

**A Constructivist Grounded Theory of Processes of Recovery in Individuals who have
Received a Diagnosis of Borderline Personality Disorder**

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Abstract

Background: Borderline Personality Disorder (BPD), also referred to as Emotionally Unstable Personality Disorder (EUPD), remains a contested diagnosis which is characterised by diagnostic ambiguity and stigma. Existing research has started to highlight the importance of understanding recovery as it applies to those who have received the diagnosis and from the perspectives of those with lived experience. Recent research has begun to move beyond symptom-focused clinical definitions of recovery towards more personal and relational understandings.

Aim: This study explored the processes involved in recovery as experienced by those who have received a diagnosis of BPD and identified themselves as being in recovery.

Methods: The research was informed by the researcher's ontological and epistemological position and utilised a constructivist grounded theory methodology to explore participants' subjective experiences. A reflexive approach was adopted throughout the research process. Participants were recruited using purposive and theoretical sampling, and qualitative data were collected through semi-structured interviews.

Findings: The analysis generated a series of interrelated categories and subcategories that together formed a theoretical model of recovery as a relationally scaffolded, non-linear and ongoing process of reshaping the relationship to the self and to the meaning of recovery.

Conclusion: The findings contribute a novel conceptualisation of processes involved in recovery following a diagnosis of BPD and highlight implications for clinical practice. These involve emphasising the importance of relationally informed approaches that support both connection and the development of individuals' own resources for recovery.

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CHAPTER ONE: INTRODUCTION

1.1 Chapter Overview

This chapter introduces borderline personality disorder (BPD), also known as emotionally unstable personality disorder (EUPD) in UK clinical contexts. It covers the historical development of personality disorder diagnoses and theoretical models of the aetiology. Further, the chapter highlights the diagnostic ambiguity that surrounds BPD, which is important in considering potential treatments and recovery. The chapter also outlines evolving conceptualisations of recovery, and contrasts clinical definitions with personal, lived-experience perspectives. Finally, it discusses the growing body of existing literature which focuses on recovery in individuals with BPD and highlights issues around stigma and epistemic injustice in clinical and research contexts.

1.2 Historical Development of the Diagnosis

1.2.1 Early Psychiatric Conceptualisations of Personality Disorder (1800s – 1900s)

The concept of personality disorder has a long and complex history within psychiatry, and understanding the historical development of the conceptualisation is critical for appreciating contemporary recovery narratives that are linked to the diagnosis. Early descriptions of patterns of behaviour which resembled those that later formed the basis of modern personality disorder diagnoses date back to the early nineteenth century (Ekselius, 2018). At that time, mental illness was understood as a “disturbance” in reason or intellect, and it was often associated with delusions, hallucinations or perceived impaired thinking (Shorter, 1997). Individuals who did not display these traits did not fit this framework (Berrios, 1993), and it was during this period that clinicians began to formulate those whose behaviour appeared persistently disruptive or socially deviant despite the absence of psychosis or intellectual impairment. The concept of “mania without delirium” is associated

with the French physician Philippe Pinel (Foucault, 1965; Berrios, 1993) to describe individuals who retained the ability to reason but behaved in ways that were deemed impulsive, aggressive or socially disruptive. This marked one of the first attempts within psychiatry to identify enduring patterns of behaviour that did not align with existing knowledge of mental illness.

Throughout the nineteenth century, behaviours now recognised as symptoms of BPD were also often interpreted through a lens of morality as opposed to within a purely medical framework. For example, the British physician Prichard introduced the term “moral insanity” in 1835 to describe individuals who appeared to display disturbances in moral judgement and emotional regulation while maintaining intact intellectual capacities (Prichard, 1835). Prichard described this condition as involving a “perversion of the natural feelings, affections and moral dispositions”, which reflected the moralised language that characterised much psychiatric discourse during this period. Similarly, broader cultural and social norms influenced what was deemed “difficult” or deviant behaviour, with factors such as gender, class and adherence to social conventions being what shaped clinical interpretation (Shorter, 1997; Berrios, 1993). Behaviours outside accepted social norms were often pathologised, which highlights the interweaving of social values within psychiatric classifications.

1.2.2 Early Psychiatric Classification

As psychiatry progressed into the late nineteenth century, efforts shifted from moral and descriptive interpretations to attempts at systematic classification. However, subsequent psychiatric writings continued to utilise similar terminology which further illustrates the ways in which psychiatric classification systems have historically intersected with social and political values (Millon, 2011). Concepts such as “psychopathic inferiority” and “moral defectiveness” were used to describe individuals whose behaviour was historically perceived as socially deviant or disruptive. These classifications were both attached to clinical discourse

and became embedded within legal and institutional frameworks. For instance, the Mental Deficiency Act 1913 introduced the category of “moral imbeciles” (or “moral defectives”), which informed the legalised institutional detention of individuals who were deemed to have “vicious” or criminal tendencies (Berrios, 1993; Shorter, 1997). It can be argued that such legislation reflected broader societal anxieties about social order and criminality (Tyrer & Steinberg, 2013).

During the early twentieth century, efforts were made to develop more systematic approaches to categorising what we know today as personality disorders. The German psychiatrist Kraepelin proposed several subtypes of what he termed psychopathic personalities, which included excitable, unstable, antisocial and quarrelsome personalities (Kraepelin, 1971). Kraepelin’s work represented an attempt to organise clinical observations into distinct diagnostic categories, although these classifications remained largely descriptive and lacked clear theoretical explanations. Later, Schneider further developed the concept of psychopathic personality by identifying a series of personality types which he depicted as being characterised by enduring patterns of behaviour and emotional functioning (Schneider, 1970). Schneider proposed that these personalities were defined by traits that either caused suffering to the individual or to others around them. While Schneider’s framework contributed to the development of personality disorder classifications, it was also criticised by scholars such as Berrios (1993) for being conceptually vague and influenced by normative judgements about socially acceptable behaviour.

The concept of “psychopathic personality” subsequently became influential in early psychiatric diagnostic systems and informed the classification of personality-related conditions in the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). In DSM-I, published by the American Psychiatric Association (APA) in 1952, personality disorders were included under the category “Sociopathic Personality

Disturbance” (APA, 1952). This classification encompassed patterns of chronically maladaptive behaviour, including antisocial and emotionally unstable personality patterns, which reflected the continued influence of earlier concepts such as psychopathic personality.

1.2.3 The Emergence of Borderline Personality Disorder (1930s and Onwards)

The specific concept of BPD began to emerge during the mid-twentieth century. The “borderline” term was used to refer to individuals whose presentation appeared to be on the border between neurosis and psychosis (Stern, 1938). These individuals often presented with intense emotional instability, impulsive behaviour, unstable relationships and transient disturbances in perception or identity, yet they did not consistently exhibit the persistent psychotic symptoms associated with conditions such as schizophrenia. The concept was further developed within psychoanalytic literature, where it was used to describe a particular pattern of personality organisation characterised by unstable identity, primitive defence mechanisms and intense interpersonal dynamics. Kernberg’s (1985) work on borderline personality organisation was particularly influential, and he differentiated borderline structures from neurotic ones. He emphasised the use of primitive defence mechanisms such as splitting, projective identification and idealisation/devaluation cycles. Further descriptions of Kernberg’s depictions of borderline personality organisation will be provided later in the chapter.

1.2.4 Contemporary Conceptualisations

A contemporary understanding of BPD has largely been shaped by modern diagnostic classification systems, most notably the DSM, which is widely used in North American clinical contexts, and the International Classification of Diseases (ICD), which is the World Health Organisation (WHO) system used internationally, including within UK clinical practice.

The DSM-III operationalised BPD and specified nine diagnostic criteria. For a diagnosis to be made, the presence of at least five criteria was required (APA, 1980). Within the DSM-IV, BPD was conceptualised as a pervasive pattern of instability in interpersonal relationships, self-image, and affect, alongside marked impulsivity beginning by early adulthood and present across contexts (APA, 2000). These features include fears of abandonment, unstable relationships, identity disturbance, impulsivity, recurrent self-harm, affective instability, chronic emptiness, and transient stress-related paranoia or dissociation. The DSM-V retained this categorical diagnosis and located BPD within Cluster B personality disorders, which is a grouping characterised by dramatic, emotional and erratic presentations (APA, 2013). Alongside this, it introduced a dimensional alternative model that conceptualises personality pathology in terms of impairments in self and interpersonal functioning as well as maladaptive trait domains.

In contrast, the ICD-10 uses the diagnosis of Emotionally Unstable Personality Disorder (EUPD), with impulsive and borderline subtypes (WHO, 1992), which broadly overlaps with the DSM construct of BPD. More recently, the ICD-11 (WHO, 2019) has moved away from categorical diagnoses of personality disorder altogether, and instead classifies personality disorder by severity, with optional trait qualifiers and a “borderline pattern specifier” used when symptoms align with BPD, as defined in the DSM-IV/V (Bach et al., 2022). The ICD-11 borderline pattern specifier may be diagnosed when at least five of the specified criteria are met (see Table 1). These criteria indicate a pattern of personality

disturbance characterised by pervasive instability in interpersonal relationships, self-image and affect, and marked impulsivity (WHO, 2019).

Table 1

Criteria of the Borderline Pattern Specifier in the ICD-11 (WHO, 2019)

• frantic efforts to avoid real or imagined abandonment; • a pattern of unstable and intense interpersonal relationships, which may be characterized by vacillations between idealization and devaluation, typically associated with both strong desire for and fear of closeness and intimacy; • identity disturbance, manifested in markedly and persistently unstable self-image or sense of self; • a tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours (e.g. risky sexual behaviour, reckless driving, excessive alcohol or substance use, binge eating); • recurrent episodes of self-harm (e.g. suicide attempts or gestures, self-mutilation); • emotional instability due to marked reactivity of mood – fluctuations of mood that may be triggered either internally (e.g. by one's own thoughts) or by external events, as a consequence of which, the individual experiences intense dysphoric mood states, which typically last for a few hours but may last for up to several days; • chronic feelings of emptiness; • inappropriate intense anger or difficulty controlling anger, manifested in frequent displays of temper (e.g. yelling or screaming, throwing or breaking things, getting into physical fights);

-
- transient dissociative symptoms or psychotic-like features (e.g. brief hallucinations, paranoia) in situations of high affective arousal.
-

Other manifestations of borderline pattern, not all of which may be present in a given individual at a given time, include the following:

- a view of the self as inadequate, bad, guilty, disgusting and contemptible;
 - an experience of the self as profoundly different and isolated from other people, and a painful sense of alienation and pervasive loneliness;
 - proneness to rejection hypersensitivity, problems in establishing and maintaining consistent and appropriate levels of trust in interpersonal relationships, and frequent misinterpretation of social signals.
-

Furthermore, although “complex emotional needs” is not a formal diagnostic category, the term has gained traction within UK mental health services as a person-centred, needs-based alternative that emphasises support rather than pathology (NHS England [NHSE], 2019). Collectively, the historical development of the diagnosis illustrates a broader paradigm shift from rigid, categorical models toward dimensional and formulation-based understandings of personality pathology. However, despite the increasing movement toward dimensional models, categorical diagnoses such as BPD continue to function as the primary operational framework within clinical services and research in the UK (Confue et al., 2025; Lamph et al., 2023; Monk-Cunliffe, 2022).

1.3 Prevalence of BPD

In recent decades, BPD has attracted increasing clinical and research interest due to the profound psychological, social and economic impact that it can have on both those that are diagnosed and the systems that support them (Leichsenring et al., 2023). Prevalence

estimates vary according to diagnostic methods and the population sampled. A recent meta-analysis reported a pooled prevalence estimate of 2.41% in the general population, although considerable heterogeneity was observed across studies (Ramos-Suárez et al., 2025). In the UK, McManus et al., (2016) found that approximately 2.4% of adults aged 16–64 screened positive for BPD using the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II). The estimated population prevalence was between 2.0% and 2.9%. Although more women (2.9%) than men (1.9%) screened positive, this difference was not statistically significant. In the same report, younger adults were also more likely to screen positive, particularly among women.

1.4 Potential Diagnostic Overlap and Conceptual Debates

1.4.1 Heterogeneity of the Diagnosis

Despite the increasing standardisation of diagnostic criteria within contemporary classification systems, personality disorders remain among the most contested constructs within psychiatry. As touched on in the ‘historical development of the diagnosis’ section, early critiques such as (Berrios (1993) suggested that personality disorder diagnoses were often based on subjective judgements regarding socially undesirable behaviours rather than clearly defined pathological processes. Consequently, questions regarding the validity and reliability of the BPD construct have persisted across successive revisions of diagnostic systems. One frequently discussed issue concerns the heterogeneity of the diagnosis. Within the diagnostic criteria for both the DSM-V diagnosis and the borderline pattern specifier as outlined in the ICD-11, individuals must meet five out of nine criteria to receive the diagnosis (WHO, 2019). This combinatorial structure allows for numerous possible symptom presentations, which means that two individuals may share the same diagnosis while displaying substantially different patterns of difficulties. Researchers have therefore questioned whether the diagnosis represents a single coherent condition or a broad grouping

of emotional and interpersonal difficulties (Gunderson et al., 2018). In addition, Tyrer (2009) proposed that BPD can be more appropriately understood as a condition characterised by recurrent unstable mood and behaviour, which he termed fluxithymia. He argued that BPD may be better categorised as a mood disorder as opposed to a personality disorder. He even argued that BPD “should be abolished as it is a passport to heterogeneity”.

1.4.2 Diagnostic Overlap

Whilst neurodevelopmental conditions such as autism spectrum disorder (henceforth, autism) are typically recognised and diagnosed during early childhood (Crane et al., 2016), differentiating autism and BPD clinically during adulthood can be challenging due to common overlapping characteristics, including dysregulation in emotional expressivity, self-injurious behaviours and difficulties in interpersonal functioning (De Cagna et al., 2019; Nanchen et al., 2016). As a result, some autistic individuals within adult mental health services may initially receive a BPD diagnosis before autism is recognised (Tamilson et al., 2025). This pattern appears particularly relevant for autistic females, whose use of social camouflaging strategies may mask autistic characteristics and contribute to diagnostic overshadowing or misdiagnosis (Hull et al., 2017; Kentrou et al., 2021). Further, a recent systematic literature review highlighted a bidirectional relationship, which indicated that there were higher rates of autistic traits in BPD populations and higher rates of BPD diagnoses among autistic individuals (Dell’Osso et al., 2023). This overlap has gained increasing recognition in recent years, which reflects a growing awareness of autistic traits and a rise in the number of adults seeking neurodevelopmental assessments (Huang et al., 2020).

Similar debates have emerged in relation to attention-deficit hyperactivity disorder (ADHD), which is another neurodevelopmental condition. Researchers have identified overlapping features between ADHD and BPD, particularly in relation to difficulties with

emotional regulation, impulsivity and interpersonal sensitivity (Asherson et al., 2014). Emotional dysregulation associated with ADHD may therefore resemble behavioural features linked to BPD, which may include difficulties regulating emotions and impulsive responses to distress (Soares et al., 2025). These similarities have led some researchers to question whether certain presentations conceptualised as personality pathology may instead reflect underlying neurodevelopmental differences (Tyrer, 2009). This therefore highlights the importance of careful assessment when distinguishing between neurodevelopmental conditions and BPD.

