2 Ethical Approval

The study proposal was reviewed by the Division of Clinical Psychology Research Sub-Committee within the University of Manchester. Following this, the study was reviewed by the National Research Ethics Committee and ethical approval was granted. Local approval from relevant NHS Trusts was also granted.

2.3 Study Design

The study used a Q methodology design. Q method involves the ranking of different statements in relation to one another. Statements can be interpreted in different ways depending upon the perspective of the participant (Davis & Michelle, 2011). Statements are considered in relation to one another. Factor analytic techniques are applied to highlight groups of participants who rank statements in a similar way, and therefore, share viewpoints.

2.3.1 Overview of Q Methodology

There are a number of stages to designing and administering a Q sort.

- The first step is exploring the Q concourse, which consists of the range and diversity of information around a topic.
- A Q set is developed from the concourse. It is usually a sample of statements, which aims to be representative of the themes in the concourse. The statements are presented as individual cards.
- Participants are required to sort the statements, in relation to one another according to order of importance. This is known as the Q sorting process.

- Each individual Q sort is compared to one another through factor analysis. The aim is to uncover opinions, highlighting shared meaning and understanding between respondents.

These various stages are described in more detail within the following sections.

Figure 1 shows a diagrammatic version of the stages involved in the design of a Q sort.

2.4 Exploration of the Q Concourse

A Q concourse consists of the everyday views, discourse and opinions surrounding a particular topic (Brown, 1993). It has been referred to as ‘the flow of communicability surrounding any topic’ (Brown, 1993) and ‘all that can be thought and said about a situation, event, or phenomenon’. A concourse is not restricted to words, but can include a variety of mediums, such as photographs, artwork, music and even odours (e.g., Stephenson, 1935). Within psychological study, it is more usual for opinions to be collected in word form (Watts & Stenner, 2005).

A concourse can be obtained from primary sources (e.g., interviews or group discussion with the Q respondents) or secondary sources (e.g., media sources and literature). These have been described as naturalistic and ready-made Q samples (McKeown & Thomas, 1988). Ready-made Q samples are drawn from sources other than the Q respondents. Statements can be ‘borrowed’ from existing questionnaires (e.g., Watts, 2002). Quasi-naturalistic Q samples are similar to those obtained from interviews, but are developed from sources external to the study; for example, taking data from existing interviews (McKeown & Thomas, 1988; van Exel & de Graaf, 2005). The method of obtaining the concourse depends upon the topic being studied; neither method is superior (McKeown & Thomas, 1988).

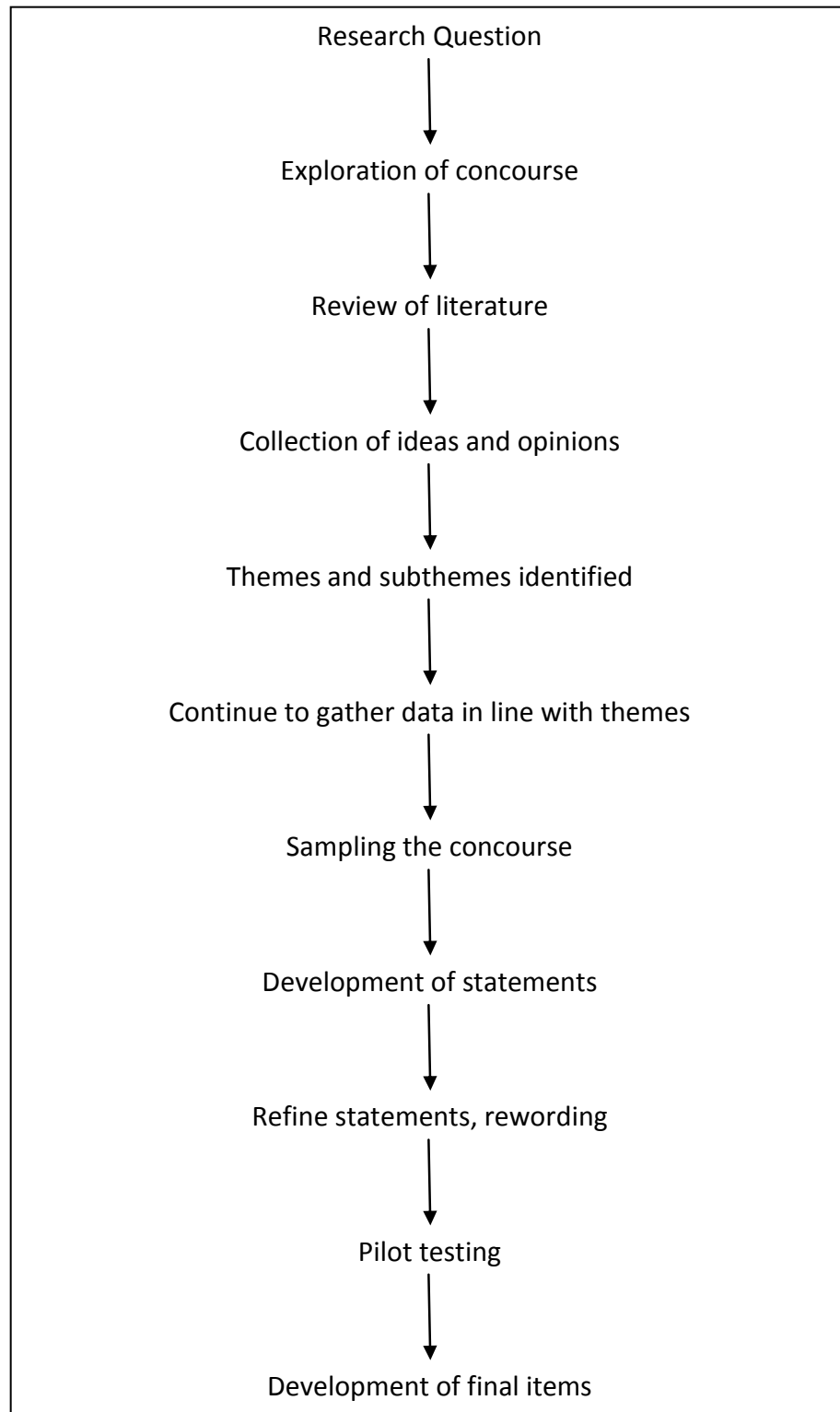


Figure 1. Flowchart of stages in Q methodology

The aim of the current study was to explore and capture the diversity of views around recovery in borderline personality disorder. In the current study, the concourse was explored using a combination of methods, including quasi-naturalistic Q samples, ready-made Q samples and secondary sources. The reason for this was that there is an abundance of available literature on recovery and one of the study aims was to investigate the applicability of the existing literature to people with a diagnosis of borderline personality disorder.

2.5 Source of Items: Review of Literature

An extensive review of recovery literature was conducted to sample the Q concourse. Search engines PsychInfo, PubMed and Google Scholar were used to identify literature. The term ‘recovery’ was used in a combined search with the terms ‘mental illness’, ‘borderline personality disorder’ and ‘recovery measure’. The aim was to gather a wide range of ideas about recovery from a variety of sources (Amin, 2000).

- Quasi-naturalistic Q samples were taken from qualitative research (interviews) on recovery (e.g., personal accounts of recovery)
- Ready-made Q samples were taken from items on existing recovery measures
- Secondary sources included white paper documents, resources from mental health providers (e.g., Centre for Mental Health) and empirical research.

A list of sources can be found in Appendix C.

2.6 Development of the Q Set

2.6.1 Theme Extraction

The concourse was deemed to be explored thoroughly once repetition started to emerge. Theme extraction was guided by the researcher’s prior knowledge of recovery literature (van Exel & de Graaph, 2005). Thirty-one themes were identified. Themes were scrutinised and discussed with the research team and similar themes were collapsed together, resulting in fourteen themes (each with sub-categories). The following final themes and subthemes were identified:

1. Relationships

Family

Friends

People with similar difficulties

Pets

2. Activities

Enjoyable/social activities

Sport

Employment

Education

3. Symptoms

Drugs and alcohol

General mental health symptoms

Personality disorder related symptoms

4. Coping skills

5. Physical health

Personal care

Diet

Exercise

6. Relapse

Support

Hospitalisation

7. Understanding

Insight/ knowledge

Being given information

8. Hope

Future

9. Roles

Identity

Acceptance

Independence/responsibility

Self-esteem/ self confidence

10. Society

Housing

Stigma/prejudice

Community

11. Treatment

Access to services

Choice

Medication

12. Achievements

Having goals

Achieving goals

13. Religion

14. Finance

It was recognised that there was still some overlap and that themes were not independent of each other.

2.6.2 Q Sampling

The next stage was to generate a list of items (the Q set). A 'concourse is to Q set what population is to person sample' (Watts & Stenner, 2012, p.34) and the process of sampling the concourse works in the same way as participant sampling. Therefore, the aim was to create a miniature but representative version of the concourse. This is the researcher's responsibility (van Exel & de Graaf, 2005).

A distinction between structured and unstructured sampling techniques has been outlined in choosing items for a Q set (McKeown & Thomas, 1988). With structured sampling, a systematic process is used. The topic is broken down into themes, and items are chosen purposely according to the identified themes (Watts & Stenner, 2012). The final Q set is constructed by sampling from each category. This sampling method is thought to provide clarity and representativeness and limit bias (van Exel & de Graaf, 2005). The use of a structured Q sample allows the Q sample to be focused around

existing conclusions on the topic in question. It was believed that this would be appropriate for the current study, as it would enable participants to give their opinions on the current recovery literature.

The researcher extracted material from the literature, which reflected opinions, beliefs and ideas relating to recovery. This included direct quotes, research findings and questionnaire items. Approximately 400 statements relating to recovery were identified. It is advisable to generate a large number of statements to begin with (Watts & Stenner, 2005). Each of these statements was placed under the theme on the basis of 'best fit'. The items under each theme were reviewed and repetition was removed. This resulted in 124 statements, grouped under the 14 themes. The list of statements was printed out and laid out under their corresponding themes. These were reviewed by the research team and two Experts by Experience (people with personal experience of borderline personality disorder, who use this experience as part of the work they do). In order to reduce the number of items, some statements were combined and worded in a more general fashion (Amin, 2000). For example the following statements: *Stopping my misuse of alcohol or drugs* and *Stopping addictive behaviour (e.g., gambling, shopping)* were combined to make the statement *Stopping addictive behaviour (e.g., gambling, shopping, alcohol, drugs)*. Sometimes, different aspects of the same statement had to be addressed (Brown, 1980). For example, the decision was made to keep the following statements separate: *Recovery is about having goals in life* and *Recovery is about achieving goals*. Editing and/or removal of statements were carried out in collaboration with the research team and Experts by Experience. Experts by Experience were further consulted on clarity and rephrasing of statements and making sure any ideas were not overlooked. Following several reviews, 58 statements grouped under 14 different themes were agreed for inclusion in the final Q set (Appendix D).

The size of a Q set is usually dictated by the size of the subject (Watts & Stenner, 2012). Between 55-75 items has been suggested as appropriate, being enough to achieve statistical reliability, but not too many to burden the participant (Schlinger, 1969). The number of statements was comparable to other Q methodology studies (e.g., Greg et al., 2009; Wood et al., 2013).

2.6.3 Preparation of Statements for Q Sorting Process

All statements were phrased in a similar style. Technical language was avoided. Only one idea was expressed per statement (i.e., double barrelled statements were avoided). Each statement was printed on a separate piece of card.

2.6.4 Pilot Testing

The Q set was pilot tested before proper use. The use of experts on the topic being studied has been recommended in pilot testing (Watts & Stenner, 2012) because they are best placed to comment. Two female Experts by Experience (the same people who collaborated on design of the statements) and a third year male trainee clinical psychologist completed the Q sort as a pilot. They were familiar with the concept of recovery and with the difficulties associated with having a diagnosis of borderline personality disorder, but had little experience of Q methodology.

The purpose of the pilot was to check the clarity and appropriateness of the statements (e.g., ambiguity) and to assess the administration and procedure of completing the Q sort (e.g., completion time, comprehension of instructions, and design of materials). Following the pilot, the original statements were retained, but two statements were re-worded. The statement *Improving my relationships with others* was amended to *Having good relationships*. The statement *Understanding my history* was amended to *Understanding myself*.

The verbal instructions given to participants were amended to make them clearer. The researcher informed participants that the order of the statements within each column was not important (e.g., all +5 statements could be of equal importance). The shape of the cards was re-designed so that each card fitted into a box on the distribution grid (Figure 2). This allowed participants to see all the placing of all their final responses. The sorting condition of instruction was written on a piece of card and displayed for participants to refer to throughout the Q sort.

2.7 Materials

2.7.1 The Q Sort Pack

The Q sort pack consisted of the 58-item Q set, guide bar, distribution grid, narrative instruction sheet and scoring sheet.

2.7.2 58-item Q Set

The Q set items were presented to participants on white laminated cards approximately 3cm x 3cm in size. Numbers were on the back of each card to identify each statement.

2.7.3 Guide Bar and Distribution Grid

The guide bar consisted of a piece of paper with three boxes labelled *important*, *not important* and *neutral*. The purpose of the guide bar is to help participants complete the initial sort into three piles.

The actual Q sort is completed using the quasi-normal distribution grid. The distribution is forced choice, meaning that a fixed number of statements can be assigned to each column. Fewer statements are allowed in the extremes and the majority of statements are placed in the centre. This type of distribution helps with decision-making, because it forces participants to make choices (McKeown & Thomas, 1988) and is thought to be more convenient for participants (Watts & Stenner, 2005). Q sorts can also be completed using a free distribution. A near normal and symmetrical distribution is preferred for methodological reasons (Watts & Stenner, 2012). There are guidelines for the range and slope of the distribution grid. An eleven-point distribution ranging from +5 to – 5 has been suggested for Q sets under 60 items (Watts & Stenner, 2012). Figure 2 shows the distribution shape the current study employed.

Very important

Figure 2. Quasi-normal distribution grid

The narrative instruction sheet was designed to standardise the Q sort process. Details of the instructions given to participants are detailed in the Procedure section.

The score sheet was a miniature replication of the quasi-normal distribution grid printed on a sheet of paper (A4 size).

Part 2

2.8 Participants

2.8.1 Identification and Recruitment of Participants

In Q methodology, study participants are equivalent to study variables and known as the P-set. A P-set must always be more ‘theoretical or dimensional than random or accidental’ (Brown, 1980, p. 192). For this reason, a strategic approach to recruiting participants was used. As the study aim was to explore perceptions of recovery in borderline personality disorder, people who had sufficient knowledge of borderline personality disorder and who would have relevant viewpoints on this subject were selected (Amin, 2000; Watts & Stenner, 2012). People with a diagnosis of borderline personality disorder and staff members working with people with borderline personality disorder were invited to take part. Opportunistic sampling techniques were used to identify potential participants and snowball sampling was used.

Recruitment took place from four NHS Trusts. It was considered important to target staff from a variety of professional backgrounds and people with borderline personality disorder at different stages of recovery, in order to gain a wide view of opinions surrounding the topic. The study encouraged participation from people with borderline personality disorder at various stages of recovery.

2.8.2 Recruitment Procedure

Participants were recruited from personality disorder services and services that typically see people with a diagnosis of borderline personality disorder. These were all mental health Trusts in the North West of England. These included personality disorder services, psychotherapy departments, a community mental health team, and a recovery team. The researcher circulated details of the study via email and/or presented the study to services and invited people to take part. The study adverts and information sheets (Appendix E) were distributed. Potential participants had the opportunity to ask questions about the study during face-to-face meetings or through other means (i.e., via email or telephone).

2.9 Inclusion and Exclusion Criteria

2.9.1 People with a Diagnosis of Borderline Personality Disorder

Inclusion Criteria

Anybody with a formal diagnosis (diagnosed using DSM or ICD-10 criteria) of borderline personality disorder or emotionally unstable personality disorder, borderline type, was suitable for inclusion in the study. It was understood that participants may have multiple diagnoses, but borderline personality disorder had to be the main diagnosis. Participants could be using services or not using services at the time of participation and included Experts by Experience. All participants who showed interest in the study met the inclusion criteria.

Exclusion Criteria

Participants who did not have capacity to give informed consent were excluded from the study. Participants who did not read or speak English were excluded from taking part. Participants under age 18 were also excluded from taking part (there was no upper age limit).

2.9.2 Staff Members

Inclusion Criteria

Any staff members working with people with borderline personality disorder were invited to take part in the study, regardless of professional background (e.g., psychiatry, psychology, psychotherapy, nursing). Trainees (e.g., trainee psychologists and psychiatrists) were also invited to take part.

Exclusion Criteria

Staff members not working with people with borderline personality disorder were excluded from the study. Staff with less than 6 months experience of working with

people with personality disorder were excluded from the study, regardless of role. It was decided that participants needed to have a basic understanding of the difficulties associated with borderline personality disorder in order to give views on what might be important for recovery. Participants who did not have capacity to give informed consent were excluded from the study. Participants who did not read or speak English were excluded from taking part. Participants under age 18 were also excluded from taking part (there was no upper age limit).

2.10 Sample Size

In Q methodology, the ‘breadth and diversity’ of the participant sample is considered as important as proportion (Brown, 1996). A large sample size is not necessary in Q methodology. However, there are guidelines regarding sample size. The number of statements (Q set) should be larger than the number of participants (P- set). A ratio of at least two Q set items to every participant has been recommended (Watts & Stenner, 2012). Additionally, there should be enough Q sorts to adequately summarise the viewpoints that make up the concourse. It is not known how many viewpoints there are in a concourse, but there are usually three or four, rarely more than six (Brouwer, 1999). Four or five participants are needed to represent each viewpoint in the concourse (Brown, 1980). As the current study used a 58-item Q set, a sample size of 25-30 was considered sufficient.

2.11 Conducting Q Sorts

2.11.1 Place and Environment

The study researcher conducted the Q sorts. Following prior agreement, individual meetings were arranged with participants at times and places which were convenient for them. Meeting locations were NHS premises (participants’ local service or place of work), and university premises. Effort was made to ensure that environmental conditions were similar for all participants. Q sorts were conducted in quiet places with sufficient desk/ floor space for the distribution grid. Average completion time took 60 minutes (including consent and questions at the end).

2.11.2 Consent

Prior to completing the Q sort, the researcher went through the information sheet (which participants had been given prior to attending) with participants. This included reminding participants of the study aims, what was being asked of them and information about confidentiality. Informed consent was obtained (example consent form Appendix F) after making sure participants understood the information.

2.11.3 Demographic Information

Participants were asked to provide their date of birth, gender and ethnic origin on a question sheet. Staff members were asked to provide additional information. This was their professional role, service orientation and number of years' experience of working with people with personality disorder.

2.12 Instructions for Q Sort

This section details the procedure in completing the Q sort. Participants were presented with a Q sort pack. The pack included written instructions, the 58-item Q set, guide bar, distribution grid and the condition of instruction. In Q methodology, the condition of instruction serves as a guide for how the participant should rank the statements, for example '*most like my point of view*' to '*most unlike my point of view*' (Davis, 2011). This is usually derived from the research question. Participants were instructed to sort the statements according to the condition of instruction:

What factors are most important to you in recovery?" For staff members this was
What factors are most important for recovery in borderline personality disorder?

The Q sort statements were shuffled prior to use for each participant. Before beginning the Q sort, participants were asked if they had any questions. Verbal instructions were given to the participant by the researcher.

2.12.1 Initial Sort

Participants were presented with the Q set (58 statements) and the guide bar. They were asked to read the statements and complete an initial sort into three categories; *important*, *not important* (or *disagree*) and *neutral*, using the guide bar. Participants were

instructed that the *neutral* category could be used for statements they felt ambivalent or uncertain about. This initial sorting helped participants to familiarise themselves with the statements and allowed researcher to see the distribution of statements in each category (Vahey, 2013). The researcher recorded the statements in each category.

2.12.2 Main Sort

Participants were then asked to take the statements from the *important* pile and to select the three statements they felt were most important to them. These were placed on the outermost column of the distribution grid at the right hand side labelled +5. Participants were asked to take the next four statements they most agreed with from the pile and to continue to work inwards (Figure 2). Participant were asked to do this with all statements from the *important* pile. Participants were reminded that their answers were not fixed at this stage. They were informed that the order of statements within the columns were not important.

The same instructions were given for the *not important* pile, but this time beginning with the three statements they felt were least important, placing these on the outermost column on the left hand side of the distribution grid (-5 column). Participants were asked to do this with all statements from this pile. The *neutral* pile was the last to be sorted. Participants were asked to place the remainder neural statements according to the ones they felt least strongly about in the middle column and to work outwards or inwards. The number of statements allowed in each column of the distribution grid can be seen in Figure 2. The Q sort was complete once all the statements had been placed. Participants were asked to review their Q sort and check they were satisfied with their responses. The researcher recorded the answers using a score sheet.

2.12.3 Brief Feedback Interviews

Participants were asked to give qualitative feedback on completion of the Q sort. The following questions were asked to each participant:

- i.) How did you find completing the Q sort?
- ii.) Were there any statements, which stood out to you?
- iii.) Can I ask about your three most agree statements?

- iv.) Can I ask about your three most disagree statements?
- v.) Was there anything you feel is important that was not in the Q sort?

Participants' responses were audio recorded.

2.12.4 Payment

Participants with a diagnosis of borderline personality disorder were given payment as an incentive for taking part and as a token for their time. They were paid ten pounds each and asked to sign a receipt.

2.13 Reflexivity

It seemed important to outline the researcher's history, experiences and reading relevant to the study. The researcher's own conceptual stance, experiences and cultural and societal beliefs can influence the development of research (Finlay, 2002). The researcher was aware that personal factors could influence the selection of Q statements, their interactions with participants and the scope of the study as a whole. The researcher is a British female, mixed race. She has 10 years' experience of working in mental health settings and an interest in working with people with personality disorder. The researcher has an interest in recovery and had attended meetings within her workplace about the inclusion of recovery principals to clinical psychology teaching programme. In order to reflect on personal processes, the researcher kept a journal during the duration of the study and discussed the development of the research with professional colleagues and throughout supervision.

2.14 Data Handling and Confidentiality

The procedures for handling, processing, storage and destruction of information within the current study were in accordance with the Data Protection Act 1998.

To ensure confidentiality, all data (Q sort scores, qualitative data, demographic information) were anonymous. Data were given a unique code which linked them to the participant. Only the researcher had access to identifiable information (e.g., codes, consent forms, participants' email addresses) and this was stored in a locked filing cabinet within a locked room at the University of Manchester. Q sort data were entered

onto a password protected computer. Qualitative data were audio-recorded and transferred onto a secure computer at the University of Manchester and transcribed by the researcher. Direct quotes were used in the study but only quotes that would not identify a participant.

2.15 Data Analyses

A dedicated Q methodology statistical programme, PQMethod, Version 2.35 (Schmolck, 2002) was used to analyse the Q sort data. This programme automatically computes correlations between Q sorts and uses factor analysis to identify factors emerging from the data. Factor analysis is a statistical technique used to group data together in an orderly way. It does this by reducing a large number of variables to a smaller number of factors (Dancey & Reidy, 2011).

A correlation matrix, comparing each person's Q sort with every other Q sort was computed. The correlation matrix highlights the level of agreement between each individual's Q sorts. Initial factors were extracted using principal components analysis. This shows the natural grouping of Q sorts by similarities and highlights how many different Q sorts are evident within the data. Factor loadings for each Q sort were examined (these are determined automatically by PQMethod). Factor loadings represent the extent to which each individual Q sort is associated with a factor.

Varimax rotation was executed to identify the clearest representation of patterns of observations. By rotating factors, they can be examined from different angles. Varimax rotation has been recommended for use (Watts & Stenner, 2005) because it maximises the amount of variance explained by the extracted factors. It does this by increasing the factor loadings of some Q sorts whilst decreasing their loadings on other factors.

Each resulting final factor represents a group of individuals' Q sorts that are highly correlated with each other and uncorrelated with others (van Exel & de Graaf, 2005). Factor arrays for each factor were produced through calculating the weighted average of Q sorts loading significantly onto each factor. Factor arrays are exemplary Q sorts for a factor and serve as a 'best estimate' of the pattern which characterises a factor (Thomas & Watson, 2002). The factor arrays were subject to interpretation.

Chapter 3 Results

3.1 Participant Information

Participants were 16 staff members and six people with a diagnosis of borderline personality disorder, recruited from five different services, across three different mental health Trusts. The total sample size was 22. All participants described their ethnicity as being White British or White other. Participants' self-report demographics are outlined in Table 2.

Table 2 *Participant Demographics*

	People with personality disorder	Staff	All participants
Mean age	35.33	43.87	41.54
(SD; range)	(7.00; 27- 45)	(11.42;25- 59)	(10.95; 25- 59)
Gender			
Female (%)	5 (83.33)	9 (56.25)	14 (63.63)

Staff members were recruited from a range of professions and services. Table 3 shows the breakdown of staff participants by profession, service type and mean number of years' experience.

Table 3: *Breakdown of Staff Members by Profession and Service Type*

Profession	Number (%)	Service Type
Nurse	6 (37.50)	Community mental health team, Recovery team, Therapeutic community
Assistant mental health practitioner	1 (6.25)	Community mental health team
Occupational therapist	1 (6.25)	Community mental health team
Psychodynamic therapist	2 (12.50)	Psychotherapy department
Cognitive analytic therapist	1 (6.25)	Psychotherapy department
Psychologist (and psychodynamic therapist) Trainee psychologist	3 (18.75)	Psychotherapy department; Community mental health team
Social worker	2 (12.50)	Recovery team; Therapeutic community
Mean years experience (SD; range)	11.43 (6.91; 2.50- 20)	

All interested participants met the inclusion criteria. The uptake rate was 84.62%. There were four people with a diagnosis of personality disorder who expressed initial interest but then were unable to participate or decided not to.

3.2. Factor Analysis

Principal components analysis yielded eight initial factors. A method of selecting factors for extraction is to select factors with an eigenvalue over one (Watts & Stenner, 2005). Factors with eigenvalues below one explain less of the study variance than a single Q sort. Six factors had an eigenvalue over one. This solution resulted in six factors, with 71% of variance explained but only made use of 13 Q sorts (Appendix G). One of the

factors only had one Q sort loading onto it. A factor should have at least two Q sorts loading significantly onto it to be interpretable (Watts & Stenner, 2012).

A scree test was carried out (Appendix H). Based on the point of inflexion, the scree plot indicated that 2-3 factors should be included. These were both trialled. A three-factor solution was decided upon, because this included 19 Q sorts and explained overall 55% of the study variance. Having more Q sorts loading onto factors is advantageous, because the final factor arrays are based upon averages. As more Q sorts define a factor, this becomes more stable (Watts & Stenner, 2012). Table 4 shows the variance explained by each factor and their corresponding eigenvalues.

Table 4: *Final Extracted Factors with Eigenvalues and Explained Variance*

Factor	Eigenvalue	Unrotated	Rotated
		variance (cumulative)	variance (cumulative)
1	8.17	37% (37%)	24% (24%)
2	2.30	10% (48%)	19% (43%)
3	1.69	8 % (55%)	12% (55%)

Correlations between each factor were examined. If two factor arrays are significantly correlated, they may be too alike to interpret as separate factors. Correlation scores showed that each factor was significantly different from each other.

Table 5: *Correlations Between Factors*

	Factor 1	Factor 2	Factor 3
Factor 1	1.00	0.43	0.42
Factor 2	0.43	1.00	0.44
Factor 3	0.42	0.44	1.00

3.2.1 Factor Loadings

Table 6 shows the factor loadings for participants' Q sorts onto the three factors. As can be seen in Table 6, the majority of the loadings were positive, meaning participants agreed with the factors. All of the significant loadings were positive. Eight participants loaded significantly onto Factor 1, seven participants onto Factor 2, and four participants loaded onto Factor 3. Participants who were significantly associated with a factor were assumed to share a viewpoint (McKeown & Thomas, 1988). Three Q sorts were not included in the final analysis, because they did not load onto any factors (one person with borderline personality disorder and two staff members). Their scores were similar on more than one factor.

Table 6 *Rotated Factor Matrix with Loadings for each Q Sort*

Participant	Factor 1	Factor 2	Factor 3
P1	0.44	0.49	-0.25
P2	0.09	0.18	0.69*
P3	0.83*	0.26	0.12
P4	0.81*	0.08	0.12
P5	0.16	0.51*	0.33
P6	0.03	-0.02	0.71*
S1	0.03	0.68*	0.15
S2	0.11	0.74*	0.18
S3	0.43	0.29	0.39
S4	0.62*	0.25	0.19
S5	0.59*	0.54	0.15
S6	0.30	0.47*	0.02
S7	0.38	0.55*	0.12
S8	-0.40	0.61*	0.08
S9	0.62*	0.61	-0.06
S10	0.35	0.075	0.42*
S11	0.61*	0.28	0.41

S12	0.23	0.35	0.66*
S13	0.49	0.35	0.45
S14	0.68*	0.13	0.11
S15	0.22	0.66*	0.28
S16	0.78*	-0.17	0.27

Note: *= Significant loading ($p < 0.05$) Significant loadings automatically calculated by PQMethod

P= Person with diagnosis of borderline personality disorder

S= Staff member

3.2.2 Factor Arrays

Factor arrays are Q sorts which are statistically configured to represent the viewpoint of a factor. They represent the ideal Q sort for a factor. As this is done using a weighted average of significantly loading Q sorts, there is little chance that a single participant's Q sort will load completely onto a particular factor (Watts & Stenner, 2012). Table 7 shows the factor array for each factor. This shows the average ranking for each statement within each factor. Rankings range from +5 (*very important*) to -5 (*least important or not important*). Factor arrays are also reproduced in the shape of the distribution grid (Figures 3, 4 and 5).