Closely related to this debate is the question of whether some individuals diagnosed with BPD may more accurately meet criteria for complex post-traumatic stress disorder (C-PTSD). C-PTSD, formally recognised within the ICD-11, describes psychological difficulties that may arise following prolonged or repeated interpersonal trauma, particularly during childhood (WHO, 2019). Symptoms include difficulties in regulating emotions, negative self-concept and persistent relational difficulties, which overlap considerably with symptoms associated with BPD. Some scholars have therefore argued that presentations conceptualised as personality disorder may in some cases represent trauma-related responses rather than enduring personality pathology (Cloitre et al., 2014; Ford & Courtois, 2014).

1.5 Aetiology and Theoretical Models of BPD

1.5.1 Object Relations Theory

Psychoanalytic object relations theorists, most notably Kernberg (1985, 1993), alongside earlier work by Klein (1946) and Fairbairn (1994), have contributed to the conceptualisation of the aetiology of BPD. Kernberg (1985, 1993) proposed that the development of BPD occurs from resultant difficulties in early relationships with primary caregivers and the internal representations, or “objects”, that develop from these experiences.

Kernberg (1985) proposed that early interactions with caregivers shape the internal mental models that individuals hold about themselves and others. Within this framework, individuals who later develop BPD are thought to experience inconsistent, neglectful or traumatic caregiving environments, which in turn, disrupt the integration of positive and negative representations of the self and others. As a result, individuals may struggle to develop a stable and cohesive sense of identity and may experience relationships in extreme or contradictory ways (Kernberg, 1985). In addition, he argued that individuals with BPD rely heavily on primitive unconscious psychological defence mechanisms, particularly splitting, which is whereby positive and negative representations of the self and others are kept separate rather than integrated. This leads to the characteristic relational instability observed in BPD, such as rapidly shifting between the idealisation and devaluation of others. From this perspective, the symptoms of BPD reflect disruptions in early developmental processes involved in forming stable internal object relations and regulating emotions within relationships.

1.5.2 Attachment Theory

Attachment-based perspectives have also contributed to understanding the development of BPD. Attachment theory, originally proposed by Bowlby (1969), suggests that early interactions with caregivers shape internal working models of the self and others. Meta-analytic research has demonstrated associations between BPD and insecure or disorganised attachment patterns (Agrawal et al., 2004) which may develop within contexts of early attachment disruption (Fonagy & Bateman, 2008). Researchers such as Fonagy have proposed that disruptions in early attachment relationships may interfere with the development of mentalisation, which is the capacity to understand one's own mental states and those of others (Fonagy et al., 2002). The theory proposes that difficulties in mentalisation may contribute to misunderstandings in interpersonal relationships, emotional

dysregulation and unstable self-concepts. These challenges may increase vulnerability to the interpersonal sensitivity, identity disturbance and relational instability that characterise BPD.

1.5.3 Biosocial Model

One of the most widely recognised frameworks is the biosocial model developed by Linehan (1993). This model proposes that BPD arises through the interaction between heightened emotional sensitivity and an invalidating social environment. According to Linehan, some individuals are biologically predisposed to experience emotions more intensely and to take longer to return to their emotional baseline following distressing events. When such vulnerabilities occur within environments that dismiss, punish, or invalidate emotional experiences, individuals may struggle to develop effective strategies for regulating their emotions. Linehan (1993) proposed that over time, maladaptive coping behaviours such as self-harm, impulsivity or interpersonal conflict may emerge as attempts to manage overwhelming emotional states.

1.5.4 Biological Theories

Biological theories of BPD emphasise the role of genetic vulnerability and neurobiological differences (Perez-Rodriguez et al., 2018). Twin and family studies suggest that BPD has a moderate heritable component, with heritability estimates typically ranging between approximately 40-60% (Torgersen et al., 2000). These findings indicate that genetic factors may contribute to underlying traits associated with BPD, such as emotional sensitivity, impulsivity and affective instability. Neurobiological research has identified differences in fronto-limbic brain regions, which are involved in processing and regulating emotions, in individuals diagnosed with BPD (Ruocco et al., 2013; Schulze et al., 2016). They have reported heightened reactivity in the amygdala, which is a brain structure associated with processing emotional stimuli (Ruocco et al., 2013; Schulze et al., 2016).

Altered activation has also been observed in the prefrontal cortex and anterior cingulate cortex, which are brain regions involved in emotion regulation and cognitive control (Minzenberg et al., 2008). These patterns may contribute to the heightened emotional reactivity and difficulties regulating emotions which is commonly experienced by individuals with BPD (Ruocco et al., 2013). Biological explanations also highlight the role of neurochemical systems, including the neurotransmitters serotonin, dopamine and noradrenaline, which help to regulate emotions (Perez-Rodriguez et al., 2018). Research suggests that dysregulation within the serotonergic system may contribute to impulsivity and aggression, both of which can be experienced by those with the diagnosis of BPD (Coccaro et al., 2010; Gollan et al., 2005).

1.5.5 Biopsychosocial Model

However, contemporary perspectives emphasise that biological vulnerabilities alone are unlikely to fully explain the development of BPD. Instead, many researchers conceptualise BPD within biopsychosocial frameworks, in which genetic predispositions interact with environmental experiences such as trauma, attachment disruption and invalidating developmental contexts (Crowell et al., 2009; Gunderson et al., 2018; Linehan, 1993). Developmental models suggest that early relational adversity may influence the development of neurobiological systems involved in emotion regulation across the lifespan (Crowell et al., 2009; Fonagy et al., 2002). This integrative perspective aligns with attachment-based accounts which propose that neurobiological systems involved in emotion regulation are shaped through early caregiving experiences and interpersonal relationships (Fonagy et al., 2002; Gunderson et al., 2018). Such frameworks highlight the complex interaction between biological, psychological and social processes in the development and maintenance of BPD. These theoretical perspectives have not only informed understandings of the development of BPD but have also guided the development of psychotherapeutic

interventions. For example, Linehan's (1993) biosocial model underpins dialectical behaviour therapy (DBT), attachment and mentalisation theories have informed mentalisation-based treatment (MBT; Bateman & Fonagy, 2016), and object relations theory has influenced transference-focused psychotherapy (Clarkin et al., 2006; Kernberg, 1993).

1.6 Conceptualising Recovery in Mental Health Contexts

Recovery is not a single, universally agreed concept. As such, it encompasses a range of meanings that reflect different theoretical perspectives and priorities. Researchers have distinguished between two broad understandings of recovery: clinical recovery and personal recovery (Slade, 2009). The former reflects a traditional clinical perspective, in which recovery is defined primarily in terms of symptom remission or cure (Pelletier et al., 2020). Within this framework, recovery is typically measured through changes in symptom severity, functional outcomes or service utilisation (Lloyd et al., 2008). In contrast, a second understanding of recovery has emerged from the narratives of individuals with lived experience of mental health difficulties (Roberts & Hollins, 2007). This perspective emphasises recovery as a deeply personal process which involves the development of meaning, identity, and purpose, even in the presence of ongoing symptoms (Roberts & Boardman, 2013). An influential definition of recovery was proposed by Anthony (1993), who described recovery as a process of changing attitudes, goals, values, feelings, skills, and roles to live a satisfying and meaningful life alongside any hindrances associated with mental illness. A similar view of recovery proposes that recovery involves recognising the person beyond the illness and supports individuals to rebuild meaningful roles, relationships and aspirations (Repper & Perkins, 2009; Perkins & Repper, 2016). From this perspective, recovery is better understood as an ongoing journey rather than a fixed endpoint or cure.

The Connectedness, Hope, Identity, Meaning and Empowerment (CHIME) framework, developed by Leamy and colleagues (2011), represents one of the most

influential efforts to synthesise recovery narratives within mental health research. Based on a systematic review of 97 qualitative studies, the framework identified five interrelated processes that characterise recovery experiences: connectedness, hope, identity, meaning and empowerment (Leamy et al., 2011). Together, these processes describe recovery as a multidimensional experience that involves how individuals think about themselves, relate to others, and make sense of their lives over time. More recent developments have extended the CHIME framework by emphasising that these processes do not occur in isolation within the individual. Instead, recovery is increasingly understood as relational and context-dependent. This means that recovery is shaped through interactions with others, such as family, friends, peers and professionals. It is also influenced by wider social and cultural contexts, including access to support, stigma, and opportunities for social inclusion (Slade et al., 2014; Stuart et al., 2017). This viewpoint conceptualises internal psychological processes such as hope, identity, and empowerment as developed and maintained through relationships and social environments. This extension is particularly important for understanding how recovery is experienced in practice, as it highlights that recovery is often achieved and sustained through interpersonal support and meaningful social connection. It also suggests that recovery may look different depending on an individual's relational context and life circumstances, rather than following a singular or linear pathway.

1.6.1 Recovery in the UK Mental Health Context

In the UK, recovery has become a central focus of mental health policy and service delivery. Many NHS services emphasise their aim to provide person-centred care, be socially inclusive and to develop collaborative approaches to service delivery in co-production with service users (Department of Health [DoH], 2011; NICE [National Institute for Health and Care Excellence], 2012). Recovery-oriented practice is reflected in the NHS Long Term Plan (NHSE, 2019) which advocates for services to support autonomy and participation in

meaningful social roles. Despite this policy emphasis, integrating recovery into mainstream mental health services has not been straightforward. Although recovery originated as a service user-led movement, some authors argue that mental health services have sometimes adopted and redefined it in ways that move away from those original values (Slade, 2009; Repper & Perkins, 2017). In particular, the concept has occasionally been interpreted in ways that prioritise independence and self-management, sometimes at the expense of recognising an individual's ongoing relational, social and systemic support needs (Beresford, 2002; Rose, 2018). Another challenge relates to how recovery is measured in clinical research and practice. Common clinical outcome measures tend to focus on symptom severity and functional impairment, for instance, the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM; Evans et al., 2002) and the Health of the Nation Outcome Scales (HoNOS; Wing et al., 1998). While these measures provide valuable information about clinical change and functioning, they may not fully capture broader aspects of recovery, such as identity reconstruction, meaning-making, empowerment and relational connectedness (Leamy et al., 2011; Slade, 2009). Consequently, many researchers argue that recovery should also be understood as a subjective and relational process which is shaped by individuals' lived experiences. Similarly, guidance recommends that services incorporate relationally focused and psychosocial interventions to support recovery outcomes beyond symptom reduction (NICE, 2009).

1.7 Overview of Recovery Research in BPD

BPD has historically been conceptualised as a chronic and difficult-to-treat condition within psychiatric literature (Stern, 1938). However, longitudinal research conducted over the past two decades has started to challenge these assumptions and has demonstrated that many individuals experience substantial symptomatic improvement, or recovery, over time (Paris, 2002; Zanarini et al., 2010, 2012). These findings have contributed to a growing interest in

understanding the processes through which recovery may occur specifically within individuals with this diagnosis.

Alongside this shift in thinking, a substantial evidence base has emerged supporting the effectiveness of psychological interventions for BPD. Psychological therapy is considered the first-line treatment for BPD according to the NICE (2009) guidelines. Theoretical frameworks of BPD have guided the development of psychotherapeutic interventions. These include DBT (Linehan, 1993), which focuses on developing skills in emotion regulation, distress tolerance, interpersonal effectiveness and mindfulness; Mentalisation-Based Therapy (MBT; Bateman & Fonagy, 2004; Fonagy & Bateman, 2008), which aims to strengthen individuals' capacity to understand their own and others' mental states; Transference-Focused Psychotherapy (TFP; Clarkin et al., 2006), which uses psychodynamic principles to explore relational patterns within therapy; and Schema Therapy (Young et al., 2006), which explores early maladaptive schemas and entrenched patterns of relating. Although these approaches differ theoretically, they share a focus on addressing emotional dysregulation, relational instability and identity disturbance (APA, 2013; WHO, 2019).

Much of the research examining recovery in BPD has focused on the effectiveness of these psychological interventions in terms of the effectiveness in reducing BPD related symptoms. A meta-analytic review of randomised controlled trials found that DBT and psychodynamic psychotherapies are moderately more effective than control conditions in reducing BPD symptoms, including self-harm, suicidal behaviours and general psychopathology (Cristea et al., 2017). The control conditions in these studies consisted of treatment as usual or other treatments not specifically developed for BPD.

Similarly, a more recent review found that DBT, MBT, DBT skills training, emotion regulation groups and manual-assisted cognitive therapy and Systems Training for Emotional

Predictability and Problem Solving (STEPPS) were associated with improvements in self-harm, suicide-related outcomes and psychosocial functioning (Stoffers-Winterling et al., 2022). In contrast, evidence for pharmacological interventions remains limited. In a systematic review of 46 randomised controlled trials involving 2769 individuals diagnosed with BPD, Stoffers-Winterling and colleagues (2022) found that medications, including antidepressants, antipsychotics and mood stabilisers, produced little or no improvement in overall BPD severity, self-harm, suicide-related outcomes or psychosocial functioning compared with a placebo. Consistent with these findings, NICE (2009) recommends that medication should not be used as the primary treatment for BPD and should instead be considered cautiously and primarily in the context of crisis management.

Whilst these findings challenge earlier assumptions that BPD is inevitably chronic, they primarily frame recovery in terms of symptom reduction or behavioural change. Consequently, several researchers have argued that recovery cannot be fully understood through clinical outcomes alone and that greater attention should be paid to how individuals themselves define and experience recovery. Several review papers have examined recovery within this population. For instance, Nesnidal et al., (2020), in a narrative review of recovery in BPD, emphasised that recovery should not be conceptualised solely as symptom remission and argued instead that recovery should be understood as a subjective experience that may involve improvements in quality of life, treatment engagement and understanding of an individual's own condition. Similarly, a systematic review by Ng and colleagues (2016) examined perspectives of recovery from BPD across consumers, clinicians, family members and carers. The authors noted that while symptomatic remission is commonly reported in research, broader indicators of recovery such as engagement in meaningful work and relationships are less frequently examined. These findings highlight the importance of

exploring recovery beyond symptom reduction in order to capture individuals' subjective experiences more broadly.

Although several qualitative studies have explored recovery experiences from the perspectives of individuals with lived experience, this literature remains comparatively small when contrasted with the extensive treatment outcome literature. For instance, Castillo and colleagues (2013) explored recovery amongst individuals diagnosed with personality disorders. Whilst not specifically or exclusively focused on BPD, their findings conceptualised recovery as a journey characterised by a gradual progression through a series of small steps, leading to the development of the concept of "transitional recovery", which describes recovery as a staged process. Other qualitative studies have examined recovery experiences across different stages of the recovery journey. Ng and colleagues (2019), for example, explored the experiences of individuals located at different ends of the recovery continuum and contrasted those earlier in recovery with individuals who considered themselves further along in their recovery journey. They proposed a three-stage process of recovery which involved initially "being stuck", to "diagnosis" and then "improving experience". Chugani (2016) examined recovery experiences through poetic analysis of narratives from individuals who identified themselves as having recovered from BPD. She reflected upon seeing less diagnostic symptomatology than expected within participant accounts, and noted that deeply personal experiences such as early interpersonal abuse, trauma and feeling unheard were emphasised throughout participants' experiences of recovery.