Table 7: *Factor Arrays for Factors 1, 2, and 3*

Statement	Factor 1	Factor 2	Factor 3
1. Having good relationships	2	0	5
2. Being able to trust others	2	-1	0
3. Having belief from others	-1	-2	0
4. Socialising more	-1	-1	-1
5. Being in employment (paid or unpaid)	-2	-4	3
6. Being in education or training	-3	-4	-2
7. Doing enjoyable activities	-1	-1	1
8. Having "me" time	-3	-3	0

9. Having a meaningful life	0	5	4
10. Stopping addictive behaviour (e.g., gambling, shopping, alcohol, drugs)	4	-2	-4
11. Having more stable and balanced emotions	5	0	2
12. Having less suicide attempts	4	-2	-1
13. Self-harming less	5	-2	-2
14. Being able to stop and think before acting	4	1	4
15. Being able to manage conflict	3	0	1
16. Being able to get on with life, despite having difficulties	3	3	-1
17. Being able to cope with strong feelings (e.g., feeling sad or angry)	5	1	4
18. Being able to cope with disturbing thoughts	3	3	-1
19. Being able to cope with stress / bad things happening	4	3	2
20. Being able to sleep	1	-2	1
21. Doing things differently	0	-3	2
22. Being in good physical health (e.g., exercising, eating healthily)	1	-3	0
23. Taking care of self	1	-1	1
24. Knowing how to stay well	3	2	-1
25. Being able to ask for help when it's needed	1	0	2
26. Getting the support needed when things are hard	2	4	4
27. Learning from mistakes	0	-1	-1
28. Understanding one's self	1	5	5
29. Knowing what helps and what doesn't help	2	1	3
30. Having no difficulties	-5	-5	-4
31. Learning to live with one's self	2	2	-3
32. Trusting in one's self	-2	1	3

33. Feeling hopeful about the future	3	5	2
34. Personal growth and discovery	-3	4	2
35. Having setbacks	-4	-2	-2
36. Living a life like others	-5	-4	-3
37. Feeling alert and alive	-2	0	0
38. Taking risks	-3	1	-4
39. Knowing when it is the right time to make important changes	-1	0	0
40. Feeling accepted	1	4	-3
41. Having inner peace	-1	1	-2
42. Feeling able to make mistakes	-2	3	0
43. Having a sense of identity	1	2	3
44. Becoming less self-critical	2	0	3
45. Knowing ones good qualities	-2	1	1
46. Belief in one's self	0	4	1
47. Making choices for self	0	2	-2
48. Being independent	-1	-1	-2
49. Having the right kind of place to live	0	-3	-1
50. Freedom from prejudice	-4	-1	-3
51. Feeling part of one's community	-3	0	-4
52. Being treated with dignity and respect by others	0	2	5
53. Having choices in care	-1	3	0
54. Being medication free	-4	-5	-5
55. Having goals in life	-2	2	-3
56. Achieving goals	0	-3	-5
57. Having religion and/or faith	-5	-5	-5
58. Being financially comfortable	-4	-4	1

3.3 Distinguishing Statements and Consensus Statements

Distinguishing and consensus statements aid interpretation of factors by highlighting similarities and differences between each factor. Distinguishing statements are statements that are ranked statistically different between factors. These statements help to define a factor. Distinguishing statements for each factor are described in Factor Interpretations.

Consensus statements are statements whose rankings do not distinguish between any pair of factors (Watts & Stenner, 2012), meaning they have been ranked similarly by each factor. Consensus statements in the current study are outlined in Table 8, grouped into order by positively and negatively ranked statements. Some of the consensus statements are discussed, and qualitative data (italicised and numbered by participant, indicated by *P* or *S* for person with personality disorder or staff member respectively) are presented to aid understanding and interpretation.

Table 8

Consensus Statements and Ranking for Each Factor

Statement	Factor 1	Factor 2	Factor 3
19. Being able to cope with stress / bad things happening	4	3	2
29. Knowing what helps and what doesn't help	2	1	3
43. Having a sense of identity	1	2	3
25. Being able to ask for help when it's needed	1	0	2
39. Knowing when it is the right time to make important changes	-1	0	0
27. Learning from mistakes	0	-1	-1
4. Socialising more	-1	-1	-1
3. Having belief from others	-1	-2	0
48. Being independent	-1	-1	-2
6. Being in education or training	-3	-4	-2
36. Living a life like others	-5	-4	-3
54. Being medication free	-4	-5	-5
57. Having religion and/or faith	-5	-5	-5

There were more negatively ranked consensus statements than there were positively ranked statements, suggesting that participants across factors were more in agreement about what recovery was not, rather than factors which were important.

3.3.1 Factors Ranked Important to Recovery

Being able to cope with stress/ bad things happening (statement 19) was ranked as important across all factors, although this was also a distinguishing statement in Factor 1 (discussed in further detail in Factor 1). Knowing what helps and what doesn't help (statement 29), and being able to ask for help were ranked (overall) as important to recovery. Having a sense of identity was ranked as important to recovery. This seemed to be relevant to participants in terms of the diagnosis of borderline personality disorder but also more generally: *'Identity-very commonly what we see is people presenting with*

no sense of self. The emptiness. They have no resources' (S10) and *'Having a sense of self of your own identity is relevant, no matter what you do, behaviourally'* (S11).

3.3.2 Factors Ranked Not Important to Recovery

Having religion or faith (statement 57), being medication free (statement 54) and living a life like others (statement 36) were ranked strongly as not important for recovery across all factors. Having religion or faith (statement 57) was ranked with perfect agreement (-5) across all factors. Interestingly, qualitative data revealed that participants did not have such strong views on this statement. They discussed how this was very dependent upon the individual and could be an important recovery factor, but was not essential for all: *'Can have an influence but circumstantial. Could be important, could not be'* (P3). In relation to being medication free (statement 54), participants talked about how this could be an unrealistic goal for some people, and other people discussed the benefits of medication: *'If I took this person off medication, they would be in a crisis'* (S13) and *'Well being able to sleep...I have meds. If didn't, this would be a massive issue'* (P1). In general, participants did not think that being on medication was particularly related to recovery: *'In terms of medication. I'm of the opinion that if it helps and it's not detrimental then I don't think that's separate from recovery. You don't have to be medication free'* (P5) and: *'It doesn't matter if I never stop taking it'* (P4).

Regarding living a life like others (statement 36), participants said: *'What does having a life like others mean? Who? Is that the best we can aspire to, just to be like everybody else? It a bit limiting isn't it?'* (S11) and *'Life like others? Really, we should be encouraging people to live their life that they feel comfortable in'* (S11). A participant with borderline personality disorder said: *'It's not about them, it's about me'* (S3). Another participant said *'They haven't had a life like others-they have mostly has lots of trauma'* (S16). Being in education or training (statement 6) was also viewed overall as not important to recovery, although not as strongly as the abovementioned factors. One participant discussed people needing to have other recovery needs met first *'Feeling accepted and learning to live with one's self – these are the main things to look at before you can get on with any recovery work. You can't be expecting someone to go and get a job or go to college or socialise if they're so chaotic'* (S9).

However, being in employment (statement 5) was viewed differently from education. Being in employment was ranked as not important in Factors 1 and 2 but more important in Factor 3. This is discussed in more detail in Factor 3.

Socialising more (statement 4) was ranked as *not important/towards neutral*. There appeared to be mixed views from participants in terms of qualitative feedback. One participant (staff member) discussed how they felt that this was not important for people with borderline personality disorder because they did not seem like lonely people or ask for help with socialising. The idea of risk was related to this:

'I worked with a couple of people that when they socialise it's not a good thing for them, it causes risk and has bad consequences. So actually maybe I do agree with this with certain conditions, when they have the right support if they know appropriate ways to socialise and things like that' (S15).

Having no difficulties (statement 30) was not a consensus factor statistically, but will be presented with consensus factors, because it was ranked very similarly across the three factors (-5, -5, -4). Qualitatively, there was also little difference between the three factors. Participants described how this was unachievable and unhelpful: *'If people believe they can go on with life with no difficulties, then if someone dies or whatever, then they're not able to deal with those stressors'* (S9) and *'we learn from difficulties'* (S2). The acceptance of having difficulties was important: *'When I came to therapy, I wanted to fix everything but that's not possible. Normal people have difficulties. That's what's come out of the work that I've done. I'm not going to be diagnosis or symptom free'* (P5).

3.4 Factor Descriptions and Interpretation

The following section describes themes arising from the three factors, based upon the factor arrays (Table 7). Factor arrays represent the ideal Q sort for each factor. Exemplary statements (statements ranked as *most important* and *not important*) for each factor array are discussed, along with distinguishing statements for each factor. Only distinguishing statements ranked higher or lower than other factors are presented, therefore highlighting statements which were considered more or less important in relation to other factors. For example, a statement may have been ranked as 0

(neutrally), but ranked even less in other factors. So statements were considered in relation to their place within the distribution, in relation to other statements, but also in relation to other factors.

Interpretation of factors was based upon a systematic method (Watts & Stenner, 2012), whereby all the items for each factor array were attended to, rather than only the exemplar statements. Statements were considered conjointly, rather than individually, because it is the configuration of statements together that create meaning (Shemmings, 2006). This is in line with Q methodology's aim of the 'pursuit of holism' (Stephenson, 1936). In order to do this, interpretation sheets were developed, which considered exemplar statements, items ranked higher/lower than other factors, and neutrally scored items (Appendix I).

Each factor interpretation also considers the participants whose Q sorts exemplified the factor in terms of demographic data and qualitative feedback. Qualitative data (italicised and numbered by participant, indicated by *P* or *S* for person with borderline personality disorder or staff member respectively) are presented to aid understanding and interpretation of each factor.

3.4.1 Factor 1: Difficulties Associated with Borderline Personality Disorder

Factor 1 explained 24% of the study variance. Eight participants were significantly associated with this factor (two people with a diagnosis of personality disorder and six staff members). Table 9 shows participants' demographic details. A visual representation of the factor array and list of exemplary statements and distinguishing statements are presented in Appendix J.

The group of people comprising this factor strongly endorsed a reduction in diagnostic features of borderline personality disorder as being important in recovery. A reduction in behavioural features related to borderline personality disorder, such as less self-harming (statement 13), less suicide attempts (statement 12) and stopping addictive behaviours (statement 10) were seen as important in recovery. In addition to behaviours, internal features of borderline personality disorder, such as having more stable and balanced emotions (statement 11), coping with strong feelings (statement 17) and being able to stop and think before acting (statement 14) were seen as important. In giving

feedback, participants talked about how fundamental these difficulties seemed to be to borderline personality disorder: *'All about emotions. To me, in borderline personality disorder, this is the main difficulty; managing emotions'* (S5) and *'with a lot of my clients, they struggle to deal with who they are and how their emotions work'* (S9).

Participants discussed the impact of these difficulties on their life: *'They're like behaviours, like self-harming and things. They're all really important to me. That's caused me a lot of problems and the consequences, which makes your life a lot harder'* (P4). They discussed what such behaviours meant in terms of recovery: *'addictive behaviours... are harmful, it's not a healthy state of mind...it's being against self'* (P3).

Some participants linked the internal and external features together and the relationships between the two: *'If people can do these two things, [sic; have more stable and balanced emotions and stop and think before acting], then they won't self-harm'* (S16). Participants in this factor seemed to discriminate between internal and external symptoms, and had differing opinions on the order that change might take place. One participant talked about external behaviours as being 'practical' difficulties that once reduced, would impact upon internal features. Another participant saw recovery as being the opposite way around: *'I think the internal world drives the external factors. So if they're not in place, then the other things are irrelevant'* (S11) and: *'You can't just stop these things. You need to go from inside first'* (P4).

The idea of being able to manage and cope was important in this factor; for example, being able to get on with life despite difficulties (statement 16), coping with stress (statement 19) and coping with disturbing thoughts (statement 18). Similarly, being able to manage conflict (statement 15) and knowing how to stay well (statement 24) were ranked as important.

However, feeling able to make mistakes (statement 42), having setbacks (statement 35) and getting support needed when things are hard (statement 26) were not considered as important. Doing enjoyable activities (statement 7) was not considered as important to this factor. Additionally, general mental health recovery factors were less important for this group, such as knowing one's good qualities (statement 45), trusting in one's self (statement 32) and personal growth and discovery (statement 34). One participant with a diagnosis of borderline personality disorder said: *'At the moment,*

personal growth. I don't like myself much so that's not important' (P4). Being able to trust others (statement 2), was important within this factor, but trusting in one's self (statement 32) was not.

The relationship between an individual's recovery goals and service requirements was highlighted with regard to behaviours such as suicide and self-harm:

'I mean you can spend an hour just completing a risk assessment based on self-harm..... it's not always the most important in terms of people's recovery. But if you get it wrong, in terms of how you manage it, you can lose your job' (S14).

Related to this was the idea of taking risks (statement 38), which participants in this factor ranked as less important for recovery. However, in qualitative feedback, there appeared to be mixed opinions and the statement was ambiguous to some: *'could be agree or disagree-especially for somebody with personality disorder it could be risky behaviour or positive risk taking'*. Other participants were more decisive: *'We want to get them out of taking risks'* (S16).

There are a number of hypotheses (arising from the factor interpretations), about why reducing symptoms was important to recovery. The idea that symptom severity would impact upon being able to cope, manage, or get on with life better was inferred. Secondly, and particularly for people with a diagnosis of borderline personality disorder, the massive impact of these difficulties on their lives was highlighted as a reason why this may have been so important. Thirdly, for some staff members, reducing some symptoms may have been important in relation to the amount of risk such behaviours might pose (e.g., self-harming or impulsive behaviours). This was seen as dependent upon service requirements and the amount of clinical time spent on these symptoms.

Table 9: *Factor 1 Participants*

Participant	Number	Service
Person with borderline personality disorder diagnosis	2	Psychotherapy department-dialectical behaviour therapy Not using services
Nurse	3	Recovery team, community mental health team, therapeutic community
Social worker	1	Recovery team
Psychodynamic psychotherapist	1	Psychotherapy department
Cognitive analytic therapist	1	Psychotherapy department

3.4.2 Factor 2: Universality of Recovery

Factor 2 explained 19% of the study variance. Seven participants were significantly associated with this factor (one person with a diagnosis of personality disorder and six staff members). Table 10 shows participants' demographic details. A visual representation of the factor array and list of exemplary statements and distinguishing statements are presented in Appendix K.

The group of people comprising this factor endorsed statements associated with general mental health recovery principals as being important. Having a meaningful life (statement 9), belief in one's self (statement 46), feeling accepted (statement 40) and personal growth and discovery (statement 34) were ranked as important for recovery in borderline personality disorder. Taking risks (statement 38) and having goals in life (statement 55) were also ranked as more important within this factor and were related to these statements: *'Life's about taking risks otherwise your life becomes less meaningful'* (S8). Having goals in life (statement 55) was more important than achieving goals (56), and was interpreted as being more about aspirations, values and dreams.

Participants talked about the universality and humanness of these statements: *'These three factors are important, not only for people with borderline but absolutely for*

everybody' (S1) and *'For everybody's mental health. If you're not treated with dignity and respect then that's going to have bad consequences for anyone'* (S15). Participants (staff members) talked about what was personally important to their own wellbeing, and how this would be similar for any person's happiness, regardless of having mental health difficulties or a diagnosis of personality disorder:

'At times, maybe people are focusing too much on what's specific about mental health disorders and around these difficulties, there is a person. This person is very similar to the way I am, the way you are and the way that other people are' (S1) and *'if I was self-harming and I was emotionally dysregulated and I struggled with life on a day-to-day basis, the last thing I would want to hear is-you need to stop self-harming as much'* (S8).