Qualitative synthesis research has also contributed to understanding recovery experiences in those diagnosed with BPD. Katsakou and Pistrang (2018) conducted a meta-synthesis of qualitative studies examining individuals' experiences of treatment and recovery in BPD. Their findings highlighted areas of change experienced by individuals receiving

treatment, as well as characteristics of treatment that were valued by participants. However, the authors also noted that further research is needed to better understand how these changes occur. Further, the studies included in the synthesis primarily examined recovery within the context of individuals' experiences of psychological treatment. Collectively, the literature suggests that recovery from BPD may extend beyond symptom remission and encompass broader processes relating to identity, relationships, meaning and participation in everyday life. Nevertheless, existing qualitative findings remain dispersed across individual studies, and understanding of how recovery is experienced from the perspective of those with lived experience remains limited.

1.8 Stigma as a Barrier in Clinical Practice

Although qualitative research suggests that recovery extends beyond symptom remission and involves identity, relationships and participation in everyday life, these processes occur within broader interpersonal and service contexts. One important factor that may shape opportunities for recovery is the stigma associated with a diagnosis of BPD, particularly within mental health services. Despite the presence of longitudinal research which indicates that many individuals who are diagnosed with BPD experience meaningful symptomatic and functional improvement over time (Zanarini et al., 2010, 2012), within clinical discourse, historical pessimistic narratives of individuals diagnosed with BPD being “treatment-resistant” or “difficult to treat” largely remain commonplace (Baker & Beazley, 2022; Lewis & Appleby, 1988; Papathanasiou & Stylianidis, 2022). For example, evidence indicates that healthcare professionals (HCP)s often carry negative perceptions of individuals with BPD, which are frequently framed by stereotypes such as “manipulative”, “attention-seeking” or “difficult” (Gallop et al., 1989; Baker & Beazley, 2022). These attitudes have been documented across psychiatric nurses, general practitioners, and other HCPs (Baker & Beazley, 2022; Wlodarczyk et al., 2018). Studies suggest that such stigma can manifest in

practice as emotional distancing, avoidance of interactions or a reluctance to work exclusively with this clinical population (McGrath & Dowling, 2012; Nehls, 2000; Papathanasiou & Stylianidis, 2022; O’Connell & Dowling, 2013). While this framing may reflect genuine clinical challenges encountered in practice, including emotional intensity in crises, relational ruptures and high service utilisation (Hughes et al., 2017; Stroud & Parsons, 2013), it may also become a stabilised explanatory narrative that precedes and shapes clinical engagement.

NICE (2009) guidance emphasises the importance of HCPs establishing and maintaining a therapeutic relationship with those with a diagnosis of BPD, with specific emphasis on clear communication throughout the course of treatment. In practice, HCPs should ideally have comprehensive knowledge of BPD and possess attitudes conducive to collaboration. However, HCPs frequently report feeling undertrained, frustrated and ill-equipped to manage the complexities of BPD, which may exacerbate negative attitudes and reduce therapeutic engagement (Hughes et al., 2017; Stroud & Parsons, 2013). Individuals with BPD are often perceived as consciously responsible for their difficulties, which can result in lower empathy and diminished support relative to other psychiatric populations such as schizophrenia (Papathanasiou & Stylianidis, 2022; Woollaston & Hixenbaugh, 2008). The historical framing of personality disorder as socially deviant behaviour may have contributed to iatrogenic effects of the diagnosis, which may indirectly shape both HCPs’ perceptions and patients’ self-concept (Lewis & Appleby, 1988). This may also contribute to processes of implicit demedicalisation, whereby individuals are positioned as less deserving of medical attention due to perceptions of behavioural difficulty. For example, Sulzer (2015) argues that the “difficult patient” status in BPD can function to shift clinical interpretations away from medical need and toward behavioural management, thereby reinforcing exclusionary dynamics within services. Labels such as “personality disorder” may reinforce negative

expectations and influence clinical interactions, which in turn may also affect an individual's treatment pathway, further perpetuating stigma within mental health services. This can contribute to feelings of shame, abandonment and an understandably reduced willingness to engage in care. This creates a tension with evidence from intervention research, where psychological therapies have been shown to produce significant improvements in symptom severity, self-harm and psychosocial functioning (Cristea et al., 2017; Stoffers-Winterling et al., 2022). In this sense, “treatment resistance” may reflect the complexity and intensity of required care rather than a lack of treatability. Recent initiatives have sought to address these issues through enhanced training, trauma-informed practice and greater involvement of individuals with lived experience in service development (NHSE, 2019; NICE, 2009).

1.9 Epistemic Injustice in Research and Clinical Contexts

The stigma discussed can be understood through the concept of epistemic injustice (Fricker, 2007). Epistemic injustice refers to situations in which individuals are wronged specifically in their capacity as knowers. In other words, a person's experiences or testimony may be dismissed or given reduced credibility due to prejudice or assumptions about their identity. Epistemic injustice may extend to the production of knowledge within academic research. Historically, psychiatric research has often prioritised clinical observation and quantitative outcomes over first-person accounts of lived experience. While such approaches provide important information regarding symptom patterns and treatment outcomes, they may fail to capture the subjective meanings that individuals attach to their experiences. This privileging of clinician-defined outcomes has systematically marginalised service user perspectives and contributed to gaps in understanding recovery.

Furthermore, even attempts to reframe diagnostic terminology may inadvertently reproduce epistemic injustice. For example, some publications describe BPD using medicalised terminology such as “disease” (Nesnidal et al., 2020), while alternative proposals

such as “Emotional Intensity Disorder” (Hayward et al., 2026) continue to retain pathologising language through the term “disorder”. While often intended to reduce stigma or improve clinical understanding, such terminology may nonetheless reinforce deficit-based constructions of distress and shape how individuals are perceived within both clinical and research contexts. Attention to language is therefore critical in recognising whose perspectives are centred and how lived experience is represented.

Within mental health contexts, diagnostic labels may shape how an individual’s account of their experiences is interpreted. For example, when a person has been diagnosed with BPD, clinicians may interpret their expressions of distress through the lens of existing stereotypes associated with the diagnosis. As a result, the person’s account may be viewed as exaggerated, manipulative or unreliable. Such testimonial injustice can occur even when individuals provide detailed and accurate accounts of their experiences, highlighting the power of diagnostic framing and professional authority in shaping whose knowledge is considered legitimate. This form of testimonial injustice can undermine collaborative therapeutic relationships. If individuals feel that their perspectives are not taken seriously, they may become less willing to share their experiences openly. In turn, HCPs may lose access to crucial experiential information about how distress is experienced and understood by the individual. Diagnostic stigma may also reinforce hierarchical power dynamics within care, where HCPs’ interpretations are prioritised over service users’ subjective accounts, limiting opportunities for genuine co-production of meaning within therapy. Increasingly, qualitative research methods are recognised as a corrective to these injustices, as they inherently centre lived experience as legitimate knowledge (Elliott et al., 1999). By prioritising first-person narratives, qualitative approaches enable individuals to define recovery and articulate meaning in ways that are not constrained by diagnostic frameworks.

1.10 Chapter Overview

This chapter provided an overview of BPD, and it began by tracing its historical conceptual development and contemporary understanding. The chapter also explored theoretical models of aetiology and debates regarding the diagnosis. Recovery was examined from both clinical and personal perspectives, and highlighted the limitations of symptom-focused outcomes and the importance of obtaining personal experiences of recovery. The chapter concluded by providing an overview of the literature that explores recovery in individuals with a diagnosis of BPD and discussed issues around stigma and epistemic injustice.

CHAPTER TWO: A QUALITATIVE SYSTEMATIC REVIEW AND META-ETHNOGRAPHY

2.1 Aims and Rationale of the Synthesis

There is a growing body of qualitative research exploring how individuals diagnosed with borderline personality disorder (BPD) understand recovery. However, these studies often remain isolated from one another, which makes it difficult to form a broader conceptual understanding of what recovery means to people with lived experience of BPD. A systematic review and synthesis provides a structured approach to bringing these studies together, which enables the development of more coherent and in-depth interpretations that exceed the limits of individual contexts.

The aim of this review is to synthesise qualitative accounts of recovery from BPD in order to develop a richer conceptual understanding of how individuals make sense of recovery in their own terms.

The research question guiding this review is:

How do individuals diagnosed with borderline personality disorder understand and experience recovery?

Rather than adopting a predefined clinical framework, the review seeks to understand how individuals define and experience recovery, and what factors they perceive as supporting or hindering that process. While recovery is a central concept in contemporary mental health services, there remains limited conceptual clarity around how it is understood by those with a BPD diagnosis. Addressing this gap is important for informing both future research and the design of services that are responsive to service user perspectives.

2.2 Method

2.2.1 Design

To explore patterns and overarching themes in the growing body of qualitative literature on recovery among individuals diagnosed with BPD, the following synthesis adopted a meta-ethnographic approach. This method, originally developed by Noblit and Hare (1988) and later adapted for health and mental health research (Britten et al., 2002; Cahill et al., 2018; Sattar et al., 2021), is well-suited for synthesising qualitative studies that seek to understand lived experience. Meta-ethnography is designed to move beyond summarising findings and instead aims to interpret and translate qualitative data across studies in order to generate new conceptual understandings. It involves identifying both similarities and contradictions across individual studies and involves synthesising them into a coherent narrative. This process results in a synthesis that may take the form of a reciprocal translation, where studies report similar or overlapping concepts. It may also involve a refutational translation, where findings differ or contradict each other. Alternatively, it can produce a line of argument synthesis, which brings the findings together to offer a broader interpretive explanation of the phenomenon under study. The current review follows the

seven-phase framework outlined by Noblit and Hare (1988), whilst also acknowledging the inherently iterative nature of the process. These stages are: getting started; deciding what is relevant; reading the studies; determining how the studies are related; translating the studies into one another; synthesising the translations and expressing the synthesis. Each stage is carried out reflexively, with attention to both conceptual richness and methodological rigour, to ensure a synthesis that is grounded in participants' perspectives and meaningful across contexts. The review protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO; CRD420261447305) to provide transparency regarding the methodology, eligibility criteria and planned approach to the synthesis.

2.2.2 Inclusion and Exclusion Criteria

The SPIDER framework (Sample, Phenomenon of Interest, Design, Evaluation and Research type; Cooke et al., 2012) was used to define the inclusion and exclusion criteria (see Table 2).

Table 2

Inclusion and Exclusion Criteria

Parameter	Inclusion criteria	Exclusion criteria
Sample	Current or previous diagnosis of BPD	No current or previous diagnosis of BPD; accounts given from the perspective of others (e.g. carers, clinicians)
Phenomenon of Interest	Recovery	Does not explore experiences of recovery
Design	Interviews Focus groups	Insufficient qualitative depth for meta-ethnographic synthesis

Evaluation	Relates to the perspectives of recovery	Does not relate to the perspectives of recovery
Research type	Qualitative	Quantitative; systematic reviews

Eligibility criteria were developed in line with the aim of the review and the interpretive methodology of meta-ethnography (Noblit & Hare, 1988). Consistent with this, studies were included if they involved participants with a current or previous diagnosis of BPD and excluded if they did not include first-person accounts or instead reported the perspectives of carers, clinicians or other third parties. The phenomenon of interest was defined as recovery, with inclusion limited to studies that explicitly explored experiences and perspectives of recovery from BPD; studies that did not address recovery perspectives were excluded as they did not contribute to the focus of the synthesis. Only qualitative studies which used interviews or focus groups were included, as these methods typically generate rich, interpretive narrative data suitable for reciprocal and refutational translation within meta-ethnography. Qualitative and mixed methods studies that lacked sufficient qualitative depth were excluded as they were unlikely to provide the conceptual richness that is required for synthesis (Atkins et al., 2008). Studies were also required to relate directly to participants' perspectives of recovery in BPD, and studies not addressing recovery perspectives were excluded. Quantitative studies and systematic reviews were excluded as they do not produce the primary qualitative accounts necessary for meta-ethnographic synthesis. Additional criteria relating to the publication type and language were made. Both peer-reviewed and grey literature sources were eligible for inclusion to maximise comprehensiveness and reduce publication bias, provided sufficient methodological detail was available to support appraisal

and interpretation. Finally, studies published in English or translated into English were included. Due to pragmatic constraints on translation resources, non-English-language studies excluded to ensure consistency in data extraction and interpretive analysis.

2.2.3 Search Strategy

A systematic literature search of several EBSCO databases (Medline Ultimate, CINAHL Ultimate, PsycINFO) and Web of Science was completed on 10.05.2025 to include all documents from the earliest available date to May 2025. The adapted SPIDER framework (Cooke et al., 2012) was used to inform the search strategy. Search terms were identified within titles, abstracts or keywords (see Table 3).

Table 3

Search Terms Used on PsycINFO, CINAHL Ultimate, Medline Ultimate and Web of Science

SPIDER	Search terms
Sample	1. EUPD OR “Emotionally unstable personality disorder” OR BPD OR “Borderline personality” OR “Borderline personality disorder”
Phenomenon of Interest	2. Recovery OR Recovering OR Recovered
Design	3. “qualitative interviews” OR “focus groups” OR interviews OR “semi-structured interviews” OR “unstructured interviews” OR “in-depth interviews” OR “narrative interviews” OR “ethnographic interviews” OR “open-ended interviews”
Evaluation	4. Attitudes OR Experiences OR views OR perspectives OR beliefs OR Perceptions
Research type	5. Qualitative OR “qualitative study” OR “qualitative method*” OR “qualitative research”
	6. #1 AND #2 AND #3 AND #4 AND #5