The idea of choice was important, in having choices in care (statement 53) and making choices for self (statement 47). Hope for the future (statement 33) was ranked highly. In qualitative feedback, hope emerged as a two-way process. Participants talked about the importance of feeling hopeful for themselves but also the importance of other people being hopeful on their behalf: *'Have to have it for yourself but it's good that other people think that things are more hopeful'* (P5). Related to this was the importance of understanding one's self (statement 28). This seemed to be more about understanding in general, as participants talked about the importance of feeling understood: *'If someone believes in you and understands where you're coming from'* (P5). In the case of staff members, trying to understand a person was important: *'Because there is always a reason and a rationale behind it. Whether we understand it or not, our job is to understand, or try to'* (S8). Interestingly, belief in one's self (statement 46) was ranked highly, but having belief from others (statement 3) was ranked as less important in relation to these statements.

Reducing self-harm (statement 13) and suicide attempts (statement 12) were ranked as less important. There was acknowledgment that these difficulties would naturally reduce as a result of the higher ranked factors, such as getting support when things are hard (statement 26):

'I don't put them up there ([sic] suicide and self-harm). Because they are result of these kind of things-having a meaningful life and having proper quality of life is really

important. And once you've got that, and you trust other people and you feel heard and feel validated, and all those things....then these things naturally come' (S8).

Table 10: *Factor 2 Participants*

Participant	Number	Service
Person with borderline personality disorder	1	Dialectical behaviour therapy
Nurse	2	Recovery team
Occupational therapist	1	Community mental health team
Assistant practitioner	1	Community mental health team
Social worker	1	Therapeutic community
Trainee psychologist	1	Community mental health team

3.4.3 Factor 3: Relationship with Self and Others

Factor 3 explained 12% of the study variance. Four participants (two people with personality disorder diagnosis and two staff members) were significantly associated with this factor. Table 11 shows participants' demographic details. A visual representation of the factor array and list of exemplary statements and distinguishing statements are presented in Appendix L.

The group of people comprising this factor endorsed the importance of relationships, both with the self and others as being important to recovery. Some of these factors were practical in nature, but seemed to be related to themes of stability and the idea of making connections with other people and defining one's identity, such as being in employment (statement 5), doing enjoyable activities (statement 7) and being financially comfortable (statement 58). It is also likely that these factors were important because they are related to living a meaningful life (statement 9), which was also dominant within this viewpoint. However, achieving goals was ranked as not important: *'A number of clients that we see would be happy just to live in the present, rather than feeling they have to plan for the future' (S10) and 'It's more about having a fulfilling life. Sometimes you can set goals far too high' (P2).*

The role of support and positive interactions with other people were important for recovery in this factor, such as having good relationships (statement 3), being treated with dignity and respect by others (statement 52) and getting the support needed when things are hard (statement 26). In relation to this, participants talked about struggles in relationships and the enormity of this in their life: *'It feels a bit like I'm a dog groomer and I'm allergic to dogs. I'm allergic to people in a sense. I don't know what to do about that'* (P6) and *'They have enormous interpersonal difficulties; it's not just about relationships but having relationship that's good for them. One of their biggest difficulties is extricating themselves from bad relationships'* (S10).

Freedom from prejudice was ranked as not important. Participants talked about how prejudice would always exist within society: *'There will always be prejudice in the world, you can't get away from that'* (S12) but they discussed the importance of prejudice from services and staff and how people with borderline personality disorder are not always treated well by others: *'I think being treated with respect from services is more important'* (S10) and *'feeling like you're being let down and not listened to properly, that matters'* (P2) and *'They almost always have experience of being treated as an attention seeker'* (S10).

The idea of internal development and identity came through in this factor; understanding one's self (statement 28) and personal growth and discovery (statement 34) and becoming less self-critical (statement 44) were important. Internal development was seen as a priority in recovery, for example being able to trust self (statement 32) before being able to trust others (statement 2). Again, these seemed to be about creating a positive relationship with the self. In addition, having me time (statement 8) was ranked higher in this factor than other factors. Understanding one's self (statement 28) was ranked as more important than learning to live with one's self (statement 31) and feeling accepted (statement 40) was not important. One participant talked about how feeling accepted could be seen as unhelpful at times: *'It's not just about being you and saying I am who I am-take it or leave it. Sometimes you need to fit in'* (P2). Trusting in one's self (statement 32) was ranked as important, whilst being able to trust others (statement 2) was ranked more neutrally. Two participants gave very similar feedback in

relation to this: *‘Trust others- not that I disagree-they need to trust themselves before they can trust others’* (S10) and *‘How can I trust others when I can’t trust myself?’* (P2).

A change in some features of borderline personality disorder were ranked as important; these seemed to be more internal features, such as being able to stop and think (statement 14), doing things differently (statement 21) and coping with strong feelings (statement 17) but other behavioural features, such as less suicide attempts (statement 12) and less self-harm (statement 13) were not.

Table 11: *Factor 3 Participants*

Participant	Number	Service
Person with borderline personality disorder diagnosis	2	Recovery team
Psychologist/psychodynamic therapist	1	Psychotherapy department
Psychodynamic therapist	1	Psychotherapy department

3.4.4 Additional Feedback

Many participants emphasised the individual and personal nature of recovery: *‘What’s right for one person, isn’t necessarily right for another’* (S14). In doing so, participants discussed how statements they had ranked as *not important*, could easily have been ranked as *very important*. Being in employment (statement 5) and being financially comfortable (statement 58) were often mentioned in relation to this. Staff talked about the possibility of discrepancies in recovery ideas, both between people with borderline personality disorder and with their colleagues: *‘It’s difficult. Every answer’s got a valid reason. What I think is important might not be important for the client. A different practitioner might think it’s not important’* (S9).

Each participant was asked at the end of the Q sort if they wanted to add any further comments or if they felt anything had been missed in relation to recovery in borderline personality disorder. Within the qualitative feedback, a majority of

participants talked about relationships, particularly the therapeutic relationship as a factor in recovery. Included within this were ideas around being listened to, feeling safe, forming attachments, boundaries, consistency, availability and containment. In regards to relationships, one participant said: *It's massive. For me, it's one of the defining factors in whether somebody recovers*' (S8) and *I've always been in shit relationships, that would be important to me in recovery*' (P4) and *I'm frightened of losing people*' (P1). In qualitative feedback, there sometimes seemed to be a tension between staff members thinking about the importance of attachment and building relationships with people with borderline personality disorder and the idea of dependency or creating something more unhelpful: *Can create dependency and relying on others. Can be twenty times a day. Need agreement*' (S6) and *Relationships are difficult because people are pushing all the time to see if you'll reject them*' (S9).

The idea of specialist teams that were able to understand and meet the needs of people with borderline personality disorder was highlighted. One staff member talked about hospital admissions and how these seemed to be unhelpful for people with borderline personality disorder. The importance of understanding a person's difficulties and the need for continuing education of staff arose: *The terminology of personality disorder is not the best is it? –there's a lot of stigma attached. There's not a lot of education out there. So if people present in a different way, they could be seen as badly behaved, attention seeking*' (S9) and:

There needs to be a greater understanding of people with borderline personality disorder. Professionals. Nurses in A&E. Crisis team. Re-educating. They should know what the traits are-for all personality disorders' (P1).

Some participants talked about the services and therapies they had accessed and how helpful these had been. This included DBT, mindfulness and being in a therapeutic community. Participants talked about how having the right service for them and gaining access to this was important.

Participants talked about being able to recognise their recovery and how this could be difficult: *I am making new progress even though I think I'm not. I'm doing things that even a year ago, I wouldn't have thought I would do*' (P4) and about being able to define their personal meaning of recovery: *It's not a case of you can get better*

and that's it. It's not that you'll never feel a certain way again. It's recognising why you've got feelings, knowing how to process, deal with them in safe and manageable way, instead of self-harming or overdosing' (P1).

Chapter 4 Discussion

4.1 Discussion Overview

The following chapter will discuss the study findings in light of the existing literature on borderline personality disorder and recovery. The strengths and limitations of the study are highlighted. The clinical and theoretical implications of the study findings will be discussed, along with considerations for future research.

4.2 Summary and Interpretation of Findings

The current study set out to explore views on recovery in borderline personality disorder, using Q methodology. Three main factors, representing the viewpoints of 19 participants emerged from the data (six people with a diagnosis of borderline personality disorder and 16 staff members working in services that typically see people with borderline personality disorder).

Factor 1, labelled *Difficulties Associated with Borderline Personality Disorder* represented the views of eight participants (two people with a diagnosis of borderline personality disorder and six staff members). Factor 1 was a primary factor, accounting for 24 percent of the study variance. Reducing and managing diagnostic features (termed as symptoms) of borderline personality disorder were deemed important in recovery. This included reducing behaviours associated with borderline personality disorder and having more stable emotions. The impact and consequences of these symptoms on individuals' lives were highlighted, and the extent to which they defined the diagnosis of borderline personality disorder. Being able to manage or cope with difficulties better was highlighted within this viewpoint. Symptoms were seen as linked and inter-dependent upon each other and distinction was made between internal and external symptoms. Taking risks were generally interpreted as impulsive or dangerous behaviours and reducing risk was important to recovery in this factor and linked to service requirements. Factors that have been shown to be important in recovery across mental health problems (termed general recovery factors) were less important to this factor.

Factor 2, labelled *Universality of Recovery*, represented the views of seven participants (one person with a diagnosis of borderline personality disorder and six staff members). The dominant viewpoint in this factor was concerned with general recovery principals, such as having a meaningful life and feeling hopeful about the future. The idea that these factors were universal emerged, and there was an emphasis on humanistic values, rather than a focus on mental illness. Having choices was important in this viewpoint. Participants in Factor 2 were less risk averse than participants in Factor 1 and tended to see taking risks and having goals as positive and helpful to recovery, as it made life more meaningful. Hope for the future and understanding emerged as two way processes in this viewpoint. Similarly, whilst understanding the self was important, feeling understood by others and (for staff members) trying to understand a person's behaviour was important. This viewpoint felt that symptoms such as self-harm would naturally reduce as a result of humanistic, universal recovery factors being present.

Factor 3, labelled *Relationship with Self and Others*, represented the views of four participants (two people with a diagnosis of borderline personality disorder and two staff members). The dominant viewpoint in this factor was concerned with relationships with the self, in terms of internal development and identity, and the need for stability. The role of practical factors to aid stability and develop identity was important, for example doing enjoyable activities. Having good relationships and having support from others was important in this viewpoint, particularly positive interactions with others. Experiencing prejudice in general was not important but the role of staff attitudes, such as being treated with respect, getting support when needed and being listened to, was highlighted as important in recovery.

4.3 Findings in Light of Previous Research

The emphasis on reducing symptoms and improvements in functioning within the current study are not in complete accordance with mainstream mental health recovery literature. In particular the findings relating to reducing 'diagnostic specific' symptoms, unique to borderline personality disorder, such as less self-harm and suicide attempts, are not integral to mainstream recovery principals or to investigations of recovery in specific severe mental illnesses. Recovery is thought to represent a move away from

‘pathology and symptoms’ (Shepherd, Boardman & Slade, 2008). Investigations into recovery in bipolar disorder found that people placed less importance on becoming symptom free (Todd, Jones & Lobban, 2012). Similarly, a Q sort exploring recovery in psychosis found that symptoms were not important to people who experienced psychosis (Wood, Price, Morrison & Haddock, 2012). The current study findings on reducing behavioural symptoms of borderline personality disorder are in accordance with previous studies of recovery in personality disorder (e.g., Katsakou et al., 2012; Turner et al., 2011) in which reducing suicidality, self-harm and alcohol and drug use were reported as recovery goals by participants. Additionally, the emphasis on internal change such as having more stable emotions and being able to cope with strong feelings have been reported in these studies.

However, studies exploring recovery in severe mental illness have reported that everyday functioning and being able to manage the impact of mental illness is important in recovery (e.g., Dilks, Tasker, & Wren, 2010; Mansell, Powell, Pedley, Thomas & Jones, 2010) which may be linked to a reduction in symptoms. This is in accordance with the current study findings that being able to cope and manage was important to recovery. The extent to which certain symptoms impacted upon participants’ lives was also highlighted.

Recovery as a highly personal process and being unique to an individual was demonstrated in the current study. These findings are consistent with existing accounts of recovery (e.g., Anthony, 1993; Turner, Neffgen & Gillard, 2011; SLAM & SWLSTG, 2010). The study findings on the importance of universal recovery factors were also consistent with well-known established components of recovery, such as hope (Hobbs & Baker, 2012; Pitt et al., 2007), identity (Bonney & Stickley, 2008) having a meaningful life (Leamy et al., 2011) and choice (DH, 2012). A previous personality disorder study has reported that being treated as a human being was important to people with personality disorder (Castillo et al., 2013). The importance of humanistic values was reflected within the current study findings.

Having good relationships appeared to be a prominent recovery factor in the current study. Despite not all groups ranking relationships as most important, in qualitative feedback, a majority of participants referred to the importance of

relationships and factors associated with this, such as feeling listened to and forming secure attachments. In mainstream recovery literature, relationships are often cited as highly important to recovery. This literature tends to focus on an individual's support networks, reducing isolation and the way that positive relationships can enhance other aspects of recovery such as contributing towards a positive role and identity (e.g., Davidson & Strauss, 1992). Some of the current study findings regarding relationships were consistent with existing descriptions of recovery, such as the importance of being treated with dignity and respect (Repper & Perkins, 2003) and being able to access support when required. However, it could be argued that the role of relationships is more complex and important in borderline personality disorder, due to the likely early attachment difficulties in this group of people (Levy, 2005; Liotti, 2014), their heightened emotional sensitivity and the difficulties they experience in interpersonal relationships such as fear of abandonment (Scott et al., 2013). The complexity of relationships in relation to recovery has previously been found in personality disorder studies. The idea of feeling understood and validated within the context of relationships, was highlighted as important in the current study. This is similar to a previous study of recovery in personality disorder which reported that feeling cared for was needed as a basic precursor to recovery (Castillo et al., 2013). Within that study participants were anxious that being recovered would be associated with loss of support and withdrawal of services. Similarly, the need for enduring and trusting relationships in recovery has been discussed (Turner et al, 2011). Certainly in qualitative feedback from staff, there appeared to be some tension between the need to form secure attachments with people with borderline personality disorder and anxieties around creating dependency or being 'too available'. In the current study, getting support needed was rated as more important than being independent, but the idea of this being difficult within a clinical context was highlighted by some staff.

Additionally, the negative effects of prejudice from staff and services were highlighted in the current study; for example, experience of being labelled as an 'attention seeker' and feeling let down or not listened to. The negative effects of staff attitudes towards people with personality disorder have been widely documented within the literature. For example people with personality disorder on inpatient units have

experienced being treated as though they were undeserving of care (Fallon, 2003). Similarly, people with personality disorder have reported experiencing dismissive and unsympathetic attitudes (Rogers & Acton, 2012) and mental health staff making comparisons to people with other mental illnesses (Rogers & Dunne, 2011).