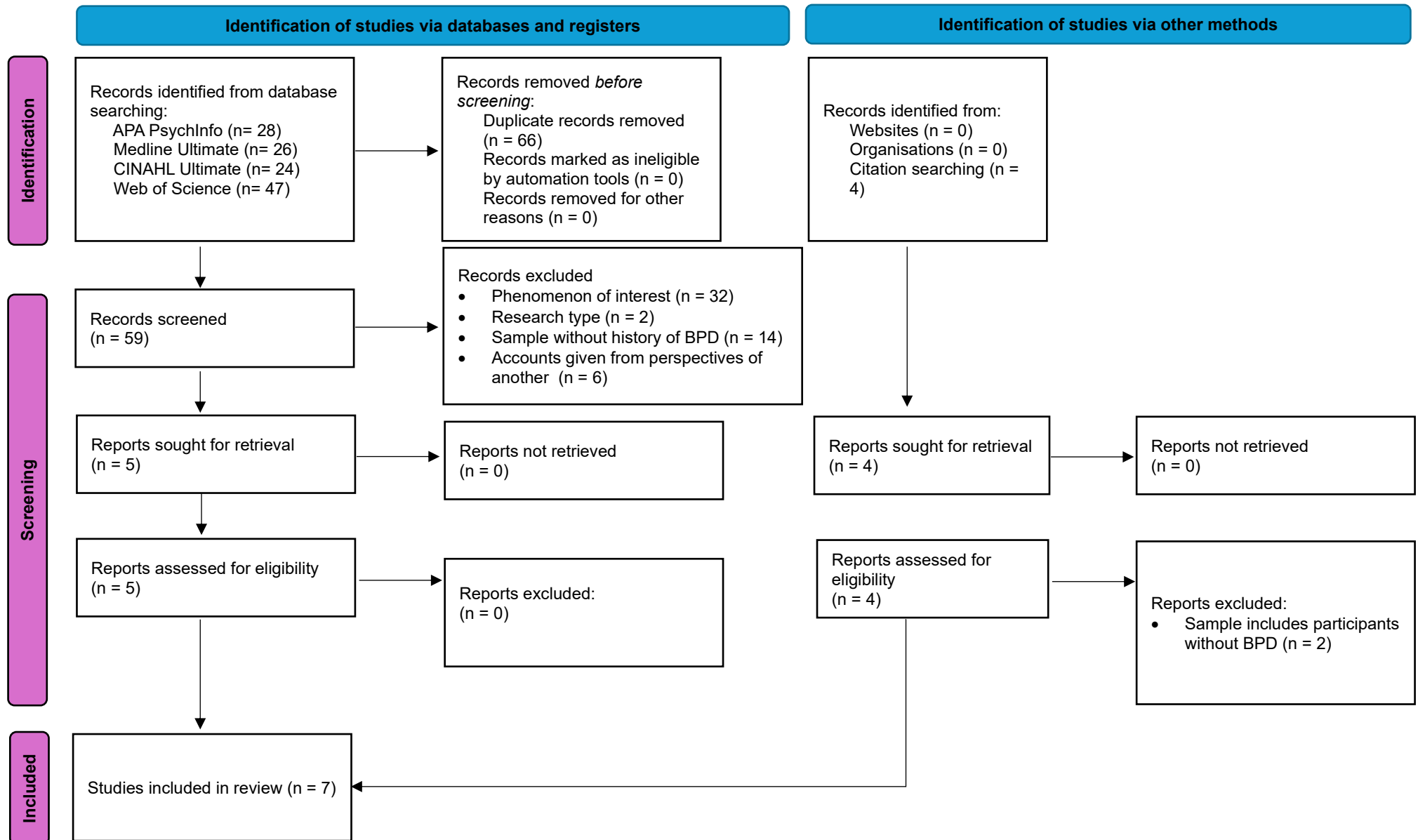
The final search term included searching of #1 AND #2 AND #3 AND #4 AND #5. A total of 125 results were found and 66 duplicates were removed. Titles and abstracts of the remaining 59 results were screened by the primary researcher against the inclusion and exclusion criteria and 54 papers that did not meet the criteria were removed. 32 papers were

excluded as they did not explore recovery as the primary phenomenon of interest or did not report participants' experiences or meanings of recovery. Two papers were excluded due to the research type: one involved the use of methodology with an insufficient qualitative depth (Soloff, 2021) and one was a systematic review (Lamont & Dickens, 2021). In addition, 14 studies were excluded due to the sample not including individuals with a history of BPD, and a further six papers were excluded due to the sample involving accounts from the perspectives of those without a diagnosis of BPD. Just two dissertation papers were found, and both were excluded due to not focusing on recovery in individuals diagnosed with BPD. Further, no conference abstracts were discovered through the search and no records that were not written or accessible in the English language were found.

Subsequently, full texts of the remaining five studies were read and screened to determine eligibility. A further four papers were assessed for eligibility following scrutiny of the remaining five papers' reference lists. However, of these, two papers were excluded due to the samples including participants without a history of BPD (Gillard et al., 2015; Shepherd et al., 2017) which meant that an additional two papers were identified as eligible from this process. Seven eligible papers with a total of 120 participants were identified and used in the final synthesis. To illustrate the search strategy in full, a PRISMA flow diagram (Page et al., 2021) of the search process is presented in Figure 1.

Figure 1

PRISMA Flow Diagram of Search Process (Page et al., 2021).



2.2.4 Characteristics of the Included Studies

Study characteristics of the included papers were recorded and are reported in Table 4.

Table 4

Study Characteristics

Study	Setting	Sample size and gender	Sample age range/mean	Ethnicity	Data collection, analysis
Donald et al., (2017)	Australia, 1 Community Specialist Personality Disorder treatment service	N= 17 (2 Male, 15 Female)	Mean 33.9 19 – 59 yrs	-	Thematic analysis within a grounded theory framework. Interviews.
Katsakou et al., (2012)	UK, 2 Community Specialist BPD treatment services, 3 CMHTs and 1 psychological therapies service	N= 48 (9 male, 39 female)	Mean = 36.5	White = 33 Black = 5 Asian = 10	In-depth semi-structured interviews. The study drew on grounded theory and thematic analysis.
Kverme et al., (2019)	Norway, receiving community treatment for BPD	N= 12 females	Between 21-36 yrs	-	Thematic analysis, in-depth interviews
Larivière et al., (2015)	Canada, completed minimum 2 years in specialised BPD treatment	N= 12 12 female	23 to 63 (mean = 37.2)	-	Thematic analysis, semi-structured interviews and picture collage
Liljedahl et al., (2023)	Sweden, Non-profit organisation	N= 9 females	Median = 32 Range 24-41	European= 9	Semi-structured interviews, thematic analysis
Mooney et al., (2023)	Australia, Receiving treatment from community mental health services	N= 12 10 female, 2 male	mean: 35.5 years range: 22–58 years	-	in-depth, semi-structured interviews, thematic analysis
Sarwendah et al., (2022)	Indonesia, Receiving pharmacotherapy and/or psychotherapy	N= 10 3 male, 7 female	Mean: 29.5. range: 18-43.	-	In-depth interviews, descriptive phenomenology

Note: - denotes information was not reported.

Spanning six countries, the studies were conducted in the United Kingdom, Australia, Sweden, Norway, Canada and Indonesia. Most participants at the time of recruitment in the included studies were engaged in treatment for BPD. The majority of the studies sampled individuals receiving treatment from either community mental health teams or specialist

treatment services for BPD (Donald et al., 2017; Katsakou et al., 2012; Kverme et al., 2019; Mooney et al., 2023). Whereas, one study (Liljedahl et al., 2023) recruited participants who were receiving treatment from a non-profit organisation and Sarwendah and colleagues (2022) did not specify the type of service that participants were receiving either pharmacological or psychotherapy care from. Larivière and colleagues (2015) sampled participants who had all completed a minimum of two years treatment, although it was unclear whether they were still receiving treatment at the time of recruitment. Sample sizes ranged from nine to 48; the lowest reported participant age was 18 and the highest was 59. Three studies exclusively sampled females (Kverme et al., 2019; Larivière et al., 2015; Liljedahl et al., 2023) and the remaining papers sampled males also, although they made up the minority of the samples. All studies utilised interviews for their main data collection method. Although, one study (Larivière et al., 2015) combined the use of semi-structured interviews with picture collages to collect their data. For data analysis, Sarwendah et al., (2022) utilised descriptive phenomenology, whilst all other studies utilised either thematic analysis or grounded theory.

2.2.5 Quality Appraisal

The quality assessment of the included studies was conducted using the CASP checklist (Critical Appraisal Skills Programme, 2018). The checklist is structured to appraise each paper's methodological quality, recruitment, data collection and analysis, bias, ethical considerations, findings and the overall value of the research. Each study was evaluated to determine whether it met, did not meet, or if it was unclear whether it met the criteria for each quality indicator. The decision to not exclude studies on the grounds of perceived poor quality was made in advance. This was due to the consideration that the absence of adequate description of methods may not necessarily equate to poorly conducted research (Atkins et

al., 2008). Results of the quality appraisal using the CASP are outlined in Appendix A (Table A1).

All studies adhered to at least eight out of ten criteria in the CASP quality checklist, with four studies (Katsakou et al., 2012; Liljedahl et al., 2023; Mooney et al., 2023; Sarwendah et al., 2022) scoring nine out of ten and one study (Kverme et al., 2019) that met all ten areas. All but one study (Donald et al., 2017) failed to explicitly state that ethical approval was granted, and hence did not meet the criteria for ethical considerations, whilst Kverme and their colleagues (2019) were exclusively noted to explain their ethical considerations very well. Kverme and colleagues (2019) were also the only study that acknowledged the relationship between the research team and participants, namely that there was no treatment relationship between them. While Katsakou et al., (2012) mentioned that some of the research team worked with people with BPD clinically, it was unclear as to whether this clinical experience related directly to the participants. It was a concern that all other studies omitted this information which means that the relationships between the researchers and participants is unclear. Notably, few studies offered co-production with individuals with lived experience, which could have enriched the reflexivity and depth of the studies. Despite these concerns, all studies met the criteria for aims and provided conceptually rich findings suitable for meta-ethnographic synthesis. The studies present valuable contributions to the field, and their qualitative methods were deemed appropriate for their aims.

2.2.6 Reading the Studies

The researcher repeatedly read and re-read each study to become familiarised with the findings. Raw data extraction involved identifying first-order and second-order constructs from the studies. First-order constructs are the research participants' own words; second-order constructs are the researchers' interpretations of the first-order constructs, which are

often described as themes, metaphors and concepts used to interpret the phenomena being investigated (Cahill et al., 2018). First-order and second-order constructs were extracted and collated into tables (see Appendix B) using either identical or similar language to the original studies to elicit the authors' intended meanings. During this process, each study was considered within the framework of its contextual characteristics, which were the sample characteristic details (see Table 4) in order to preserve the impact of context and culture on the findings.

2.2.7 Determining How the Studies Are Related

In meta-ethnography, the synthesis approach is determined by how studies are related. Comparison of first-order concepts, second-order concepts and contextual characteristics across the seven studies aimed to uncover similarities, differences and connections. Through this process, it transpired that the studies appeared to share commonalities, which formed the basis for further exploration with the assumption of the studies being reciprocal in nature.

2.2.8 Translating Studies Into One Another

Reciprocal synthesis involved translating studies by mapping their original concepts into one another. Utilising a constant comparison method (Charmaz, 2006), studies' first and second-order concepts (Appendix B) and their corresponding contextual characteristics (Table 4) were juxtaposed. A cross comparison of key concepts by study is included in Table 5.

Table 5*Cross Comparison of Studies by Concept*

Third-order concepts	Donald et al., (2017)	Katsakou et al., (2012)	Kverme et al., (2019)	Larivière et al., (2015)	Liljedahl et al., (2023)	Mooney et al., (2023)	Sarwendah et al., (2022)
Recovery as ambivalent	✓	✓	✓	✓	✓	✓	-
Reconstructing a Coherent and Compassionate Self	✓	✓	✓	✓	✓	✓	✓
Understanding and Regulating Emotions	-	✓	✓	✓	-	✓	✓
Increased agency and responsibility	✓	✓	✓	-	✓	✓	-
Relational connection	✓	✓	✓	✓	✓	✓	✓
Experiences with mental health services	-	✓	✓	✓	✓	✓	✓
Meaningful occupation	-	✓	-	✓	✓	-	✓

Note. – means that the concept is not present within the study.

Seven key concepts emerged: recovery as ambivalent; reconstructing a coherent and compassionate self; understanding and regulating emotions; increased agency and responsibility; relational connection; experiences with mental health services and meaningful occupation.

2.2.9 Synthesising Translations

The aim within this stage was to view the studies as a whole, rather than as parts (Noblit & Hare, 1988). As recommended by Sattar et al., (2021), the decision was made to break stage six of the meta-ethnography down into the following stages; (a) reciprocal synthesis and (b) lines of argument synthesis.

(A) Reciprocal Synthesis. Across the studies, recovery experiences described by participants aligned with personal recovery definitions (Slade, 2009). Further, similar recovery related concepts emerged across studies, although they were sometimes framed differently. Most studies adopted a retrospective and optimistic perspective, which identified factors that facilitated recovery. However, Sarwendah et al., (2022) focused on barriers to recovery and therefore described many of the same concepts in inverse form. For example, Sarwendah and colleagues (2022) highlighted several challenges associated with relational connection in terms of recovery, whilst all other studies described the impact that improving their relational connectivity had on recovery. This difference in framing reflected different stages or perspectives within the recovery journey rather than conceptual contradictions. Likewise, where a translated concept was not identified in a particular study (as indicated by a ‘-’ in the cells of Table 5), it was interpreted as a difference in emphasis as opposed to evidence against the concept. As such, a refutational synthesis was deemed unnecessary. This was because the translated concepts demonstrated sufficient conceptual alignment to allow for a reciprocal synthesis. Consequently, seven translated concepts were integrated and reinterpreted to form broader, overarching themes. These overarching themes represent the

researcher's interpretive contribution, which are referred to as third-order concepts (Cahill et al., 2018). These third-order concepts were further developed through a line-of-argument synthesis to construct a more comprehensive understanding that incorporated both facilitators and barriers to recovery.

(B) Lines of Argument Synthesis. The comparison of study tables revealed that each study explored nuanced aspects of recovery in individuals with a diagnosis of BPD, which could usefully be brought together to construct a new interpretation about the phenomena of recovery. As such, following the emergence of three overarching themes, a line of argument synthesis facilitated the construction of a conceptual model which made sense of the relationships between them.

2.2.10 Expressing the Synthesis

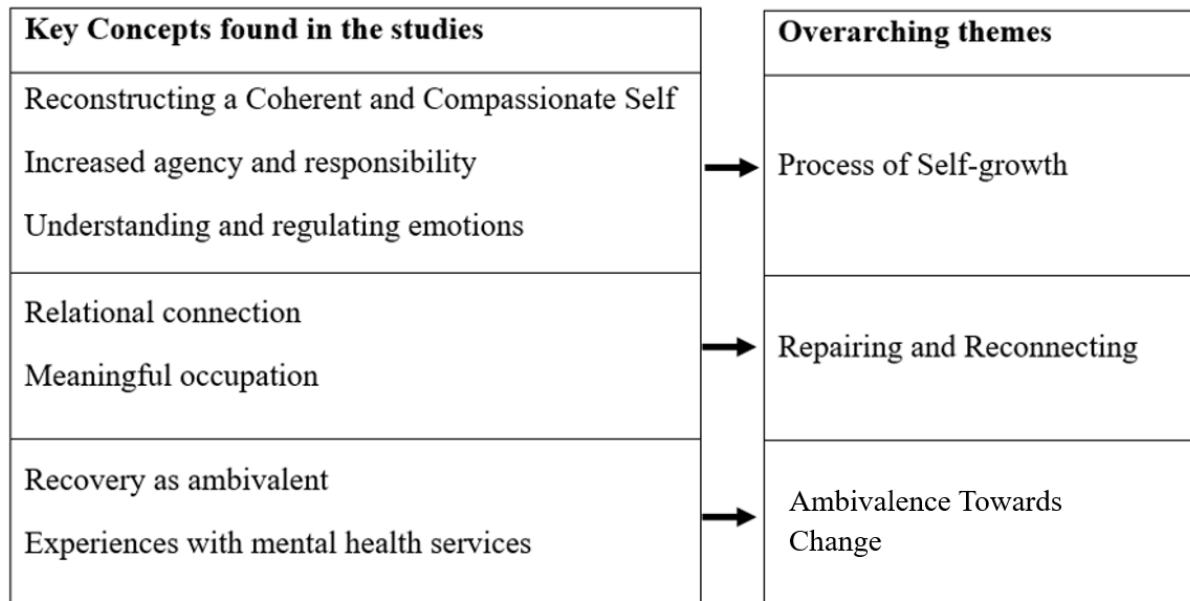
The hope is that valuable knowledge will be accessible to healthcare professionals, policy makers and laypersons alike by synthesising the qualitative findings (Toye et al., 2014). Therefore, it is essential that the synthesis is expressed clearly, in a manner which is easily accessible to a wide audience. As suggested by Toye et al., (2014), the synthesis was presented in textual format, and a simple diagram was utilised to explain the line of argument, all of which are discussed in the results section.