Overall, hope for the future was seen as important for recovery across all factors in the current study. Hope has been discussed as a key component of recovery principals (Perkins, 2006; SLAM & SWLSTG, 2010). In qualitative feedback, participants discussed hope as being a two-way-process, in which hope for self for the future was important, but also that other people being hopeful for an individual in recovery was just as important. Hope inspiring relationships have been discussed in relation to recovery between people with mental health difficulties and staff members (Repper & Perkins, 2003). The idea of hope from others is prominent within recovery literature and it has been proposed that mental health staff should be ‘holders of hope’ (Turner & Frank, 2001). Given the history of personality disorder as an untreatable disorder, staff members conveying hope and the belief that recovery is possible, may be of particular significance for people with a diagnosis of personality disorder. Similarly, clinical guidelines on borderline personality disorder state that whilst working with people, an atmosphere of hope and optimism should be maintained to emphasise that recovery is possible (NCCMH, 2009). The powerful influence that staff members can have in relation to a person’s hope has been identified (Hobbs & Baker, 2012). A qualitative study explored the views of eight people with a range of mental health difficulties who considered themselves as having experience of recovery. This study set out to explore the relationship between hope and recovery and found that relationships with staff members were a mediator in between these (Hobbs & Baker, 2012). The importance of hope from others is in line with mental health campaigner views who have suggested that within the recovery approach and the focus on individuality, there is a danger of ‘losing contact with the strength that people gain from each other, and the value of communities’ (Faulkner in Mind, 2008, p. 11).

Hope has been linked with a belief in one’s ability (Andresen, Oades & Caputi, 2003) and therefore may be closely related to a belief in one’s self. Within the current study, although hope for the future was important, the role of belief was ranked more

neutrally in Factors 1 and 3. All factors ranked belief in one's self as more important than belief from others in recovery (this was particularly prominent within Factor 2). These are important findings within the current study, given the literature around the role of staff as holding hope for people with mental health problems.

The idea of a distinction between internal and external change was highlighted within qualitative feedback in the current study. More specifically, there appeared to be differing thoughts about whether internal or external change was more important to recovery. This was sometimes in relation to symptoms; for example, some participants thought that having more balanced emotions was needed, before being able to reduce self-harm. Other participants felt that more general recovery values, such as feeling validated and belief in one's self were more fundamental and that if these were 'in place' then external, observable behaviours such as self-harm would reduce naturally.

However, the current study also demonstrated that for some people, beginning with external factors such as enjoyable activities or reducing suicide attempts might be more important, perhaps as a means of gaining stability. The idea of certain recovery factors being precursors to other recovery factors has similarities with a previous study of recovery in borderline personality disorder (Castillo et al., 2013). This study framed its qualitative findings as a hierarchy of needs, with more basic elements of recovery needing to be fulfilled before further development, such as feeling cared for and building trust in order to develop skills and achieve goals. This finding is also similar to a finding from a qualitative study exploring recovery in psychosis (Pitt et al., 2007) which, concluded that recovery was dependent upon internal and external mechanisms of change. The current study findings about differing factors interacting with each other over time provides some support for models of recovery as a process (Castillo et al, 2013; Deegan, 2002). It may be a matter of personal choice as to 'which way' an individual might start their recovery journey. This might be predicted by the severity of a person's symptoms and difficulties or it may be guided by the orientation of therapy that they experience. For example, some therapies place emphasis upon changing an individual's attachment styles and object relations (e.g., transference focused therapy), or capacity for reflection (e.g., mentalisation based therapy) which, focus on more internal mechanisms of change, where other therapies such as DBT emphasise change in

external behaviours such as reduction in self-harm as priority. The idea that the severity of borderline personality disorder might influence an individual's recovery goals was highlighted by one of the participants: *'I guess the level of disability is often determined by their early experiences and for those who we see that are more highly functioning, do have different goals. Because there are things that they have been able to do and they want to get back to a place where they can do those things again. Compared to people who haven't had those things'*. So it may be that an individual's past experiences affect their recovery goals.

Having a sense of identity was viewed as important to recovery within the current study and was ranked similarly between each viewpoint. General mental health recovery literature discusses re-claiming identity following mental illness and how recovery may involve individuals defining themselves aside from mental illness (e.g., Mansell, Powell, Pedley, Thomas & Jones, 2010). The idea of identity may be more complex in borderline personality disorder. Lack of a sense of self is a feature of borderline personality disorder and it may be more difficult for people with borderline personality disorder to reclaim identity or re-define the self if they have always experienced a lack of identity and have unintegrated representations of self and others. It was difficult to gain further understanding of this and how it may relate to recovery within the current study; because identity was not ranked particularly highly, there was a lack of qualitative feedback around this statement. However, within the little qualitative data obtained, participants seemed to have in mind that identity could be more problematic for people with borderline personality disorder. Similar findings have been previously reported in studies on recovery in borderline personality disorder (e.g., Katsakou, et al., 2012). In this study, participants did not feel they could recover from borderline personality disorder and saw recovery as becoming a different person and not what they wanted. They viewed the recovery process as meaning they had to separate themselves from borderline personality disorder and felt that this was not possible. Within borderline personality disorder, identity may be less about re-building of the self than 'discovering' of the self (Turner, Lovell & Brooker, 2011). The current study findings on the importance of internal development and strengthening the relationship with the self, seem to support this view.

The current study findings that important factors for people with borderline personality disorder are similar to those reported in general recovery literature have been reported in previous personality disorder studies on recovery (Katsakou et al., 2012; Turner, et al., 2011). The differing viewpoints which emerged in the current study were similar to a results of a qualitative study (Turton et al., 2011) which, explored the meaning of recovery in people using specialist mental health services (specifically eating disorders, dual diagnosis and forensic services). This study is particularly relevant because personality disorder is likely to be prevalent within these settings. The study was also of relevance, because one conclusion from this study was that diagnostic specific factors may affect recovery values, and therefore similar to the current study aims and findings. This research highlighted three broad themes arising from the data analyses which were relevant to people using specialist services. Key ideas from general recovery were identified as meaningful to participants but also ‘universal, core human values’. In addition, this research identified that themes related to clinical aspects of recovery were important (within two-thirds of the sample) such as being symptom free and the role of medication in helping with symptoms. The three themes found in that research seem to be consistent with two of the viewpoints found within the current study.

In terms of the three distinct viewpoints in the current study, there were more negatively ranked consensus statements than there were positively ranked, suggesting that participants across viewpoints were in agreement about factors that are not important to recovery but differed more in their views on what they felt was important. In general, participants agreed that the role of religion and/ or faith, taking medication and living life like others was not important to recovery. Recovery studies have emphasised the role of religion, faith and spirituality in recovery (e.g., Deegan, 1996; Henderson, 2010). Although the current study found religion and faith not important to recovery, in qualitative feedback, participants discussed how this could be extremely important for some individuals. Recovery literature takes a balanced approach towards medication, stating that medication can be part of recovery and recognises that medication may, or may not, be helpful for individuals (Slade, 2009). The focus appears to be more towards individual choice in taking medication and collaboration and shared

decision making with staff in deciding whether medication would be helpful (SLMT & SLGMT, 2010). A study of recovery in personality disorder found that participants wanted to reduce the amount of medication they took and reported some of the negative effects of taking medication, such as feeling sedated, but also reported how medication could be helpful in conjunction with psychological therapy (Turner et al., 2011). The negative effects of medication were not highlighted in the current study, but participants generally felt that recovery was unrelated to being on medication (i.e., it did not matter if an individual was taking medication). Participants talked more about the benefits of taking medication. Participants were in agreement that being able to cope with stress, knowing what helps, having a sense of identity and being able to ask for help were important to recovery, although not necessarily the most important things.

Within the current study there was evidence of potential cultural differences that can impact upon recovery values. One participant, whose first language was not English, talked about *Knowing one's good qualities* (statement 45) and how within their language this would not be viewed as something positive. In their native language (within European culture) there was a word for this which was more akin to showing off or boasting, and so would not be important for recovery, due to its negative connotation. Similarly, another participant talked about the idea of having 'me' time and commented how they were unsure about ranking this, because this could vary depending upon an individual's culture and the meaning that is given to spending time within one's community or network. The idea that recovery is culturally sensitive has been well documented (e.g., Ralph et al., 2000; Schon & Rosenberg, 2013; Slade, Leamy et al., 2012) and the current study findings reflect this suggestion.

The importance of being financially comfortable was rated as not important for recovery in two of the three viewpoints. However, a majority of participants in the study were staff members, who were employed and therefore with a steady income. It may be that the role of finance would be rated as more important in a study only looking at the views of people with borderline personality disorder, who may be less likely to be in paid employment (Elliott & Konet, 2014).

Participants did not differ in terms of age between the three factors. There did not appear to be any remarkable differences in terms of grouping between factors with

regards to staff members' professions. It may be that perceptions of recovery are not dependent upon professional group and perhaps the way that people form ideas about recovery are through life experiences and unrelated to their professional training. There is little literature on how mental health staff form recovery views. It is of note that the staff members in Factor 3 were both trained in psychodynamic psychotherapy (one was also trained as a clinical psychologist). There were more nurses in Factor 1, but there were more participants loading highly onto Factor 1, so no conclusions can be drawn from this observation. There were two participants in factor one with experience of DBT and this might make some sense of the importance of personality disorder specific, behavioural recovery factors, such as less self-harm, which is a focus in DBT. However, there was also a participant with experience of DBT in Factor 2.

4.4 Summary

This research fulfilled the study aims of exploring perceptions of recovery in borderline personality disorder and identified certain factors that are more important to recovery in borderline personality disorder. The study also highlighted ways in which perceptions of recovery were similar and different to general mental health recovery principals. Overall, important factors in recovery were concerned with symptoms, core, humanistic, universal values and relationships, both with the self and others. The findings of the study indicated that participants identified with general mental health recovery values, in addition to more diagnostic specific factors. This is in line with previous research exploring recovery in personality disorder. The findings of the current study highlight questions concerning the extent to which recovery is transdiagnostic or diagnosis specific. It may be that whilst recovery can be applied to mental health problems across the board, specific mental health problems may incorporate slightly differing views. As with previous recovery work, it is likely that people with personal experience of borderline personality disorder are needed to work towards developing a model of recovery, because this may or may not be in accordance with staff views.

4.5 Study Limitations and Strengths

4.5.1 Study Strengths

To the researcher's knowledge, this is the first study to carry out a Q sort exploring recovery views in borderline personality disorder. The study looked at the views of people with borderline personality disorder from a range of trusts and services. Although the study used clinical services as a means of recruiting people with borderline personality disorder, participants were not expected to be using services, or 'in treatment' and therefore aimed to be as inclusive as possible. The study made use of staff views, in addition to people with a diagnosis of borderline personality disorder. This allowed the researcher to examine which recovery viewpoints were shared between staff and people with borderline personality disorder.

A strength of the research is the personal benefit that participants took from participating. Even though participants often said that they found sorting the statements difficult, they reported to enjoy completing the Q sort. This is often found in Q methodological studies (van Exel & de Graaf, 2005). Participants discussed that the statements seemed comprehensive and that completing the Q sort was 'thought-provoking'. Some participants with borderline personality disorder said that participating in the study helped them think about wider issues around their own recovery. In reflections made by staff members, more than one staff member commented on the benefit of having a similar tool to use clinically: *'Could use with people-help to make goals- sometimes it's hard for people, especially young men when you ask them what they want - they don't know. Then it feels like you're suggesting stuff. Could use it in care plans'*. This is a strength of the research, because it highlights possible clinical applications for how to develop recovery in people who use mental health services.

The researcher used a form of triangulation in data collection, by conducting brief semi-structured interviews in addition to administering the Q sort. Conducting brief interviews after completion of the Q sort was considered valuable, because it allowed the researcher to check participants' understandings of the Q set statements and therefore better understand how and why they ranked certain statements. The qualitative feedback gained from the interviews was used to aid the interpretation of the Q sort data.

Without the qualitative feedback gained from interviews, interpretation of factors would have been more difficult and the researcher would have had limited understanding of the overall results. Gaining qualitative data from interviews also allowed the researcher to examine and use the data of participants whose sorts did not load onto any factors (three participants), so all the data from participants were utilised. Examining qualitative feedback from these participants allowed the researcher to identify ways in which their views were similar to the factors (these were not reported within any of the factor interpretations but their data are reported in overall findings).

Being with participants whilst they carried out the Q sort was considered highly valuable, because it meant the researcher could make notes and clarify participants' interpretations of certain statements (e.g., if a participant said they were unsure about the meaning of a statement). Being with participants whilst sorting allows for greater understanding of participants feelings around topics (Dennis, 1986) and this is a strength of Q methodology. In keeping with the aims of Q methodology, this provided greater insight into participants' subjectivity and would not have been achievable in a questionnaire design. Using Q methodology and presenting a range of recovery statements allowed participants to rank multiple aspects of recovery. If the researcher had used interviews, some of these recovery ideas may not have become known.

A strength of the study is the combination of methods used to sample the Q concourse. This included using items from existing recovery measures, which enabled the researcher to develop a more comprehensive Q set that included factors relevant across other clinical groups other than borderline personality disorder. Although the statements were not derived from primary sources (e.g., through conducting interviews with people with borderline personality disorder) they were taken from current literature. Additionally, the study used a quasi-naturalistic Q sample, utilising existing interview data from qualitative research. Therefore, in addition to the possibility of new findings, the study was able to indirectly evaluate the current findings surrounding recovery and borderline personality disorder.

The use of Experts by Experience was a strength in the study because this enabled thorough discussion of the Q set items concerning the wording of the statements and aided decisions on inclusion and exclusion of statements. This also helped to

minimise researcher bias in statement selection and improved content validity of the statements. The use of Experts by Experience in piloting the Q sort provided valuable information in terms of participant burden, and assessing any distress or anticipating difficulties that may arise during data collection. In terms of financial issues, the Q sort was cost effective to design and administer. The use of Q methodology as a whole and its unique combination of quantitative and qualitative methods was a strength.

4.5.2 Study Limitations

Even though Q methodology does not require large sample sizes, a limitation of the current study was the low numbers of participants with a diagnosis of borderline personality disorder. There were substantially less participants with a diagnosis of borderline personality disorder than staff members in the current study, which made it difficult to know if there would be more distinct viewpoints concerning recovery. It can be difficult to engage people with a diagnosis of personality disorder in research (BPS, 2006). The researcher found that personal links with services was the most productive means of recruitment and also through word of mouth from participants whom had already taken part. It seems that people who did take part enjoyed this and viewed this as valuable and then spoke to other potential participants. However, this introduces an element of sampling bias in recruitment, and it is likely that only people with an interest in recovery took part in the study. The study may have widened the inclusion criteria to include people with a diagnosis of any personality disorder, but it was decided that this may have made the participant sample too diverse and therefore harder to make sense of differing recovery views and values. Given that people with borderline personality disorder are already a heterogeneous group in terms of symptoms and behaviours (Critchfield, Levy, & Clarkin, 2007; Sanislow et al., 2012), the decision was made to focus upon a single subtype of personality disorder. Regardless of this, it is likely that participants in the current also met criteria for other personality disorders (NIMHE, 2003a), and had additional diagnoses such as Axis 1 disorders. The researcher had initially planned to complete a questionnaire (*The Personality Diagnostic Questionnaire-Revised*, Hyler & Rieder, 1987) with participants with borderline personality disorder in order to confirm diagnosis. Not having accurate information

about diagnoses is a limitation because it makes it harder to know if the study findings on recovery are concerned with personality disorder or more in terms of mental health difficulties. However, the researcher decided to remove administration of the questionnaire from the study procedure, because it was believed that this would be too much burden on participants in terms of time. The researcher confirmed diagnoses with participants care co-ordinators instead, wherever possible (four out of six cases). Similarly, all participants who took part identified with the diagnosis of borderline personality disorder and felt that this label reflected an accurate description of their difficulties.