2.3 Results

The seven key concepts found in the studies were reciprocally synthesised into three broader overarching themes: process of self-growth, repairing and reconnecting and ambivalence towards change (see Figure 2).

Figure 2

Overview of Key Concepts and Synthesised Broader Categories



2.3.1 Overarching Theme One: Process of Self-Growth

Reconstructing a Coherent and Compassionate Self. Participants across studies described recovery to involve developing a more coherent, autonomous and compassionate sense of self. Prior to this, some experienced themselves as disconnected or elusive, having neglected their own thoughts and emotions (Kverme et al., 2019). Through being understood and having their experiences validated, they developed a clearer sense of “me”, which fostered self-respect in a newfound way (Kverme et al., 2019). Some participants in Mooney and colleagues’ (2023) study worked directly through traumatic experiences through Eye Movement Desensitisation and Reprocessing (EMDR) therapy and for some, processing trauma resulted in no longer blaming themselves for their trauma and its resultant psychological and behavioural impact (Donald et al., 2017). Conversely, others desired to distance from painful memories or unhealthy relational dynamics (Donald et al., 2017; Larivière et al., 2015; Mooney et al., 2023; Sarwendah et al., 2022). Larivière et al., (2015) discussed how participants individuated by clarifying their values, roles, and aspirations as

women, and moved toward emotional independence. Greater self-understanding was linked to increased confidence and reduced shame (Katsakou et al., 2012). Assertiveness and expressing needs were seen as reflections of growing self-worth (Larivière et al., 2015). Feeling loved and valued by others further strengthened self-acceptance (Kverme et al., 2019; Liljedahl et al., 2023). Mindful awareness and engagement in meaningful activities consolidated identity development, particularly when participants experienced themselves as capable and impactful upon others (Mooney et al., 2023; Liljedahl et al., 2023).

Increased Agency and Responsibility. Across studies, recovery was conceptualised as involving the development of increased agency, responsibility and belief in the possibility of change (Donald et al., 2017; Katsakou et al., 2012; Kverme et al., 2019; Mooney et al., 2023; Liljedahl et al., 2023). In Donald and colleagues' (2017) study, participants described moving toward acceptance of their difficulties alongside a growing willingness to change, which was underpinned by the belief that change was achievable. Similarly, Katsakou et al., (2012) reported that participants expressed a desire to become more competent in managing life's problems, more independent and gradually less reliant on mental health services. Kverme et al., (2019) identified being an active agent in one's recovery as pivotal, with participants highlighting the importance of being encouraged to learn how to help themselves, which was closely linked to taking ownership of the recovery process. This ownership extended beyond behavioural change to developing curiosity about one's thoughts, feelings, and actions, including reflecting on the impact of past behaviours on others. Learning to distinguish between emotional experiences and behavioural responses supported participants in exercising greater choice, rather than reacting automatically to distress (Kverme et al., 2019; Mooney et al., 2023). Experiencing such agency appeared to enhance engagement in treatment and foster empowerment beyond the end of therapy programmes. In contrast, some participants described not being encouraged toward self-

agency, instead experiencing attempts by others to change them, which led to a more passive stance of waiting for recovery to occur (Kverme et al., 2019). Recovery was also described as redirecting inner strengths previously used to sustain self-destructive behaviours toward constructive goals, cultivating skills learned in therapy, and developing the capacity to shape one's life in accordance with present and future aspirations. Mooney et al., (2023) likewise identified commitment to improving one's mental health as paramount, describing recovery as involving belief in the therapeutic process, having a voice in how the journey unfolds and not waiting passively to be "fixed".

Developing Emotional Awareness and Regulation. Across studies, recovery was centrally associated with developing the capacity to understand, tolerate and regulate intense emotional states. Participants described learning to experience distressing emotions without avoidance or fear, alongside gradually reducing urges toward self-harm, suicidality, substance misuse and disordered eating (Katsakou et al., 2012; Mooney et al., 2023). Intense emotions were frequently described as overwhelming and closely linked to triggers such as interpersonal conflict, loneliness, stress, trauma reminders, perfectionism and self-loathing (Mooney et al., 2023; Sarwendah et al., 2022). Maladaptive coping behaviours, including self-harm and substance use, were often conceptualised as attempts to manage dysregulated emotions, with some participants describing cycles of replacing one addictive behaviour with another (Mooney et al., 2023). Learning practical strategies to interrupt escalating emotional states was experienced as a critical step in recovery. Participants also described a general curiosity about their inner experiences, and described acquiring skills that enabled them to break emotional spirals and reduce reliance on harmful coping behaviours (Kverme et al., 2019; Mooney et al., 2023). For some, approaches such as mindfulness became newly meaningful when reframed in ways that felt accessible and relevant (Mooney et al., 2023). Across accounts, Larivière et al., (2015) reported that all participants affirmed they were

either able, or wished, to deal better with their emotions and felt less guided by them in everyday life. Some participants in this study reported that they no longer experienced suicidal thoughts. Although intense emotions were often experienced as an intrinsic part of the self, recovery involved developing the capacity to coexist with these emotions without being overwhelmed by them (Mooney et al., 2023; Sarwendah et al., 2022).

2.3.2 Overarching Theme Two: Repairing and Reconnecting

Relational Connection. Across studies, recovery was conceptualised as fundamentally relational, involving the gradual reconstruction of trust, safety, and belonging following experiences of relational trauma, invalidation and social alienation (Donald et al., 2017; Katsakou et al., 2012; Kverme et al., 2019; Larivière et al., 2015; Liljedahl et al., 2023; Mooney et al., 2023; Sarwendah et al., 2022). Rather than being framed as an individual or intrapsychic achievement, becoming well was described as unfolding within relationships that were experienced as emotionally available, authentic and non-judgemental. Supportive and reciprocal relationships, whether with professionals, peers, family members, partners, or community members, were consistently described as stabilising (Donald et al., 2017; Larivière et al., 2015; Liljedahl et al., 2023; Mooney et al., 2023; Sarwendah et al., 2022). Group-based therapeutic settings were particularly powerful in reducing isolation, fostering connection and enabling participants to witness others' progress, which in turn strengthened belief in their own capacity for change (Donald et al., 2017; Kverme et al., 2019). For some, relationships with animals provided an accessible and soothing form of connection (Liljedahl et al., 2023), while spiritual faith functioned as a stabilising relational resource (Sarwendah et al., 2022). However, relational recovery was not straightforward. Across studies, participants described longstanding difficulties with trust, vulnerability, and fears of rejection or abandonment, which was often rooted in earlier experiences of neglect, abuse, bullying,

parental mental health difficulties or familial invalidation of their diagnosis (Katsakou et al., 2012; Sarwendah et al., 2022).

Meaningful Occupation. Across studies, engagement in meaningful activities and participation in valued social roles were consistently described as central to recovery. Participants in Katsakou and colleagues' (2012) study emphasised that completing everyday tasks they had previously found difficult, such as paying bills, managing a household, using public transportation, or going on holiday enhanced their confidence and sense of functional stability. Achieving these practical milestones was experienced as evidence of progress and increasing competence in daily life. Employment and educational attainment were particularly salient markers of recovery. Participants described aspirations to secure work, maintain jobs, complete studies, and progress in their careers, which fostered a sense of productivity and "normality" (Katsakou et al., 2012; Larivière et al., 2015). Engagement in meaningful roles, such as a spouse, parent, student, or community member, was also described as important (Larivière et al., 2015). Liljedahl et al., (2023) further highlighted the significance of achieving major life milestones, including graduating or getting married, which were described as symbolising freedom and rejoining society following periods of institutionalisation. However, Sarwendah et al., (2022) reported that BPD-related difficulties often disrupted occupational stability, with some participants describing frequent job changes and difficulty tolerating roles that felt misaligned with their needs or capacities. Overall, participation in meaningful activities and socially valued roles was experienced as pivotal in restoring a sense of competence and belonging within broader society during recovery.

2.3.3 Overarching Theme Three: Ambivalence Towards Change

Recovery as Ambivalent. Across studies, ambivalence emerged as a defining feature of recovery from BPD. Participants frequently described a simultaneous desire for change alongside uncertainty, resistance or fear regarding what recovery might entail (Donald et al.,

2017; Mooney et al., 2023). For some, the term “recovery” felt inappropriate or misleading, with preferences expressed for alternatives such as “management”, “journey” or “being functional” (Donald et al., 2017; Larivière et al., 2015). Recovery was sometimes perceived as implying a binary state, being that of recovered versus not recovered, which did not reflect participants’ lived experience of fluctuation (Katsakou et al., 2012). Several participants described full recovery as unattainable, and they struggled to imagine a life without ongoing emotional difficulties (Larivière et al., 2015). The idea of being “recovered” could evoke anxiety, including concerns about losing aspects of their identity which were tied to intense emotions or becoming complacent and vulnerable to relapse (Donald et al., 2017; Katsakou et al., 2012). Emotional intensity and familiar coping behaviours, while distressing, were sometimes experienced as integral to the self, which created an internal conflict about replacing them (Mooney et al., 2023).

Recovery was widely depicted as non-linear, and was characterised by oscillations between periods of stability and struggle (Katsakou et al., 2012; Liljedahl et al., 2023). Rather than a definitive endpoint, it was more commonly framed as an ongoing process involving continued coping, adaptation and deliberate effort (Larivière et al., 2015; Liljedahl et al., 2023). Psychological barriers including shame, stigma associated with the diagnosis and concealment of symptoms further complicated engagement with recovery (Mooney et al., 2023).

Recovery was also connected to hope and a belief in the possibility for change. Further, participants who experienced moving forward in the process of recovery expressed that they were actively pursuing steps towards it (Kverme., 2019). Recovery also involved developing self-compassion and giving themselves permission to recover. In the context of treatment, it was important for therapists to provide flexibility and empathy (Kverme et al., 2019). More specifically however, Liljedahl et al., (2023) discussed recovery to look like

completing therapy and no longer self-harming. They added that a sense of enduring high functioning and distance from suffering reflected recovery.

Experiences with Mental Health Services. Across studies, experiences with mental health services were described as complex and often ambivalent, reflecting both transformative support and systemic shortcomings. In Katsakou and colleagues' (2012) study, some participants expressed frustration with interventions such as DBT, which, although beneficial for reducing self-harm and improving emotional regulation, were perceived as too narrow or misaligned with their broader personal goals. Conversely, Larivière et al., (2015) highlighted that specialised BPD programmes represented important steps toward recovery and improved well-being. Receiving an accurate diagnosis was described by some participants as a pivotal "lightbulb" moment that facilitated insight, legitimised experiences and enabled access to specialised services (Mooney et al., 2023). However, reluctance to accept a BPD diagnosis due to fear of stigma, alongside mistrust resulting from misdiagnosis or difficulty accessing appropriate care, created significant barriers (Mooney et al., 2023; Sarwendah et al., 2022). Self-diagnosis prior to professional consultation was common and generally experienced negatively (Sarwendah et al., 2022). Kverme et al., (2019) reported that feeling psychologically safe within treatment enabled participants to feel trust and to focus on recovery rather than feeling guarded; whereas the absence of openness, mutuality, transparency and trust created insecurity and hindered progress. Liljedahl et al., (2023) emphasised that multiple and sometimes intensive therapies were necessary for some individuals, with self-understanding emerging over time rather than within prescribed treatment durations.

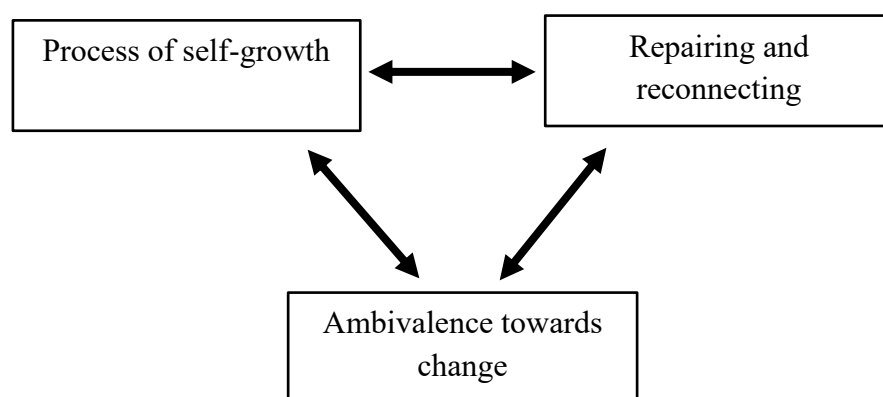
2.3.4 Line-of-Argument Synthesis

This meta-ethnography conceptualises recovery from BPD as an ongoing journey of self-growth and repairing and reconnecting which unfolds within a context of enduring

ambivalence towards change. The three overarching themes: process of self-growth, repairing and reconnecting, and ambivalence towards change do not operate sequentially, rather, they function as interdependent and mutually reinforcing processes. As such, whilst depicted as separate overarching themes, self-growth frequently occurred within validating relational contexts, while relational repair was sustained through increased self-understanding, regulation and agency. In this way, intrapersonal and interpersonal change were reciprocally constituted. Ambivalence operates as a foundational and continuous thread running through both areas. Participants simultaneously desired and feared change, valued and resisted aspects of their emotional intensity, and experienced services as both enabling and constraining. Recovery was consistently described as non-linear, and was marked by oscillation rather than steady progression. Ambivalence therefore does not represent failure or resistance; instead, it reflects the inherent tension involved in recovery. Figure 3 represents this synthesis diagrammatically.

Figure 3

Line-of-Argument Synthesis: Recovery in Individuals with a Diagnosis of BPD



The bidirectional arrows between the three recovery processes illustrate their reciprocal and mutually reinforcing relationships. Participants did not describe these

processes as occurring in a fixed sequence; rather, change within one process often shaped, and was shaped by, change within the others. For example, shifts in sense of self often emerged within relational contexts, while developments in relationships were similarly supported by increased self-understanding, agency and personal growth. Ambivalence towards change forms an underlying condition within the model, reflecting the ways in which recovery unfolds within persistent tension, including tensions embedded in the concept of “recovery” itself and within experiences of mental health services. Rather than being resolved, this ambivalence persisted over time and shaped movement across all processes.

2.4 Discussion

This meta-ethnographic synthesis of seven qualitative studies offers a conceptual reframing of recovery from BPD. Recovery, that is, self-growth and repairing and reconnecting with others being the intention, however an important caveat is that ambivalence towards change is woven throughout the process. Taken together, these findings suggest that recovery from BPD may be better understood not as a linear progression towards symptom remission, but as a relational and identity-based process shaped by both intrapersonal change and evolving interpersonal connections.

The prominence of ambivalence within the findings also reflects the broader conceptual ambiguity surrounding both BPD and recovery within the existing literature. Recovery itself remains a contested and multifaceted construct, which encompasses symptom reduction, improved functioning and the development of a meaningful life beyond diagnosis. It is therefore unsurprising that participants frequently expressed uncertainty about whether recovery was attainable or even desirable, with some questioning what recovery might look like for them in practice. Such uncertainty highlights the tension between clinical conceptualisations of recovery and the more fluid and personally defined meanings that individuals attach to their experiences of change.

An interesting pattern observed across the included studies relates to the relative emphasis placed on individual agency versus relational support within recovery narratives. For example, Kverne and colleagues (2019) placed notable emphasis on participants being encouraged to develop personal agency and responsibility within their recovery, whereas Sarwendah and colleagues (2022) foregrounded the importance of support from family and others, with less explicit emphasis on the role of individual self-agency. One possible interpretation is that these differences may reflect broader cultural orientations towards autonomy and relational interdependence, as Kverne and colleagues (2019) conducted their study within a Norwegian context and Sarwendah and colleagues (2022) from an Indonesian context. For instance, Scandinavian contexts such as Norway are often characterised by strong cultural values around individual autonomy and self-determination, whereas societies such as Indonesia place greater emphasis on collectivist and relational forms of identity. However, given the small number of studies included and the potential influence of methodological and service-context differences, such interpretations remain tentative. Nonetheless, this observation may highlight the importance of considering how cultural contexts shape the ways in which recovery from BPD is conceptualised and experienced.

An additional observation that emerged across several studies relates to how participants conceptualised emotional change within recovery. In several accounts, recovery was described in terms of learning to detach from painful memories, control emotions and manage distress more effectively. As such, this may reflect a focus on stabilisation rather than processing of traumatic experiences. Notably, explicit discussion of working through or processing trauma was present in just two studies (Donald et al., 2017; Mooney et al., 2023). This is somewhat striking given the well-established association between BPD and histories of trauma (Linehan, 1993). Trauma-informed perspectives suggest that long-term recovery may involve not only managing emotional responses but also integrating and making sense of

traumatic memories and relational experiences. In contrast, the emphasis on emotional control described in some narratives aligns more closely with treatment models such as Linehan's (1993) biosocial model which underpins DBT, in which the development of skills such as distress tolerance and emotion regulation is prioritised in order to stabilise behaviour and reduce crisis responses. Consequently, recovery may sometimes be conceptualised primarily in terms of improved emotional regulation and behavioural stability, rather than the processing or integration of traumatic experiences. The relative absence of trauma processing in many accounts raises questions about whether the existing literature may underrepresent this aspect of recovery, or whether participants themselves conceptualise recovery primarily through the lens of emotional management.

Furthermore, these findings may have important implications for clinical practice. Conceptualising recovery as an ongoing, non-linear and relational process suggests that therapeutic approaches should move beyond narrow symptom-reduction models and instead attend to the broader processes through which individuals rebuild identity, renegotiate relationships and make sense of their experiences over time. Interventions may therefore benefit from supporting both intrapersonal development and relational repair while recognising that these dimensions are closely intertwined. The prominence of ambivalence within participants' narratives further highlights the importance of clinicians adopting flexible and collaborative approaches to recovery which allow space for individuals to define what recovery means for them rather than imposing externally defined goals. Additionally, the observation that some recovery narratives emphasised emotional regulation over trauma processing may underscore the value of interventions focusing on developing emotion regulation skills. Taken together, these findings suggest that services supporting individuals diagnosed with BPD may benefit from adopting approaches that are relational, trauma-informed and attentive to the evolving and personalised nature of recovery.

2.4.1 Limitations

This meta-ethnography is not without limitations. First, the synthesis included seven studies, which may limit how fully the range of experiences and key ideas about recovery in individuals diagnosed with BPD are represented. While the included studies provided rich qualitative data, the small number of studies means that some experiences of recovery may not be captured within the synthesis. As a result, the resulting synthesis should be understood as a conceptual interpretation of a partial and developing evidence base rather than a comprehensive account of recovery experiences. Second, the majority of participants across the included studies were currently engaged in, or had recently engaged with, mental health services. Consequently, the synthesis may primarily reflect “in-service” recovery narratives, which may be shaped by interactions with clinical systems and structured treatment programmes. This may limit the extent to which the findings capture experiences of individuals who are not engaged with services, who have disengaged from services, or who conceptualise recovery outside of clinical frameworks. In addition, the included studies were conducted across six different countries and healthcare systems. This means participants’ experiences were likely shaped by local service contexts and cultural understandings of BPD. These differences are particularly relevant because diagnostic and treatment practices can vary internationally (Jani et al., 2016), and may therefore shape how recovery is described and understood. Finally, as with all meta-ethnographies, the synthesis is inherently interpretive, and the development of third-order constructs reflects the researcher’s analytical decisions in translating and integrating findings across studies. Rather than seeking to eliminate interpretive influence, reflexivity was used as a methodological safeguard throughout the analytic process to ensure transparency in how interpretations were developed and how alternative readings of the data were considered. While this approach enhances the

trustworthiness of the synthesis, it is acknowledged that alternative interpretations of the same dataset are possible.

2.5 Rationale for Current Thesis and Research Question

The findings of this meta-ethnography provide insight into how recovery from BPD is experienced, and it conceptualises recovery as a non-linear process which involves self-growth, relational reconnection and the navigation of ongoing ambivalence to change. While these findings illuminate what recovery may look like for individuals diagnosed with BPD, they provide more limited insight into the processes through which individuals move towards these positions over time. In particular, relatively little is known about the mechanisms and turning points that shape recovery trajectories, or how individuals sustain progress while navigating setbacks. Developing an understanding of these processes represents an important next step in recovery research, as it would shift the focus from recovery as an outcome towards recovery as an ongoing and dynamic process. Such research has the potential to inform clinical practice by offering insights into how services and clinicians can support recovery in ways that are more process-oriented and person-centred. Furthermore, the meta-ethnography identified limited qualitative research which explored recovery from BPD within a UK context. The only UK study included (Katsakou et al., 2012), which was conducted over a decade ago and involved participants who were currently engaged in treatment, focusing primarily on service users' perspectives on how treatment contributed to positive outcomes. As a result, the findings may be shaped by specific treatment-related experiences and may not fully capture broader recovery processes occurring outside of service contexts. Taken together, these limitations highlight important gaps in the literature and underscore the need for further research which explores how recovery in individuals who have received a diagnosis of BPD unfolds over time within a contemporary UK context which does not exclude individuals who are not currently engaged with treatment. The research question for

the current thesis is therefore as follows: How do individuals who have received a diagnosis of borderline personality disorder describe the processes through which recovery becomes possible?

2.6 Chapter Summary

This chapter presented a meta-ethnographic synthesis of seven qualitative studies which explored how individuals diagnosed with BPD understand and experience recovery. Through reciprocal translation and line-of-argument synthesis, three overarching themes were identified: process of self-growth, repairing and reconnecting and ambivalence towards change. The findings suggest that recovery is best conceptualised as a dynamic, non-linear process which is shaped by the interaction between intrapersonal changes and relational experiences. Ambivalence towards change emerged as a persistent feature of recovery, which reflected tensions surrounding identity, emotional change and engagement with services. The synthesis highlighted the relational and contextual nature of recovery and identifies important gaps in understanding the processes through which recovery unfolds, which informed the rationale for the subsequent empirical study.

CHAPTER THREE: METHODOLOGY

3.1 Chapter Overview

This chapter opens by outlining the philosophical study of ontology and epistemology before describing the researcher's ontological and epistemological stance. This is followed by a rationale for the chosen qualitative methodology. A reflexive extract, documented during the early stages of the project, is included to enhance this discussion. The chapter then details the research design, including recruitment, participants and data collection methods. The procedure and data analysis process are also explained, and the chapter concludes with a discussion of ethical considerations and qualitative quality measures.

3.2 Ontology, Epistemology and Research Paradigm

Research methods are inherently linked to methodology and epistemology, both of which stem from an ontological position. Engaging in any research requires a commitment, often implicitly, to specific ontological and epistemological stances. These positions influence how researchers approach the same phenomenon, which leads to diverse research strategies (Grix, 2018). As a result, researchers cannot be detached from their research; their beliefs and assumptions about the world and the research process inevitably influences their actions and findings (Lincoln & Guba, 1985). These influences are grounded in general theories of knowledge and particularly in the philosophical domains of ontology and epistemology. Having an understanding of these philosophical foundations, along with the language to articulate them, is crucial for conducting research. This awareness allows researchers to recognise how their assumptions align with their chosen methodology and methods, and how these, in turn, influence the findings (Guba & Lincoln, 1994). Such understanding enhances the interpretation of research, facilitates the application of theory to practice and deepens academic engagement (Finlay, 2002). As the researcher, it is important to acknowledge my own ontological and epistemological stance and provide transparency about how these positions shape this study. This section outlines the concepts of ontology and epistemology and examines my own position within the research paradigm.

3.2.1 Ontology

Ontology can be described as the philosophical study of “being” (Crotty, 1998, p. 10), which is concerned with what exists. Ontology guides an individual in their recognition of how certain they can be about the existence of the phenomena of interest. There are two key opposing ontological stances; realism and relativism. The realist ontology can be formulated as the view that reality exists independent of human experience. It is the philosophy which argues that there is one single existence which can be studied, understood and experienced as

a truth. Philosophic realism in general is defined by Phillips (1987, p. 205) as “the view that entities exist independently of being perceived, or independently of our theories about them”.

By contrast, relativist ontology is based on the philosophy that reality is constructed within the human mind, and that no one true reality exists. Instead, reality is subjective to how individuals experience it at any given time and place (Lincoln et al., 2018). Relativism asserts that reality is subjective and varies between individuals (Guba & Lincoln, 1994). Our realities are shaped by our senses, and without consciousness, the world lacks meaning. Crotty (1998) explained that reality forms when consciousness interacts with objects already infused with meaning. Each person constructs their own reality, leading to multiple, individualised versions of existence. Language plays an active role in shaping and moulding reality, rather than simply naming objects (Frowe, 2001). Therefore, from this viewpoint, reality emerges through the dynamic interaction between language and the external world.

3.2.2 Epistemology

One’s ontological stance influences their epistemological position. As such, the way we perceive reality inevitably impacts the way in which we believe that knowledge about our reality can be created, acquired and communicated. This concern with how knowledge is acquired is the philosophical study of epistemology (Crotty, 1998). As with ontological stances, epistemological positions can be viewed on a spectrum, with a positivist epistemology on one end and a constructivist epistemology on the other. Positivist epistemology aligns with objectivism, viewing the researcher and the researched as separate entities. Positivists aim to discover absolute knowledge about an objective reality, believing that meaning resides in objects themselves rather than in the researcher’s mind. Crotty (1998, p. 8) explained the following:

“A tree in the forest is a tree, regardless of whether anyone is aware of its existence or not. As an object of that kind, it carries the intrinsic meaning of treeness. When human beings recognize it as a tree, they are simply discovering a meaning that has been lying in wait for them all along”.

Thus, through the lens of positivist epistemology, phenomena exist independently and can be discovered through research. Positivist statements are factual, and this scientific paradigm is grounded in data and facts (House, 1991). Hence, discoverable knowledge is considered to be absolute and value free; it is not situated in a political or historic context. Positivists seek to identify causal relationships, aiming to develop laws for prediction and generalisation (Creswell, 2009), with their views often resonating with realist ontology. In contrast, constructionist epistemology rejects the notion of an objective truth. It argues that meaning emerges through our engagement with the world, rather than pre-existing independently of human activity or language. The value of constructionist research lies in generating contextualised understandings of specific topics or issues.

3.2.3 Research Paradigm

A constructivist research paradigm has been adopted within the current study. A constructivist research paradigm is grounded in relativism and constructivism (Guba & Lincoln, 1994), reflecting my belief that reality and knowledge are subjective and individually constructed. I view reality as something shaped by each person’s unique experiences, meaning that multiple, potentially conflicting versions of reality can coexist. This contrasts with a realist perspective, which assumes a single, objective truth. As a result, my epistemological stance naturally aligns with constructivism, as I believe that knowledge is not passively discovered but actively constructed through social interactions and personal experiences. This perspective drives my research focus on understanding how individuals with a diagnosis of borderline personality disorder (BPD) construct their own experiences of

recovery. Since I aim to explore subjective meanings and interpretations rather than uncovering an objective truth, the research design required for the study must allow me to delve into the complex, varied experiences of recovery and understand how these experiences are shaped by personal and social contexts.

3.3 Reflexivity and Positionality

The process of reflexivity is essential in qualitative research (Smith et al., 2009), and it involves an awareness of how the researcher's influence shapes the study (Willig & Rogers, 2017). Reflecting on my own views and assumptions surrounding the topic of study can help orient readers to another perspective and potential biases influencing the research (Elliott et al., 1999). Further, Charmaz (2014) highlighted the importance that researchers enter participants' worlds of meaning while also situating these meanings within their broader social discourses. Holding this in mind, throughout the research process I actively took time to pause and to reflect on my own assumptions through writing in a journal. Documenting my reflections enabled me to process my feelings and experiences whilst also giving me the opportunity to reflect on how my own beliefs may shape decisions during the process of the research. Extract 1 provides an example of one of my early reflexive entries shortly after receiving ethical approval for the study.

Extract 1:

Early in my psychology career, I worked on a personality disorder inpatient unit, where I first witnessed how individuals with BPD were often viewed with a sense of contempt and almost hysteria in some cases. What struck me was how this feeling seemed to be mirrored by all that were supposed to care for them, perpetuating the stigma and trauma that these individuals had already endured. This experience left a significant impact on me, and I have often questioned why people with personality disorders are viewed and treated in

such a way. As time progressed, a very similar narrative followed me whenever working with those with the diagnosis, whether that was directly when I worked in a crisis team or indirectly merely through conversations with professionals about the label. I feel frustrated by the misconceptions, and my empathy for those labelled with a personality disorder diagnosis is deeply held.

As a researcher with a constructivist epistemological position, I understand that I will not be able to completely remove myself from the data. My own experiences, beliefs, and positionality inevitably shape how I approach the research, as well as how I interpret participants' accounts. Rather than attempting to be entirely objective, I accept that knowledge is co-constructed between myself and the participants. My role is to engage reflexively with the data, being constantly aware of how my own perspectives may be influencing the research process. This means embracing my involvement while striving to allow the participants' voices to take centre stage.

To maintain reflexivity, I will continue to write in this diary throughout the research process, documenting my thoughts, emotions, and potential biases. I will also engage in ongoing discussions with my research supervisors to critically reflect on my analysis and the development of categories. By doing so, I aim to ensure that while I cannot fully remove myself from the data, I remain committed to presenting a nuanced, empathetic, and accurate portrayal of the participants' experiences of recovery, allowing their voices to be heard as authentically as possible. (Gibbs, personal communication, September 15, 2024)

3.4 Research Design

A qualitative research design prioritises the collection of rich, descriptive data that captures the depth and complexity of individual experiences, which aligns with the study's aim of exploring the processes of recovery in individuals who have received a diagnosis of

BPD. In contrast, quantitative designs, which typically rely on predetermined variables and standardised measures, are less equipped to capture the nuanced and context-dependent exploratory nature of the study. Given the variability in how recovery may be understood and experienced, a qualitative design allows for greater sensitivity to individual differences and the co-construction of meaning between researcher and participant.