There were no views from psychiatrists in the current study and this was something the researcher had hoped for. It would have been interesting to examine whether psychiatrists shared the views of other staff groups members and people with a diagnosis of borderline personality disorder. Views from psychiatrists on recovery in borderline personality disorder are particularly important because this staff group often lead and manage teams, and therefore have influence about the design of services and decisions on treatment. Also, psychiatrists often diagnose people with borderline personality disorder and therefore can be in a position to convey hope about recovery and treatability. Medical doctors have been found to be difficult to engage in research (Asch, Connor, Hamilton & Fox, 2000).

Similarly, there was an under-representation of people from non-White backgrounds. A more diverse range of participants with regards to ethnic backgrounds would have been beneficial, given the cultural differences surrounding meanings of recovery which have been previously reported (Lapsley et al., 2002; Leamy, et al., 2011;). Additionally, there was a lack of males with borderline personality disorder in the current study. This is a limitation for the current study findings, because possible gender differences have been found in recovery (Schon, 2013) and also in terms of coping behaviours used by males and females with borderline personality disorder (De Genna & Feske, 2013).

In sampling the concourse and designing the Q set, the researcher did not make use of primary sources; for example, conducting interviews with potential participants. Despite conducting a thorough literature search on which to sample the concourse, there

still may have been aspects of personality disorder and recovery, which were neglected within the study, for example the different aspects concerning relationships, which could be important in recovery. The researcher did attempt to rectify this by asking participants if they felt there was anything missing in the Q set and also by including Exerts by Experience in the design of the Q set. Even though the researcher used a structured sampling technique (McKeown & Thomas, 1988) by breaking down the recovery literature into themes and sampling from each themes and subtheme, there was not enough scope in the current study to represent the level of detail in relation to some recovery components. For example, the researcher endeavoured to cover different aspects of the same topic (Brown, 1980) in designing the Q set, but this was not always possible. For example, the statement *Having good relationships* was originally multiple statements addressing different aspects of relationships, such as relationships with family and friends and ending abusive relationships. However, the researcher balanced the level of detail needed against the size of the Q set and took into account how sorting may have become difficult with excess of statements to sort. Therefore, the final Q set was thought to be representative of the concourse but may not have captured all elements, particularly some of the nuances which have been found in recovery in borderline personality disorder, such as aspects of identity and the terminology of recovery.

There was some ambiguity from participants in interpreting some of the statements. For example the statement *Taking risks* was sometimes interpreted as positive risk taking but interpreted by other participants as engaging in risky behaviour. Where this was the case, the researcher informed participants to rank statements on the basis of their own interpretation. The differing interpretations were not problematic due to the researcher being with participants and being able to clarify such issues. In fact, it made for a more interesting Q sort. Q methodology acknowledges that statements can be interpreted in subtly different ways depending upon the perspective of the participant (Watts & Stenner, 2005). This is also in line with Q methodology's aims of exploring subjectivity by looking at the meaning participants give to statements (Brown, 1980).

Participants commented in qualitative feedback that they tended to agree with almost all the statements in general. It may have been that within the Q set, there were

too many agreeable statements, resulting in a rather ‘bland’ Q set. This resulted in participants sometimes ranking statements they agreed with as more *neutral* or *not important*. This tendency to group many statements as positive has been found in previous Q studies (e.g., Vahey, 2013). Perhaps there should have been more controversial statements within the Q set. However, this finding may simply be reflective of the recovery literature as it stands, and it has been previously suggested that more research is needed on negative aspects or barriers to recovery (Ralph et al., 2000). Similarly, participants did express frustration at having to sort using the forced choice distribution, but this is typical in forced choice Q sorting (Watts & Stenner, 2012). The ranking of statements meant that participants had to make discriminations that they may not have done (Dennis, 1986). Participants often talked about how they felt many of the statements could be linked together, which sometimes made it more difficult for them to sort. The researcher made use of this by gaining qualitative feedback on how they felt recovery factors were linked.

Similarly, the results of the current study cannot be generalised to wider populations. Q methodology is more concerned with exploring topics in greater detail and does not make any claims to its generalizability (Watts & Stenner, 2012).

The original analysis yielded a six-factor solution, which was rejected in favour of a three-factor solution. However, the most parsimonious factor solution, with the smallest number of factors defined by several sorts has been recommended (Davis & Michelle, 2011). Similarly, the more factors that are included, the more fragmented data becomes (Watts & Stenner, 2012). For these reasons, it was decided that a three-factor solution was a better decision, and psychologically, yielded a clearer picture. However, deciding on the numbers of factors to retain is a somewhat subjective process. The study analysis used a varimax rotation which has been described as giving the best mathematical solution, but not necessarily always the most ‘theoretically informative’ (Watts & Stenner, 2005). The researcher may have further rotated the factors by hand or used a different type of rotation. However, the researcher found the current factors to be psychologically sound.

Interpreting the factor arrays introduced some degree of uncertainty. There is no set method for determining a factor array (Brown, 1980). The process of interpretation

can introduce researcher bias (Watts & Stenner, 2012). This was minimised by discussing the array interpretations with other members of the research team and examining various factor solutions. However, the interpretative process may have been viewed or approached in a different way by another researcher resulting in different meanings and emphasis (Watts & Stenner, 2005). Additionally, the researcher aimed to be explicit about her own biases throughout the research, for example by stating her position. It was not possible to explore all of the consensus statements (ranked as *important*) in detail; because they were not ranked highly, there was little qualitative feedback around these statements.

Demographic information could have been used more to aid the interpretation of factors (Watts & Stenner, 2012). There were two people with a diagnosis of borderline personality disorder in Factors 1 and 3, but one in Factor 2. If the sample size was bigger it would have been possible to explore whether there were any significant differences in terms of the number of participants with borderline personality disorder between factors using statistical tests. A one-way analysis of variance may have been conducted in the current study but given the small sample size, the power would have been low. Similarly, statistical tests may have been conducted to explore whether there were differences between factors in terms of staff groups (e.g., chi square). Additionally, separate analyses may have been conducted for people with borderline personality disorder and staff members to create separate factor arrays. These may then have been combined together, as Q methodology allows for this technique. However, the low numbers of participants with a diagnosis of borderline personality disorder meant that this was not feasible.

Conducting Q methodology is time-consuming (McKeown & Thomas, 1988). This is a limitation of the study, because it meant some burden on participants, which is an ethical issue; in particular, exploring and sampling the concourse takes time. Conducting Q sorts with participants is a lengthy process and more intensive than administering questionnaires.

4.6 Clinical Implications

The current study findings suggest that people have differing views on what is important in recovery in borderline personality disorder. General mental health recovery principals are valued within borderline personality disorder but for some people, reducing symptoms are important in recovery. This finding perhaps highlights the need for both general and specialist personality disorder services, but certainly the need for services, which have sufficient understanding and knowledge of the difficulties associated with borderline personality disorder. Services should continue to explore symptoms with people with borderline personality disorder and the extent to which they interfere with their life. The differing recovery viewpoints in the current study suggest that it is important for staff to identify what is relevant to an individual at a particular point in time. The benefits of psychological formulation in doing so are highlighted. Formulation can also help to take into account the wider factors surrounding recovery (BPS, 2011) which were highlighted within the present study; for example, the extent to which financial issues may be relevant to an individual's recovery. Therapies, which concentrate solely on symptoms or conversely do not place enough emphasis on symptoms may be missing important issues for an individual's recovery.

Personality disorder services would benefit from reviewing risk and considering the impact that this can have on recovery. The current study findings suggest that that service requirements such as managing and reducing risk can affect staff members' views on recovery. It is also clear that risk can mean different things to people. This is important because people with borderline personality disorder are often considered a 'risky' group of people (Paris, 2012). Not all staff may feel comfortable with 'positive risk taking' when working with people with borderline personality disorder. It has been argued that without risk, people stay in a fixed state with little possibility for change (Turner & Frak, 2001). Additionally, it has been argued that risk averse cultures in services can lessen feelings of personal responsibility, and hinder growth and development in individuals (Slade, 2009).

The findings related to relationships in the current study, particularly relationships between people with personality disorder and staff members, provide strength for the need for regular clinical supervision for all staff working with people

with borderline personality disorder. Regular supervision would allow for issues around forming secure attachment relationships and being consistent without staff feeling as though they are creating 'dependency'. This may be particularly important in borderline personality disorder given the attachment difficulties in the aetiology of the disorder (Levy, 2005; Liotti, 2014). Additionally, the findings on the importance of creating secure attachments with people with borderline personality disorder as part of recovery and providing containment are related to the suggestions that not all staff members can work with people with personality disorder. For example, research has suggested that staff members' attitude and interpersonal style is important (Bateman & Tyrer, 2004), due to strong counter-transference reactions which can occur. The findings on the quality of the relationship are also in line with the increasing recognition of the therapeutic relationship as an important predictor of change within psychological therapies (BPS, 2009).

Staff members would benefit from further education and training, both into borderline personality disorder and recovery principals. Much effort has already gone into training staff who work with people with personality disorder. A training package titled 'Personality Disorder: Knowledge and Understanding Framework' (NIMHE, 2003b) has been developed. People with personality disorder have been involved in delivering this training, which has provided further insight both from a client and staff perspective (Davies, Sampson, Beesley, Smith & Baldwin, 2014), leading to a greater and deeper understanding. It has been argued that training staff around personality disorder is demanding, because it requires staff to examine their own anxieties and personal reactions (Rigby & Longford, 2004).

Similarly, recovery training for staff members should involve the importance of holding hope and belief for other people and how their role can facilitate recovery in individuals with borderline personality disorder. This may be important particularly at the point of diagnosis for people with borderline personality disorder and therefore relevant for psychiatrists, because they often diagnose people. The recovery model stresses that recovery is a self-directed individual process (Deegan, 2002) and therefore not something that can be done to a person (Slade, 2009). However, the positions which can be held by staff in terms of understanding, showing human values, validating and

understanding and particularly conveying hope, optimism and belief in recovery may mean that the role of services and the extent to which they are ‘recovery orientated’ is more important than previously suggested. It appears that services may have a larger part to play in recovery than has previously been suggested within the recovery literature.

The development of a tool for use in clinical settings to help people with borderline personality disorder (and people with other mental health difficulties) think about their own recovery issues would be useful. This would be in line with the growing push for individualised approaches to care (DH, 2012) and greater collaboration between people who use services and staff members (Lipczynska, 2011).

4.7 Recommendations for Further Research

Further research is needed to determine the extent that the current study findings are generalizable to other people with borderline personality disorder. Different study designs are needed in order to do this and greater numbers of people with borderline personality disorder should be consulted. Additionally, the views of males with borderline personality disorder are needed to establish whether there are differences in recovery perceptions between males and females.

Whilst completing the Q sort, staff members sometimes asked if they had to complete this according to what they personally felt was important for recovery, or what they felt was important for a person with borderline personality disorder. This highlighted the possibility of a gap in recovery views between people with borderline personality disorder and staff members. The idea that there may be differing views between individuals with mental health problems and staff members is not new (Dilks, 2010; Miller, Brown, Pilon, Scheffler & Davis, 2010). It may be interesting to explore possible differences in understandings of recovery between people with borderline personality disorder and staff who work in the area. Further Q sorts with more equal sample sizes of people with borderline personality disorder and staff members would enable differences to be calculated. Q methodology would be a particularly useful methodology for this, as participants could be asked to conduct multiple Q sorts

according to different conditions of instruction (i.e., what do staff view as important and what do people with borderline personality disorder view as important to recovery).

One hypothesis resulting from the current study findings was that recovery goals and values may be related to the type of service and therapies people were using or working within. For example, it was unclear to what extent being within a DBT service influenced recovery goals in terms of focusing on self-harming behaviour. Participants expressed views, which may have reflected different therapy models and types of services, but it was difficult to conclude anything further in the current study. Further research is needed to investigate differences in recovery between people with experience of different therapies, for example DBT, transference focused psychotherapy or mentalization based therapy. If it is the case that recovery goals are linked with the focus of particular therapies, this can have implications for choice of therapy and may impact upon the success of therapy. This has previously been suggested (Katsakou et al., 2012). It may be that the effectiveness of therapy is associated with the strength of fit between therapy aims and an individual's recovery goals. Further research around this would be interesting.

Similarly, little is known about how staff form recovery views and it is unclear if these are shaped by their therapeutic orientation and/or training. Further research on this would be beneficial, for example conducting qualitative research with staff members. Further Q sorts with staff from various disciplines may allow for understanding of whether there are differences in recovery views between professional groups.

Further research around barriers to recovery would be useful, given the number of statements that participants agreed with in the current study. It has previously been suggested that this area needs further investigation (Ralph et al., 2000). Further Q sorts around negative aspects of recovery in borderline personality disorder could be developed.

4.8 Personal Reflections

The scope of the study changed considerably over the course of the research. Originally, the study proposed to explore the Q concourse by interviewing participants, in addition to using the existing literature, but because recruitment was proving difficult, interviews

were removed from the study design. In addition, the researcher did not want to place undue burden on participants by asking them to take part in an interview and Q sort. The original study design had planned to only recruit participants with a diagnosis of borderline personality disorder, but again, due to recruitment issues, participation was extended to include staff members working with people with personality disorder. The addition of staff members was useful, because this highlighted possible similarities and differences in recovery views and provided new areas for future research.

The researcher was unclear why there was little interest from people with a diagnosis of borderline personality disorder. The researcher also attempted to consult people with a diagnosis of borderline personality disorder (e.g., by approaching Expert by experience groups) on how participation could be enhanced or made more attractive, but was unable to come up with any hypotheses on why the interest was low in the current study. In light of the low numbers, the researcher also advertised the study online through a service user website ran by people with a diagnosis of borderline personality disorder, but did not gain any participants through this method. The researcher concluded that perhaps being an ‘outsider’ to some of the personality disorder services made recruitment difficult and that if they were working in an established service and had good relationships with potential participants, this would have made recruitment more fruitful.

The researcher was mindful of potential ethical issues arising in the research, such as over-burdening participants or introducing potentially distressing topics, particularly given that recovery can be a sensitive topic for people with borderline personality disorder. The researcher endeavoured to be thoughtful in all interactions with participants, for example whilst arranging appointment times with people with borderline personality disorder and during completion of the Q sort.

Personally, the researcher found carrying out the research, in particular completing Q sorts with participants, enjoyable. It was fascinating to observe participants carry out the Q sort. The researcher also enjoyed the interpretive aspect of the Q sort; in particular the combination of using statistical criteria as a guide and the use of qualitative data with her own judgment to make sense of this. The researcher found it difficult to go about exploring the concourse and sampling the Q set in the early

stages. The literature on recovery is large and to begin, this felt overwhelming. There is no set method of designing a Q set (Watts & Stenner, 2012) and the selection of statements has been described as more of an 'art than a science' (Brown, 1980). For this reason, it was difficult for the researcher to know if she was going about sampling correctly.

The researcher chose the area for study because she has an interest in personality disorder. She was aware that her previous experience influenced the research process and made an effort to be transparent about this and used supervision to think about this. Additionally, the researcher reflected upon the whole research process, particularly on the possible difficulties in balancing research and clinical work in her future development as a clinical psychologist.

4.9 Conclusions

The study used Q methodology to explore and understand perceptions of recovery in borderline personality disorder. Three viewpoints amongst people with a diagnosis of borderline personality disorder and staff members working in the area were identified. It appears that clinical recovery can be as important for some, as personal recovery. The role of relationships between people with borderline personality disorder and staff members is important. The research has identified future areas of investigation into borderline personality disorder and recovery.

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Appendix A

Personality Disorder Subtypes According to the Diagnostic and Statistical Manual of Mental Disorders (5th edition) Classification (American Psychiatric Association, 2013)

Cluster A Odd/eccentric	Cluster B Dramatic/irrational	Cluster C Anxious/fearful
Paranoid personality disorder	Antisocial personality disorder	Avoidant personality disorder
Schizoid personality disorder	Borderline personality disorder	Dependent personality disorder
Schizotypal personality disorder	Histrionic personality disorder	Obsessive-compulsive personality disorder
	Narcissistic personality disorder	

Appendix B

The International Classification of Mental and Behavioural Disorders (10th revision)
Criteria for Emotionally Unstable Personality Disorder, Borderline Type (World Health Organisation, 1992)

F60.31 Borderline Type

A. The general criteria for personality disorder must be met

B. At least three of the symptoms mentioned in F60.30 Impulsive type must be present with at least two of the following in addition:

1. disturbances in and uncertainty about self image, aims, and internal preferences (including sexual);
2. liability to become involved in intense and unstable relationships, often leading to emotional crisis;
3. excessive efforts to avoid abandonment;
4. recurrent threats or acts of self-harm
5. chronic feelings of emptiness

F60.30 Impulsive Type

At least three of the following must be present, one of which must be (2):

1. Marked tendency to act unexpectedly and without consideration of the consequences;
2. Marked tendency to quarrelsome behavior and to conflicts with others, especially when impulsive acts are thwarted or criticized;
3. liability to outbursts of anger or violence, with inability to control the resulting behavioural explosions;
4. difficulty in maintaining any course of action that offers no immediate reward;
5. unstable and capricious mood;

Appendix C

List of Sources Used to Sample the Q set

Recovery Measures:

Consumer recovery outcomes system

Illness management and recovery scale

Maryland assessment of recovery in people with serious mental illness

Mental health recovery measure

Mental health recovery star

Recovery assessment scale

Recovery attitudes questionnaire

Recovery process inventory

Relationships and activities that facilitate recovery survey

Stages of recovery scale for people with persistent mental illness

Stages of recovery instrument

The Ohio mental health consumer outcomes system

Qualitative Research

Castillo, H., Ramon, S. & Morant, N. (2013). A recovery journey for people with personality disorder. *International Journal of Social Psychiatry*, 59 (3),264-273.

Katsakou, C., Marougka, S., Barnicot, K., Savill, M., White, H., Lockwood, K., & Priebe, S. (2012). Recovery in borderline personality disorder (BPD): a qualitative study of service users' perspectives. *PloS one*, 7(5), 1-8. doi:10.1371/journal.pone.0036517

Turner, K., Neffgen, M. & Gillard, S. (2011). *Understanding personality disorders and recovery*. London: Emergence.

Recovery Resources

Shepherd, G., Boardman, J. & Slade, M. (2008). *Making recovery a reality*. Sainsbury Centre for Mental Health.

South London and Maudsley NHS Foundation Trust and South West London & St George's Mental Health NHS Trust (2010). *Recovery is for All. Hope, agency and opportunity in psychiatry. A position statement by consultant psychiatrists*. London.

Appendix D

List of Statements (Q- Set)

1. Having good relationships
2. Being able to trust others
3. Having belief from others
4. Socialising more
5. Being in employment (paid or unpaid)
6. Being in education or training
7. Doing enjoyable activities
8. Having 'me' time
9. Having a meaningful life
10. Stopping addictive behaviour (e.g., gambling, shopping, alcohol, drugs)
11. Having more stable and balanced emotions
12. Having less suicide attempts
13. Self-harming less
14. Being able to stop and think before acting
15. Being able to manage conflict
16. Being able to get on with life, despite having difficulties
17. Being able to cope with strong feelings (e.g., feeling sad or angry)
18. Being able to cope with disturbing thoughts
19. Being able to cope with stress / bad things happening
20. Being able to sleep
21. Doing things differently
22. Being in good physical health (e.g., exercising, eating healthily)
23. Taking care of self
24. Knowing how to stay well
25. Being able to ask for help when it's needed
26. Getting the support needed when things are hard
27. Learning from mistakes

28. Understanding one's self
29. Knowing what helps and what doesn't help
30. Having no difficulties
31. Learning to live with one's self
32. Trusting in one's self
33. Feeling hopeful about the future
34. Personal growth and discovery
35. Having setbacks
36. Living a life like others
37. Feeling alert and alive
38. Taking risks
39. Knowing when it is the right time to make important changes
40. Feeling accepted
41. Having inner peace
42. Feeling able to make mistakes
43. Having a sense of identity
44. Becoming less self-critical
45. Knowing one's good qualities
46. Belief in one's self
47. Making choices for self
48. Being independent
49. Having the right kind of place to live
50. Freedom from prejudice
51. Feeling part of one's community
52. Being treated with dignity and respect by others
53. Having choices in care
54. Being medication free
55. Having goals in life
56. Achieving goals
57. Having religion and/or faith
58. Being financially comfortable

Appendix E

Study Information Sheets: People with a Diagnosis of Borderline Personality Disorder

Participant Information Sheet : Q sort NHS

Recovery in People with a Diagnosis of Borderline Personality Disorder

You are being invited to take part in a research study. Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve. Please ask us if there is anything that is not clear or if you would like more information about something. Take time to decide whether you wish to take part.

Why have I been invited to take part?

We are looking for ideas and views from people who have a diagnosis of personality disorder. Your views are very important to us.

What is the purpose of the study?

Recovery is a word that is being used a lot in mental health at the moment but there is no clear agreement on what recovery means or how people feel that they have “recovered”. We are inviting you to take part in a study looking at peoples’ views of recovery and what this means to people with a diagnosis of personality disorder. By doing this research we hope to find out more about what people with a diagnosis of personality disorder think about recovery, if this is a term that means something to them, or whether we should be talking about something different.

Who is organising and funding the research?

This study is funded by the University of Manchester and is being completed as part of a doctorate in clinical psychology.

Who has reviewed the study?

The study has been reviewed by The University of Manchester and the NHS Research Ethics Committee.

What would I have to do?

We would like to recruit 10 people with a diagnosis of personality disorder. If you decide to take part, you will be asked to take part in a sorting exercise. You would be sorting cards with ideas about recovery on them (this is called doing a Q sort). You will be asked to sort the cards into how much you agree or disagree with different views on

recovery. You would then be asked to take part in a short interview. The purpose of the interview will be to find out more about your responses in the Q sort and to find out about your experience of completing the Q sort. You will be asked some personal information such as your age.

The Q sort should not take longer than an hour to complete. We will try to make appointments at times which suit you. This will be done in a private room within your local service. Alternatively, this can be completed online on a secure website. There should not be anything to make you feel upset or uncomfortable. Experts by Experience have already tested the Q sort and have helped develop this. People who take part in the study will be paid £10 for their time.

Will the outcomes of the research be published?

The study is planned for 1 and a half years and the findings will be fed back to interested participants at the end of this time period. If you would like to hear about the findings you can pass on your e-mail address and the researcher will contact you after the study.

Will my taking part be kept confidential?

Information which is collected during the course of the study will be strictly confidential, although we do have a responsibility to inform your care co-ordinator if you tell us information that suggests you or someone else might be harmed.

If you agree to take part in the study, any information you give the researcher will be kept strictly confidential and in accordance with in the Data Protection Act of 1998.

Your name will not appear on any of the forms; we will give you a study number instead. With your permission, we would like to inform your care co-ordinator if you agree to take part in the study. As you are under the care of a mental health NHS Trust, a copy of your consent form will be copied into your usual medical notes and this copy may be reviewed by the Trust Clinical Audit Department to confirm that you have given written informed consent. Responsible individuals from the University of Manchester may also look at the research records to audit the conduct of the research.

What are the possible risks of taking part?

The questions we will ask in the study are unlikely to cause you any distress or harm. You do not have to answer any questions you do not want to. If you do feel distressed as a result of the interview you can contact Sara Siddiqui or Dr Katherine Berry at the

University of Manchester (contact details below). You can also arrange to speak to your care co-ordinator or another professional involved in your care. You can also speak to your local crisis team or the Samaritans (08457 909090 or jo@samaritans.org).

What are the advantages of taking part?

The benefits of taking part are that you will have a chance to give your views about recovery and this may be used to inform personality disorder services in the future. The findings will be used to develop a recovery questionnaire specifically for people with a diagnosis of personality disorder.

Do I have to take part?

No, taking part is voluntary. If you would prefer not to take part, you do not have to give a reason. Your treatment will not be affected in any way. If you decide to take part but later change your mind, you can withdraw from the study at any time without giving a reason and without detriment to yourself or your treatment. If you do decide to take part, you will be given this information sheet to keep and asked to sign a consent form. You will be asked to consent before taking part in the study. You will have at least 48 hours notice from having information about the study before giving consent. The researcher will go through the study information with you and they will take consent from you.

What do I do now?

A meeting will be planned with the researcher from the study within your local service. If you are interested you will be invited to attend. This is a chance for you to find out more about the study or ask questions. She will go through the information sheet with you and answer any questions you have. This should take about 10 minutes.

What do I do if something goes wrong?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 275 8093 or by email to research.complaints@manchester.ac.uk.

In the unlikely event that something does go wrong and you are harmed during the research, you may have grounds for legal action for compensation against the University of Manchester or NHS Trust, but you may have to pay for your legal costs.

The normal National Health Service complaints mechanisms will also still be available to you.

Thank you very much for considering taking part in our research. Please discuss this information with your family, friends or mental health team if you wish.

Contact for further information:

Sara Siddiqui, Trainee clinical psychologist

School of Psychological Sciences

Zochonis Building

University of Manchester

Oxford Road

Manchester

M13 9PL

Tel: 0161 306 0401

sara.siddiqui@postgrad.manchester.ac.uk

Study Information sheets: Staff

Participant Information Sheet : Q sort NHS Staff

Recovery in People with a Diagnosis of Borderline Personality Disorder

You are being invited to take part in a research study. Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve. Please ask us if there is anything that is not clear or if you would like more information about something. Take time to decide whether you wish to take part.

What is the purpose of the study?

We are looking for ideas and views from staff who work with people with borderline personality disorder.

Recovery is a word that is being used a lot in mental health at the moment but there is no clear agreement on what recovery means or how people feel that they have “recovered”.

We are inviting you to take part in a study looking at peoples’ views of recovery and what this might mean to people with a diagnosis of borderline personality disorder. By doing this research we hope to find out more about what people with a diagnosis of borderline personality disorder think about recovery, if this is a term that means something to them, or whether we should be talking about something different.

Who is organising and funding the research?

This study is funded by the University of Manchester and is being completed as part of a doctorate in clinical psychology.

Who has reviewed the study?

The study has been reviewed by The University of Manchester and the NHS Research Ethics Committee.

What would I have to do?

We would like to recruit 15 staff who work with people with a diagnosis of borderline personality disorder. If you decide to take part, you will be asked to take part in a sorting exercise. You would be sorting cards with ideas about recovery on them (this is called a Q sort). You will be asked to sort the cards into how much you agree or disagree with different views on recovery. You would then be asked to take part in a short interview. The purpose of the interview will be to find out more about your responses in

the Q sort and to find out about your experience of completing the Q sort. You will be asked some personal information such as your profession and age.

The Q sort and interview should last up to an hour. A researcher will arrange a convenient time and place to conduct the Q sort. Alternatively, this can be completed online on a secure website. Experts by Experience have already tested the Q sort and have helped develop this.

Will the outcomes of the research be published?

The study is planned for 1 and a half years and the findings will be fed back to interested participants at the end of this time period. If you would like to hear about the findings you can pass on your e-mail address and the researcher will contact you after the study.

Will my taking part be kept confidential?

If you agree to take part in the study, any information you give the researcher will be kept strictly confidential and in accordance with in the Data Protection Act of 1998.

Your name will not appear on any of the forms; we will give you a study number instead. Participants will be asked if they would mind the short interview at the end of the Q sort being recorded by audio tape. This to help us analyse the data later. The tape will be destroyed after it has been used and your personal details will not be disclosed. Responsible individuals from the University of Manchester may also look at the research records to audit the conduct of the research.

What are the possible risks of taking part?

The questions we will ask in the study are unlikely to cause you any distress or harm. You do not have to answer any questions you do not want to.

What are the advantages of taking part?

The benefits of taking part are that you will have a chance to give your views about recovery and this may be used to inform personality disorder services in the future. The findings will be used to develop a recovery questionnaire specifically for people with a diagnosis of personality disorder.

Do I have to take part?

No, taking part is voluntary. If you would prefer not to take part, you do not have to give a reason. If you decide to take part but later change your mind, you can withdraw from the study at any time without giving a reason and without detriment to yourself. If

you do decide to take part, you will be given this information sheet to keep and asked to sign consent form. You will be asked to consent before taking part in the study. You will have at least 48 hours notice from having information about the study before giving consent. The researcher will go through the study information with you and they will take consent from you.

What do I do now?

A meeting will be planned with the researcher from the study within your local service. If you are interested you will be invited to attend. This is a chance for you to find out more about the study or ask questions. She will go through the information sheet with you and answer any questions you have. This should take about 10 minutes.

What do I do if something goes wrong?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 275 8093 or by email to research.complaints@manchester.ac.uk.

In the unlikely event that something does go wrong and you are harmed during the research, you may have grounds for legal action for compensation against the University of Manchester or NHS Trust, but you may have to pay for your legal costs.

The normal National Health Service complaints mechanisms will also still be available to you.