3.4.1 Interpretative Phenomenological Analysis

Extensive preparation was undertaken to determine the most methodologically sound approach for the current study. Initially, the researcher considered Interpretative Phenomenological Analysis (IPA) as the analytical approach (Smith et al., 2021). IPA emphasises “trying to understand what an experience (object or event) is like from the participant’s perspective” (Pietkiewicz & Smith, 2014). Given the study’s focus on the experiences of recovery in relation to BPD, IPA appeared appropriate as it foregrounds subjective meaning-making and attends closely to participants’ personal narratives. The researcher therefore attended both introductory and advanced IPA training workshops led by Jonathan Smith, which provided a strong grounding in IPA’s theoretical underpinnings and analytic procedures. However, critical reflection during and after the training prompted a reassessment of the suitability of IPA for this study. While IPA is well-suited to idiographic, in-depth analysis of experience within relatively homogenous samples, it was anticipated that the participant group for this study would be heterogeneous, with varied experiences and understandings of recovery shaped by diverse demographic and contextual factors. IPA typically requires a degree of sample homogeneity so that observed differences are more likely attributable to individual psychological processes rather than broad contextual or demographic factors (Smith & Nizza, 2022). Moreover, the research aims extended beyond understanding individual meaning-making to examine the processes underpinning recovery and to develop a theoretical account of how recovery unfolds. While IPA provides rich

insights into lived experience, its primarily phenomenological and idiographic focus makes it less well suited to addressing this process-oriented aim of the study.

3.4.2 History of Grounded Theory Methodology and Rationale for Using the Constructivist Variant of Grounded Theory

Grounded Theory (GT) was first developed by Glaser and Strauss (1967) as a systematic methodology for generating theory grounded in qualitative data. This approach represented a move away from the dominant hypothetico-deductive tradition in the social sciences at that time, which involved testing pre-existing theories, usually using quantitative methods. Their earlier empirical research on awareness of dying among terminally ill patients (Glaser & Strauss, 1965) exemplified the potential of generating theory inductively from data, which laid the foundation for GT as a method that privileges empirical observation and iterative analysis. However, the original formulation of GT has been critiqued for its realist and objectivist assumptions, particularly the idea that researchers can discover an objective external truth through methodologically rigorous, unbiased analysis (Birks & Mills, 2015). Over time, Glaser and Strauss diverged in their methodological positions, which led to the development of several distinct variants of GT, which include Classic (Glaserian), Straussian (evolved) and Constructivist approaches (Chun Tie et al., 2019). These methodological variants share a commitment to generating theory inductively from data but differ in their philosophical assumptions, engagement with literature and analytic procedures. Classic GT (Glaser, 1978) adopts a positivist stance which assumes that an objective reality can be discovered through systematic coding and delayed theoretical engagement. It recommends postponing literature review until after data analysis to avoid contaminating emerging categories (Glaser & Strauss, 1967). In contrast, evolved GT, developed by Strauss and Corbin (1998) and later refined by Clarke (2005), is informed by symbolic interactionism and adopts a more structured, pragmatic approach. It allows for earlier literature engagement and

includes analytic procedures such as axial coding to explore relationships between categories. Constructivist Grounded Theory (CGT), developed by Charmaz (2006, 2014), moves away more substantially from objectivist traditions by adopting a constructivist epistemology. It holds that knowledge is co-constructed between researcher and participant which is shaped by social, relational and contextual influences. In CGT, the researcher's positionality is considered a valuable lens through which meaning is constructed, rather than a source of bias to be eliminated. As Charmaz (2006, p. 10) explains, "we construct our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices". Unlike Classic GT, CGT supports early and iterative engagement with literature as part of a reflexive analytic process. Analytically, it emphasises flexibility and integrates memo-writing throughout to support theoretical development (Charmaz, 2014; Birks & Mills, 2015).

The present study adopted CGT due to its close alignment with the research aim and the researcher's underlying epistemological stance. The study sought to explore individuals' processes of recovery in relation to BPD, with awareness of the social and relational contexts shaping these experiences. CGT provided the methodological flexibility to remain grounded in participants' lived experiences while supporting iterative, reflexive engagement with emerging concepts. It also enabled the researcher to draw on prior professional and academic knowledge without compromising analytic openness. This approach was echoed by Urquhart and Fernández (2013), who argued that awareness of existing theory can be managed through reflexivity rather than avoided altogether. Furthermore, CGT's emphasis on the co-construction of meaning and its focus on developing mid-level theory made it particularly well-suited to generating a conceptually rich but grounded understanding of recovery, that is, one that can inform future research, policy and clinical practice.

3.5 Research Procedure

The following section summarises the research procedure. This includes a description of the recruitment strategy and participants, followed by the data collection and data analysis process. The section ends with outlining the ethical considerations and qualitative quality measures.

3.5.1 Recruitment and Participants

Participants in this study are defined as individuals who self-disclosed either having a current or historical formal diagnosis of BPD and identified as being in “recovery” or “recovered”. Participants were recruited for the present study if they met all of the inclusion criteria and did not meet any exclusion criteria. A table of participant inclusion and exclusion criteria is outlined in Table 6, and was also presented in a participant information sheet (Appendix C). Additionally, inclusion criteria were outlined in a recruitment poster (Appendix D). A total of two participants were excluded from taking part in the study due to disclosing that while they identified with the diagnosis, they had not been formally diagnosed with BPD.

Table 6

Inclusion and Exclusion Criteria

<i>Inclusion criteria</i>	<i>Exclusion criteria</i>
To have a current or historical primary formal diagnosis of BPD	No formal diagnosis of BPD and/ or have other/ another primary mental health diagnosis
Identify as either in recovery or recovered from BPD	Identify as being acutely unwell with BPD
Willing to participate in an interview about lived experiences of BPD	Not willing to attend an interview to discuss lived experiences of BPD
Currently living in the UK	Living outside of the UK
English speaking	Does not speak English
Aged 30 or over	Under the age of 30
Able to recall past experiences	Have a memory/ cognitive impairment severe enough to inhibit ability to recall past experiences

Not currently acutely experiencing psychosis	Currently experiencing acute psychosis
Able to commit to not using alcohol or illicit substances at least 24 hours prior to interview	Are dependent on illicit substance(s)/ alcohol and unable to commit to abstinence from substances at least 24 hours prior to interview
Consent to have the interview recorded	Do not consent to have the interview recorded
Have access to a smart device such as a mobile phone, laptop, tablet or personal computer with access to the internet to access interview.	No access to a smart device and/ or no access to the internet to access an interview.
Able to sit for around an hour to attend the interview in a quiet space	Unable to sit for around an hour in a quiet space to attend an interview

Participants were recruited nationally from mental health charities, online peer support groups, social media support groups and LinkedIn. A recruitment poster was used to obtain participants on these online platforms coupled by the researcher approaching potential participants on social media platforms directly via an invitation email. The recruitment poster was shared digitally via email to the mental health charity, Mind, and permission was sought for them to share the poster with colleagues and with service users. The recruitment poster invited those that are interested in the study who meet the inclusion criteria to contact the researcher to inform them of their interest to take part via email (email provided on poster). The recruitment poster outlined at the bottom “I don’t meet those criteria but I want to support this research”. Under this brief heading, there was a sentence to invite individuals to spread the word of the research by sharing the poster on their social media pages or with others who they believe may be interested in partaking in the research. A total of 12 participants were recruited for this study, and further details of participant characteristics disclosed at the time of interviews can be found in Table 7.

Table 7*Participant Characteristics*

Participant Pseudonym	Age	Gender	Ethnicity	BPD Diagnostic Status	Other Disclosed Diagnoses
Daniel	35	Male	White British	Current	None
Stephen	35	Male	White British	Current	Autism
Mark	34	Male	White British	Current	None
Emma	52	Female	White British	Current	None
Victoria	63	Female	White British	Current	None
Darcie	38	Female	White British	Previous	CPTSD, Anorexia Nervosa, Autistic Traits
Grace	54	Female	White British	Current	CPTSD
Charlotte	40	Female	White British	Current	Unspecified Eating Disorder, ADHD
Oliver	40	Male	White British	Current	None
Cathy	55	Female	White British	Current	CPTSD
Leah	33	Female	White British	Current	None
Abigail	47	Female	White British	Current	None

Note. All participants met study inclusion criteria on the basis of a current or previous self-reported formal diagnosis of BPD. Diagnostic status shown reflects participants' self-disclosed status at the time of interview.

The sample comprised 12 participants aged between 33 and 63 years ($M = 43.8$ years). Eight participants identified as female and four as male. All participants identified as White British. At the time of interview, 11 participants reported a current diagnosis of BPD, while one participant reported that their previous BPD diagnosis had been revised to CPTSD. Two participants reported a co-occurring diagnosis of CPTSD. In addition, one participant

reported a diagnosis of autism, one reported a diagnosis of ADHD, and one reported autistic traits. Two participants also reported eating disorder diagnoses. Initial participants were selected through purposive sampling with the view to explore diverse experiences of recovery from a diagnosis of BPD. The first three interviews were conducted with male participants who were recruited via LinkedIn. Early analysis of these accounts sparked curiosity about whether gendered experiences might influence the construction of recovery, which prompted the inclusion of female participants through theoretical sampling (Charmaz, 2014). This allowed for exploration of how recovery processes may differ across gendered contexts, thereby contributing to the refinement of emerging categories in the data analysis phase. Sampling decisions continued to be guided by developing analytic insights, in line with the iterative nature of CGT. Recruitment proceeded until theoretical sufficiency (Dey, 1999; Charmaz, 2014) was achieved, with categories judged to be well-developed and conceptually coherent. Further, in line with GT procedures, the recruitment procedure continued simultaneously with data analysis.

3.5.2 Data Collection

Data were collected through individual semi-structured, intensive interviews. Intensive interviewing is a flexible, open-ended method designed to elicit rich, in-depth accounts of participants' experiences (Charmaz, 2014). While guided by an interview schedule, interviews were participant-led and responsive. They allowed individual narratives to unfold naturally and meaningfully. This approach aligns with constructivist interviewing, which recognises that data are co-constructed through the interaction between researcher and participant (Charmaz, 2014). As such, interviews were conceptualised as dialogic and relational encounters, shaped not only by the participant's narratives but also by the interviewer's active, attuned engagement. The researcher's clinical training supported a sensitive and responsive interview style, with careful attention to both verbal and non-verbal

communication. Reflexivity was integrated throughout the data collection process.

Immediately following each interview, reflexive memos were written to capture emerging thoughts, emotional responses and early analytic insights.

3.5.3 Interview Schedule

A draft interview schedule was initially developed through discussions in research supervisory meetings and informed by relevant literature reviewed in the introduction chapter. It was then collaboratively reviewed and refined with a Lived Experience Ambassador diagnosed with BPD, employed by the National Health Service. This collaboration helped to ensure the research remained sensitive and non-stigmatising (Tedesco et al., 2023) and that the questions and interview flow resonated with the study's purpose. The initial interview schedule (see Appendix E) was shaped by this consultation and closely aligned with the research question. Example questions included: "What does it mean to you to be in recovery or recovered from borderline personality disorder?" and "What were the barriers to reaching recovery?" This collaboration allowed for meaningful refinement of the schedule, it also revealed that some early questions were potentially leading. Consistent with CGT principles, these were revised to be more open-ended and broad, with original ideas incorporated as flexible prompts. As data collection progressed, the interview schedule was further adapted to remain responsive to emerging insights and participant narratives. For example, it became apparent across the first three interviews that the theme of neurodivergence and the possibility of recovery coming to involve an acceptance of potential differences in brain chemistry came about, so the interview schedule was adapted to explore this further in subsequent interviews. Importantly, since the primary aim of CGT is to generate concepts and theory inductively from the data (Charmaz, 2014; Glaser & Strauss, 1967), the interview schedule was used flexibly rather than applied in a rigid or formulaic

manner. Interviews were guided by participants' narratives, which allowed for their experiences to shape the direction of the conversation.

3.5.4 Interview Protocol

On receipt of each email that outlined interest in participating in the study, the researcher responded to each person via email by thanking them for their interest, attaching a participant information sheet and a consent form (Appendix F). Individuals were advised to carefully review the participant information sheet and consent form. They were informed that upon completion, they were to digitally sign the consent form and return it via email as an attachment if they wished to partake in the study. Individuals were informed that once written consent was received, they would be assigned a unique participant number which would be provided to them via email as a way to identify their data should they wish to withdraw from the study at any point. In addition, they were informed that an interview would be arranged at a mutually convenient date and time with the researcher. As such, on receipt of written consent, an interview date and time was arranged with the participants via email. Interviews took place online via video call on the platform Zoom. Once an appropriate date and time for an interview had been agreed, the researcher sent an email invite link for the interview. This email advised participants to complete their interview in a quiet space free from distractions. Attached to this email were instructions on how to use Zoom.

At the time of their interview, participants clicked on the Zoom meeting invitation link found in their email inbox and entered the meeting passcode provided to them. Upon entry into the virtual Zoom meeting room, they were greeted by the researcher. The interviews were prefaced with information about the structure, safety and confidentiality processes involved in the interview and study. Prior to the interview schedule commencing, a protocol was collaboratively created with the participants to safeguard in the event of experienced emotional distress throughout the interview (see 'Ethical Considerations'). The

interviews lasted between 60 and 120 minutes, and the average interview length was approximately 90 minutes. In total, approximately 16 hours of interview data were gathered. Participants involved in interviews that lasted longer than 60 minutes were offered a five-minute comfort break before continuing with the interview. Following completion of the interview, participants were thanked for their participation in the study and were reminded of the emotional support service contacts that were provided to them on their participant information sheet and signposted there should they require support following the interview. Each interview was recorded and transcribed verbatim by the researcher ready for data analysis.

3.6 Data Analysis

Interview transcripts were analysed in line with CGT using the guidance stipulated by Charmaz (2014). While Charmaz (2014) outlines a sequence of coding stages, including initial coding, focused coding, and theoretical coding, these were not treated as rigid or linear. As such, the data analysis process was iterative, with each coding stage informing and revising prior analytic decisions as the researcher engaged with participants' accounts and co-constructed meaning from their experiences. Throughout the process, constant comparison was used to explore similarities and differences within and between transcripts. This helped to refine codes, test category fit and ensure the emerging theory could account for potential convergent and divergent experiences.

3.6.1 Familiarisation and Initial Coding

Each interview recording was transcribed verbatim on a Microsoft Word document. Each transcript was read and re-read carefully to gain an understanding of the content and context of the participant's narrative. The data were analysed line-by-line. Initial codes were generated with terms that captured actions rather than themes, and gerund codes were used

where possible. These codes consisted of short, descriptive labels that summarised and accounted for participants' meanings, consistent with Charmaz' guidance (2014). Appendix G provides an example transcript, which illustrates data analysis during the initial coding stage.

3.6.2 Focused Coding

In the next stage, salient and recurrent initial codes were developed into focused codes. These focused codes represented more abstract and conceptual interpretations of the data, moving beyond the descriptive level of initial coding and facilitating the organisation of data into emerging analytic categories. Using the constant comparative method (Charmaz, 2014), focused codes were compared within and across participant transcripts to explore similarities, differences, and potential connections between categories.

Appendix H provides an example of how initial codes were developed into focused codes. Initial codes from each participant transcript were assigned a unique colour to enable the researcher to identify their source throughout the analytic process. Through constant comparison, the researcher manually reviewed and annotated printed initial codes, grouping and refining them into focused codes. Colour-coded annotations were used to distinguish between emerging focused code groupings while maintaining links to the originating participant transcripts.

3.6.3 Theoretical Coding

Throughout the coding process, multiple diagrams were drawn to explore and refine relationships between categories and subcategories. These diagrams also helped to link memos and evolving ideas from earlier stages, and examples are provided in Appendix I. The final stage involved refining and integrating the categories that emerged from the focused codes into a conceptual framework of the processes of recovery, grounded in participants' experiences. The goal was to generate a theoretical model that captured the key processes

shaping recovery in BPD. Rather than striving for full theoretical saturation, theoretical sufficiency (Dey, 1999; Charmaz, 2014) guided analytic completeness. The final diagram presented the integrated story of the emerging theory.