Thank you very much for considering taking part in our research

Contact for further information:

Sara Siddiqui, Trainee clinical psychologist

School of Psychological Sciences

Zochonis Building

University of Manchester

Oxford Road

Manchester

M13 9PL

Tel: 0161 306 0401

sara.siddiqui@postgrad.manchester.ac.uk

Appendix F

Example Consent Forms

People with a diagnosis of borderline personality disorder

Consent Form NHS

Recovery in People with a Diagnosis of Borderline Personality Disorder

Name of researcher : Dr Katherine Berry/ Sara Siddiqui

Centre Number:

Identification number for this trial:

If you are happy to participate please complete and sign the consent form below Please
initial box

- I confirm that I have read the attached information sheet (Version 6: 01.10.2013) ☐
on the above project and have had the opportunity to consider the information,
ask questions and had these answered satisfactorily.
- I understand that my participation in the study is voluntary and that I am free to ☐
withdraw at any time without giving a reason and without detriment to any
treatment/service.
- I understand that if I lose capacity to consent to the study (an unlikely event) any ☐
data I have already provided will be kept and used for the purposes of the study
but will remain confidential. ☐
- I agree to the use of anonymous quotes ☐
- I understand that the interview will be audio-recorded and I consent to this. ☐
- I agree to my care co-ordinator being informed of my participation in the study. ☐
- I understand that relevant sections of my medical notes and data collected during ☐
the study may be looked at by individuals from the University of Manchester,
from regulatory authorities or from the NHS Trust, where it is relevant to my
taking part in this research. I give permission for these individuals to have access
to my records.

- I agree to take part in the above project.

☐

Name of participant.....

Date.....

Signature.....

Name of person taking consent.....

Date.....

Signature.....

I would like to receive the results of the research after the study has ended and agree to provide my e-mail address for the researcher to contact me.

Yes No (please circle)

E-mail address (if yes):.....

1 copy for participant, 1 for researcher, 1 to be kept in case notes

Staff Members

Consent Form NHS Staff Q sort
Recovery in People with a Diagnosis of Borderline Personality Disorder

Name of researcher : Dr Katherine Berry/ Sara Siddiqui

Centre Number:

Identification number for this trial:

If you are happy to participate please complete and sign the consent form below

Please
initial box

- I confirm that I have read the attached information sheet (Version 2: 11.03.2014) on the above project and have had the opportunity to consider the information, ask questions and had these answered satisfactorily. ☐
- I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason. ☐
- I understand that if I lose capacity to consent to the study (an unlikely event) any data I have already provided will be kept and used for the purposes of the study but will remain confidential. ☐
- I understand that the interview will be audio-recorded and I consent to this. ☐
- I agree to the use of anonymous quotes. ☐
- I understand that data collected during the study may be looked at by individuals from the University of Manchester, the NHS Trust or from regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data. ☐
- I agree to take part in the above project.

Name of participant.....

Date.....

Signature.....

Name of person taking consent.....

Date.....

Signature.....

I would like to receive the results of the research after the study has ended and agree to provide my name and e-mail address for the researcher to contact me.

Yes No (please circle)

Name.....

E-mail address (if yes):.....

1 copy for participant, 1 for researcher

Appendix G

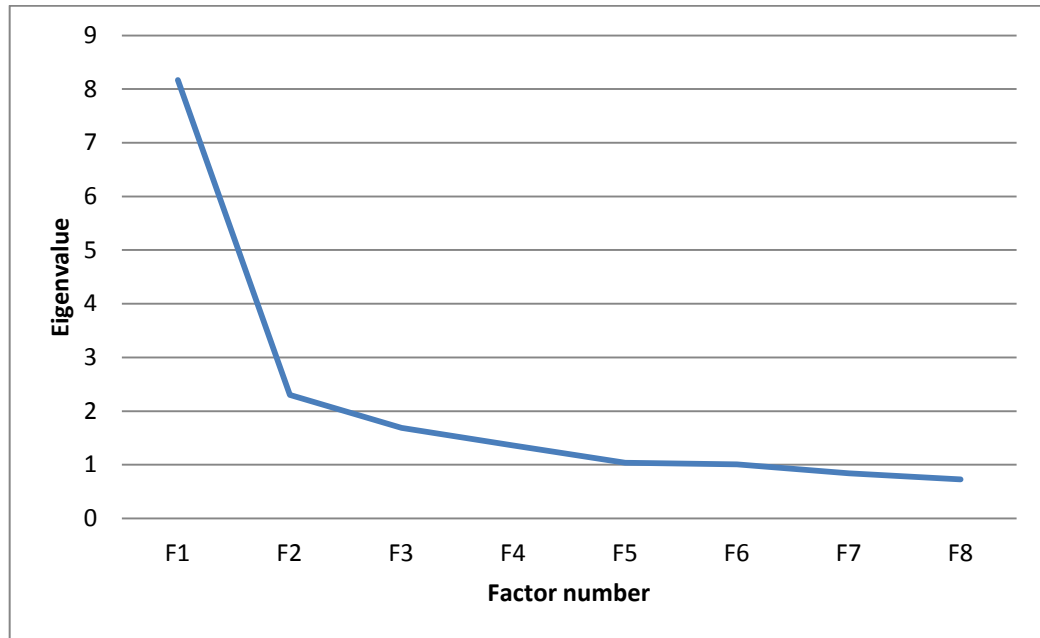
Six Factor Solution

Extracted Factors with Eigenvalues and Explained Variance

Factor	Eigenvalue	Unrotated variance (cumulative)	Rotated variance (cumulative)
1	8.17	37% (37%)	13% (13%)
2	2.30	10% (48%)	15% (25%)
3	1.69	8% (55%)	10% (35%)
4	1.36	6% (62%)	10% (45%)
5	1.04	5% (66%)	11% (56%)
6	1.01	5% (71%)	12% (68%)

Appendix H

Scree Plot



Appendix I

Interpretation Sheets

Red: distinguishing statements

Green: consensus statements

Factor 1

	+	---
5	11. Having more stable and balanced emotions 13. Self-harming less 17. Being able to cope with strong feelings (e.g., feeling sad or angry)	30. Having no difficulties 36. Living a life like others 57. Having religion and/or faith
4	10. Stopping addictive behaviour (e.g., gambling, shopping, alcohol, drugs) 12. Having less suicide attempts 14. Being able to stop and think before acting 19. Being able to cope with stress / bad things happening	35. Having setbacks 50. Freedom from prejudice 54. Being medication free 58. Being financially comfortable
3	15. Being able to manage conflict 16. Being able to get on with life, despite having difficulties 18. Being able to cope with disturbing thoughts 24. Knowing how to stay well 33. Feeling hopeful about the future	6. Being in education or training 8. Having “me” time 34. Personal growth and discovery 38. Taking risks 51. Feeling part of one’s community

2	3. Having good relationships 4. Being able to trust others 26. Getting the support needed when things are hard 29. Knowing what helps and what doesn't help 31. Learning to live with one's self 44. Becoming less self-critical	5. Being in employment (paid or unpaid) 32. Trusting in one's self 37. Feeling alert and alive 42. Feeling able to make mistakes 45. Knowing ones good qualities 55. Having goals in life
1	22. Being in good physical health (e.g., exercising, eating healthily) 20. Being able to sleep 23. Taking care of self 25. Being able to ask for help when it's needed 28. Understanding one's self 40. Feeling accepted 43. Having a sense of identity	3. Having belief from others 4. Socialising more 7. Doing enjoyable activities 39. Knowing when it is the right time to make important changes 41. Having inner peace 53. Having choices in care 48. Being independent

Factor 2

	+	---
5	9. Having a meaningful life 33. Feeling hopeful about the future 28. Understanding one's self	30. Having no difficulties 54. Being medication free 57. Having religion and/or faith
4	26. Getting the support needed when things are hard 34. Personal growth and discovery 40. Feeling accepted 46. Belief in one's self	5. Being in employment (paid or unpaid) 6. Being in education or training 36. Living a life like others 58. Being financially comfortable
3	16. Being able to get on with life, despite having difficulties 18. Being able to cope with disturbing thoughts 19. Being able to cope with stress / bad things happening 42. Feeling able to make mistakes 53. Having choices in care	8. Having "me" time 21. Doing things differently 22. Being in good physical health (e.g., exercising, eating healthily) 49. Having the right kind of place to live 56. Achieving goals
2	24. Knowing how to stay well 31. Learning to live with one's self 43. Having a sense of identity 47. Making choices for self 52. Being treated with dignity and respect by others 55. Having goals in life	3. Having belief from others 10. Stopping addictive behaviour (e.g., gambling, 12. Having less suicide attempts 13. Self-harming less 20. Being able to sleep 35. Having setbacks

1	14. Being able to stop and think before acting 17. Being able to cope with strong feelings (e.g., feeling sad or angry) 29. Knowing what helps and what doesn't help 32. Trusting in one's self 38. Taking risks 41. Having inner peace 45. Knowing ones good qualities	2. Being able to trust others 4. Socialising more 7. Doing enjoyable activities 23. Taking care of self 27. Learning from mistakes 50. Freedom from prejudice 48. Being independent

Factor 3

	+	---
5	<p>1. Having good relationships</p> <p>28. Understanding one's self</p> <p>52. Being treated with dignity and respect by others</p>	<p>54. Being medication free</p> <p>56. Achieving goals</p> <p>57. Having religion and/or faith</p>
4	<p>9. Having a meaningful life</p> <p>14. Being able to stop and think before acting</p> <p>17. Being able to cope with strong feelings (e.g., feeling sad or angry)</p> <p>26. Getting the support needed when things are hard</p>	<p>10. Stopping addictive behaviour (e.g., gambling, shopping, alcohol, drugs)</p> <p>30. Having no difficulties</p> <p>38. Taking risks</p> <p>51. Feeling part of one's community</p>
3	<p>5. Being in employment (paid or unpaid)</p> <p>29. Knowing what helps and what doesn't help</p> <p>32. Trusting in one's self</p> <p>44. Becoming less self-critical</p> <p>43. Having a sense of identity</p>	<p>31. Learning to live with one's self</p> <p>36. Living a life like others</p> <p>40. Feeling accepted</p> <p>50. Freedom from prejudice</p> <p>55. Having goals in life</p>
1	<p>7. Doing enjoyable activities</p> <p>15. Being able to manage conflict</p> <p>20. Being able to sleep</p> <p>23. Taking care of self</p> <p>45. Knowing ones good qualities</p> <p>46. Belief in one's self</p> <p>58. Being financially comfortable</p>	<p>4. Socialising more</p> <p>12. Having less suicide attempts</p> <p>16. Being able to get on with life, despite having difficulties</p> <p>18. Being able to cope with disturbing thoughts</p> <p>24. Knowing how to stay well</p> <p>27. Learning from mistakes</p>

		49. Having the right kind of place to live
--	--	--

Appendix J

Visual Representation of Factor 1 Array. List of Exemplary Statements and Distinguishing Statements for Factor 1

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
30	35	6	5	3	9	20	1	15	10	11
36	50	8	32	4	21	22	2	16	12	13
57	54	34	37	7	27	23	26	18	14	17
	58	38	42	39	46	25	29	24	19	
		51	45	41	47	28	31	33		
			55	48	49	40	44			
				53	52	43				
					56					

Positive exemplary statements (items ranked at +5)

- 11. Having more stable and balanced emotions
- 13. Self-harming less
- 17. Being able to cope with strong feelings (e.g., feeling sad or angry)

Distinguishing statements ranked higher in Factor 1 than other factors

- 11. Having more stable and balanced emotions (+5)
- 13. Self-harming less (+5)
- 17. Being able to cope with strong feelings (e.g., feeling sad or angry) (+5)
- 10. Stopping addictive behaviour (e.g., gambling, shopping, alcohol, drugs) (+4)
- 12. Having less suicide attempts (+4)

- 19. Being able to cope with stress / bad things happening (+4)
- 15. Being able to manage conflict (+3)
- 2. Being able to trust others (+2)
- 56. Achieving goals (0)

Negative exemplary statements (items ranked at -5)

- 30. Having no difficulties
- 36. Living a life like others (consensus statement)
- 57. Having religion and/or faith (consensus statement)

Distinguishing statements ranked lower in Factor 1 than other factors

- 34. Personal growth and discovery (-3)
- 32. Trusting in one's self (-2)
- 45. Knowing ones good qualities (-2)
- 9. Having a meaningful life (0)
- 52. Being treated with dignity and respect by others (0)
- 28. Understanding one's self (+1)
- 26. Getting the support needed when things are hard (+2)

Appendix K

Visual Representation of Factor 2 Array. List of Exemplary Statements and Distinguishing Statements for Factor 2

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
30	5	8	3	2	1	14	24	16	26	9
54	6	21	10	4	11	17	31	18	34	28
57	36	22	12	7	15	29	43	19	40	33
	58	49	13	23	25	32	47	42	46	
		56	20	27	37	38	52	53		
			35	48	39	41	55			
				50	44	45				
					51					

Positive exemplary statements (items ranked at +5)

- 9. Having a meaningful life
- 28. Understanding one's self
- 33. Feeling hopeful about the future

Distinguishing statements ranked higher in Factor 2 than other factors

- 9. Having a meaningful life (+5)
- 33. Feeling hopeful about the future (+5)
- 46. Belief in one's self (+4)
- 40. Feeling accepted (+4)
- 42. Feeling able to make mistakes (+3)

- 53. Having choices in care (+3)
- 47. Making choices for self (+2)
- 55. Having goals in life (+2)
- 38. Taking risks (+1)
- 41. Having inner peace (+1)
- 51. Feeling part of one's community (0)

Negative exemplary statements (items ranked at -5)

- 30. Having no difficulties
- 54. Being medication free (consensus statement)
- 57. Having religion and/or faith (consensus statement)

Distinguishing statements ranked lower in Factor 2 than other factors

- 5. Being in employment (paid or unpaid) (-4)
- 21. Doing things differently (-3)
- 22. Being in good physical health (e.g., exercising, eating healthily) (-3)
- 20. Being able to sleep (-2)
- 23. Taking care of self (-1)
- 44. Becoming less self-critical (0)
- 14. Being able to stop and think before acting (+1)
- 17. Being able to cope with strong feelings (e.g., feeling sad or angry) (+1)

Appendix L

Visual Representation of Factor 3 Array. List of Exemplary Statements and Distinguishing Statements for Factor 3

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
54	10	31	6	4	2	7	11	5	9	1
56	30	36	13	12	3	15	19	29	14	28
57	38	40	35	16	8	20	21	32	17	52
	51	50	41	18	22	23	25	43	26	
		55	47	24	37	45	33	44		
			48	27	39	46	34			
				49	42	58				
					53					

Positive exemplary statements (items ranked at +5)

- 1. Having good relationships (+5)
- 28. Understanding one's self
- 52. Being treated with dignity and respect by others

Distinguishing statements ranked higher in Factor 3 than other factors

- 5. Having good relationships (+5)
- 52. Being treated with dignity and respect by others (+5)
- 5. Being in employment (paid or unpaid) (+3)

- 32. Trusting in one's self (+3)
- 21. Doing things differently (+2)
- 7. Doing enjoyable activities (+1)
- 58. Being financially comfortable (+1)
- 8. Having "me" time (0)

Negative exemplary statements

- 54. Being medication free (consensus statement)
- 56. Achieving goals
- 57. Having religion and/or faith (consensus statement)

Distinguishing statements ranked lower in Factor 3 than other factors

- 10. Stopping addictive behaviour (e.g., gambling, shopping, alcohol, drugs) (-4)
- 31. Learning to live with one's self (-3)
- 40. Feeling accepted (-3)
- 16. Being able to get on with life, despite having difficulties (-1)
- 18. Being able to cope with disturbing thoughts (-1)
- 24. Knowing how to stay well (-1)