3.6.4 Memo Writing

Memo-writing was an important part of the analytic process and took place throughout all stages of the research (Charmaz, 2014). Memos were used to record and develop the researcher's thoughts as the analysis progressed, which helped to reflect on emerging ideas and identify areas that needed further attention. This process began before data collection as the researcher reflected on the research focus, and continued during and after interviews. Memos were used frequently particularly whilst interviews were being transcribed, these often took the form of brief questions and observations that were added to the transcriptions via the comment function in Microsoft Word. Writing memos also supported the development and refinement of codes and encouraged ongoing reflection on the researcher's interpretations and assumptions (Birks & Mills, 2015). Memos were written flexibly, allowing ideas to be explored in an open and evolving way. As the analysis developed, memos became more focused and conceptual, which supported the development of more abstract, theory-based understandings (Charmaz 2014; Chun Tie et al., 2019).

3.7 Methodological Rigour

Due to the ontological and epistemological assumptions underpinning qualitative research (Guba & Lincoln, 1994), quality is evaluated using qualitative criteria. Charmaz's (2014) criteria of credibility, originality, resonance, and usefulness was followed. Alongside Charmaz's quality criteria, an audit trail was utilised throughout the research process.

3.7.1 *Quality of the Grounded Theory*

This study drew upon Charmaz's (2014, pp. 337–338) criteria for evaluating the CGT.

Table 8 shows how each criterion was met.

Table 8

Quality Criteria for Constructivist Grounded Theory Studies. Adapted from Charmaz (2014), pp. 337–338

Quality criterion	Application to the current study
	Credibility
Intimate familiarity with topic	Familiarity was developed through in-depth interviews and iterative engagement with transcripts during transcription and analysis.
Sufficient data	Twelve interviews (approximately 16 hours of data) provided sufficient depth and variation to support theory development.
Systematic comparisons	Constant comparative methods were used throughout coding to compare data within and across transcripts.
Range of observations	Categories were developed from diverse accounts and refined to capture variation in recovery experiences.
Logical links between data and analysis	Memo-writing and diagramming supported the development of grounded and coherent analytic links.

Evidence for independent assessment	Extensive use of verbatim quotations and transparent analytic procedures enables readers to evaluate the grounding of interpretations in participants' accounts.
Originality	
Fresh categories	The analysis generated novel categories conceptualising recovery as a relationally scaffolded process of internalising external relational functions (e.g. containment, hope, reflection).
New conceptual rendering	Recovery was reconceptualised as a developmental process through which relational experiences are gradually internalised as psychological resources shaping identity and emotional regulation.
Significance	The study reframes recovery from BPD as an ongoing process of becoming rather than a cure or end state, foregrounding relational and systemic contexts.
Contribution to knowledge	Findings extend recovery literature by highlighting interpersonal and contextual processual mechanisms.
Resonance	

Fullness of experience	Categories reflect rich accounts and preserve complexity, contradiction, and variation.
Liminal/unstable meanings	The analysis captured ambiguity and shifting meanings of recovery over time.
Links to wider contexts	Accounts reflected the role of services, relationships, and social context in recovery.
Meaningfulness	Grounding in participant language enhanced interpretive relevance for those with similar experiences.
Usefulness	
Everyday usefulness	Findings support understanding recovery as an ongoing relational and intrapsychic process that can inform clinical practice.
Generic processes	Relational and identity-based processes may extend beyond BPD recovery.
Future research	The theory provides a framework for further research into relational, systemic, and cultural influences on recovery processes.
Broader contribution	The study contributes to recovery-oriented practice by positioning clinicians as active relational agents in supporting the development of internal psychological resources.

3.7.2 Audit Trail

The audit trail (see Appendix J) consisted of a “systematically maintained documentation system” (Schwandt, 2014, p.10) and includes analytic memos, reflective summaries and category development reflections. These records provided a transparent account of analytic decisions made throughout the study, and enhanced the rigour of the research process (Bowen, 2009). Examples of diagrams used to support category development are provided in Appendix I.

3.8 Ethical Considerations

The research adhered to ethical considerations as informed by The British Psychological Society (BPS) guidelines, as such, the research was conducted in a manner that respected the rights, well-being, and dignity of individuals with BPD, while also contributing to scientific knowledge and understanding in the field of psychology. Ethical approval was received from the School of Health and Social Care Ethics Committee at the University of Essex (Appendix K).

A critical component of the ethical process involved obtaining informed consent from participants. Before any interviews were conducted, participants were fully briefed on the purpose and aims of the research, as well as what their participation would involve. The potential risks, benefits and their right to withdraw at any time were clearly communicated. This information was provided in an information sheet that also outlined details of emotional support services available to participants. Consent forms were provided to potential participants, and written consent was required before interviews could be arranged. These steps allowed potential participants to make an informed decision about whether or not to participate, ensuring transparency throughout the recruitment process.

Participants' right to withdraw from the study was emphasised in both written and verbal communications. Participants were reminded before interviews began that they could withdraw from the study at any stage, even after they had consented, without any need for explanation and without consequences. This assurance was intended to create a sense of security and autonomy, allowing participants to feel in control of their involvement in the study, which was particularly important given the potentially sensitive nature of the research topic. Throughout the study, no participants chose to withdraw. In a similar vein, the participant information sheet offered participants the opportunity to express any concerns, make a complaint and to ask questions about the research. The research supervisors' and researcher's email addresses were provided for any further correspondence to be made.

By conducting the interviews via Zoom it allowed participants the flexibility to engage from their chosen location. This also eliminated the need for travel, making the process more convenient. At the start of each interview, participants were invited to inform others in different rooms (if any) to not disturb them during the course of their interview. In the case of any interruptions, the interview would pause until privacy was restored. To maintain security, interviews were conducted using the researcher's University of Essex Zoom account. On the Zoom invitation link email, each participant was provided with a unique number (chosen at random by the researcher) and instructed to quote this number in an email to the researcher at any point to withdraw from the study and request that their data be destroyed. As such, participant consent forms containing identifiable information were securely stored in a password protected folder in Cloud based storage, Box. On receipt of consent forms, the names were immediately removed and replaced with the corresponding unique assigned number provided to participants in their Zoom invitation link email. Similarly, each interview recording was saved with the file name of each participant's unique number. This was to ensure that recordings from interviews were not linked to participants'

identity, meanwhile it also provided a way of identifying a participant's data should a participant request to withdraw from the study. As with the consent forms, the recordings of the interviews were stored in a password protected folder in Cloud based storage, Box. Only the researcher and research supervisors had access to the consent forms and recordings. Once transcribed, all recordings were permanently deleted. Moreover, on completion of the project, all consent forms were permanently deleted. Interview transcripts will be kept until the research is published.

During the project write-up, any participant identifiable information was replaced with pseudonyms to maintain anonymity. Personal life history details have been minimised in the write-up to prevent participant recognition from published information. Throughout the study, confidentiality could only be breached in circumstances where the researcher identified a risk of harm to the participant, others, or the researcher. In such cases, appropriate professionals would have been contacted, and a management plan put into place to address the risk. This potential exception to confidentiality was clearly communicated verbally before interviews commenced, ensuring that participants were fully aware of the circumstances in which their confidentiality might not be maintained.

Steps were also taken to minimise the potential for harm throughout the interview process. At the outset of each interview, participants were briefed on the protocol in case of technical difficulties, such as internet disconnections or unplanned absences. If either the researcher or participant were disconnected, they were instructed to try reconnecting, and if they were unable to do so within 20 minutes, the researcher would follow up via email to reschedule. Such issues did not occur during any participant interviews. Additionally, a pre-agreed plan was developed with each participant to manage any emotional distress that might arise during the interview. Personal emotion regulation strategies were discussed at the beginning of each interview and participants were assured they could take breaks or practice

these strategies as needed. If they did not return within 20 minutes, the interview would be rescheduled, and participants would be reminded of the support services available to them. This careful planning ensured that both the participants' emotional well-being and the integrity of the interview process were safeguarded. Regular check-ins as required were conducted throughout the interviews to ensure that participants felt comfortable and were able to continue. After the interviews, participants were given the opportunity to ask questions and were signposted to their participant information sheet for information on support services they could contact if they experienced distress. This process helped to ensure that participants felt supported both during and after their involvement in the study. Finally, the researcher's own well-being was also considered, given the emotionally sensitive nature of the research topic. The researcher had the opportunity to debrief with a research supervisor following all interviews, particularly if they experienced distress. This step recognised the importance of emotional support for the researcher, ensuring they could manage any psychological impact resulting from the sensitive interviews.

3.9 Dissemination

Following completion of this thesis and the doctorate in clinical psychology programme, the study can be accessed via the University of Essex repository. Participants, as valuable contributors to this study, will be provided with the original copy of the final thesis. For those who prefer a shorter version, a condensed report will also be available. To ensure the practical application of the research, a separate report containing clinical recommendations will be disseminated to NHS mental health services across Essex. Furthermore, consultations and presentations of key findings will be conducted to enhance healthcare professionals' understanding of the experiences of people diagnosed with BPD. Efforts will be made to present at relevant upcoming conferences. Additionally, efforts will be made to publish the thesis in academic journals, in particular, the new open-access journal,

specific to BPD: Borderline Personality Disorder and Emotion Dysregulation (BPDED; <http://www.bpded.com>). This journal endeavours to provide a platform for emerging research focused on BPD and other mental health conditions characterised by emotion dysregulation to be published to share new knowledge amongst researchers and healthcare professionals alike.

CHAPTER FOUR: FINDINGS

4.1 Chapter Overview

The chapter begins with the findings of this constructivist grounded theory analysis by providing an overview of the categories and subcategories described by the participants in their recovery processes. Next, each category and subcategory is presented with examples from the interviews. The chapter follows on by outlining the final grounded theory, whereby the categories are presented in a way to form an overarching theoretical model of processes of recovery as described by participants.

4.2 Categories and Subcategories

Table 9 outlines the two categories and their corresponding subcategories which were created through thorough analysis of participant data. It also shows the frequency of each subcategory as it was present across participants.

Table 9

Categories and Subcategories

Category	Subcategory	Frequency (Participant Pseudonym)
Reshaping the relationship to the self and to the meaning of recovery	Changing of perspective of the meaning of recovery	N=12
	Becoming a different version of the self	N=12

Containment becoming possible within relational and systemic uncertainty	Acknowledging past trauma	N=11 (Stephen, Daniel, Mark, Victoria, Darcie, Grace, Charlotte, Oliver, Cathy, Abigail, Leah)
	Experiencing relational safety and attunement	N=12
	Trust building through relational consistency	N=12
	Others holding hope and providing challenge	N=11 (Stephen, Daniel, Mark, Emma, Victoria, Darcie, Grace, Charlotte, Oliver, Cathy, Abigail)
	Belonging through shared experience	N=11 (Stephen, Daniel, Mark, Emma, Victoria, Darcie, Grace, Charlotte, Oliver, Cathy, Abigail)

4.3 Reshaping the Relationship to the Self and to the Meaning of Recovery

Participants discussed how several aspects of themselves had changed, and this category depicts different ways in which their perspectives and ways of living had been reshaped. These changes however did not represent a fixed endpoint, but uniquely this category represents how participants began to view recovery as an ongoing commitment to developing the self in ways in which they saw value.

4.3.1 *Changing Perspective of the Meaning of Recovery*

The way in which participants made sense of themselves shifted over time, and this shift often came about through beginning to think critically about the messages they had been receiving about diagnostic and recovery narratives in relation to BPD. For many, receiving a diagnosis of BPD initially functioned as an explanatory turning point which offered some relief and a framework through which they could begin to understand their experiences. For

most, looking back in hindsight, the moment in which they became aware of their diagnosis, their recovery began. Emma described her diagnosis as bringing a sense of clarity and direction:

“For me subjectively, as soon as I got a diagnosis it was a case of, oh, my God. Right. So now I know what I’m dealing with. So, from that point forward, anything you do is a road to recovery”.

(Emma)

At this early stage, participants often understood their diagnosis as a defining and permanent part of their identity. This was often shaped by trust in professional expertise and longstanding, sometimes generational beliefs about medical professionals being authority figures who had the answers. As such, participants frequently described taking the diagnosis at face value, and tended to accept it as a legitimate account of what was going on for them. Grace reflected on this deference to expertise:

“It’s like being told by a teacher that you’re... you’re not good at maths. You know, you’ll believe that, won’t you? Because they’re the experts, supposedly”.

(Grace)

This sense of professional authority was also accompanied by hopes that treatment might offer a cure or a return to a more “normal” self. Some participants described initially approaching diagnosis with the expectation that professionals would fix them or provide them with a clear pathway to recovery. Grace recalled the time where her perspective aligned with this view:

“At that point, yeah, I guess I held psychiatrists in high esteem, but also, I think I'd watched a lot of films and things at that stage, where, you know, there were a few films up where psychiatrists really did heal people”.

(Grace)

Similarly, Stephen described wanting recovery to happen immediately:

“I wanted recovery to happen overnight, like I wanted a tablet there and then that would change it all, and I'd be back to normal”.

(Stephen)

Here, recovery was initially thought to be a cure and an imagined return to what was often termed as “normal”. There was a real outlook that having the diagnosis was a sign of something being wrong and that had to be fixed. However, participants’ relationships with the diagnosis often became more nuanced over time. Although the diagnosis could initially provide relief and understanding, it also introduced stigma and an awareness of how psychiatric labels could shape how others respond to them. Darcie described this tension:

“Initially, I was kind of relieved, I was like, oh, I'm not going mad, like, I'm not just a failure, but then... Slowly, that started, like, closing doors and causing, kind of, stigma as well... and but having said that... if I hadn't have had that diagnosis, I wouldn't have gone to the therapeutic community”.

(Darcie)

This reflects an important tension in participants’ accounts, specifically that the diagnosis was neither wholly helpful nor wholly harmful. Rather, it could simultaneously legitimise distress and facilitate access to care, whilst also introducing stigma and narrowing how participants were understood by others. Starting to think more critically about the diagnosis did not

therefore involve a straightforward rejection of psychiatric labels, but instead involved an ongoing negotiation of what labels meant and what role they would continue to play in participants' lives. Over time, many participants described moving from passive acceptance of diagnostic narratives toward a more critical and agentic stance, where they started to question whether the diagnosis fully captured their experiences or whether some responses had been pathologised in ways that obscured context, trauma or in some cases, neurodivergence. Emma reflected:

"I genuinely do think that BPD is a form of neurodiversity, and I really do think it should be accepted that way".

(Emma)

This illustrates a broader process in which participants became more critical of deficit-based interpretations of distress and started to question whether all of their emotional responses should be viewed through a pathological lens. Oliver and Cathy reflected upon whether all emotional experiences should be framed within the context of a mental health diagnosis:

"I do also think that, actually, sometimes what we think is BPD-related emotional dysregulation is actually just human dysregulation. Where, like, say, for example, you're in a situation and you kind of get overwhelmed, some people who have BPD will instantly connect that to their BPD, when actually it's maybe just a general situation that any normal or, say, well-balanced person without BPD would experience some anxiety. Maybe that person with BPD is just experiencing it to a higher degree. And I think sometimes we can categorise ourselves as all our emotions go in to react to a BPD trait, when actually some of them are just general human experience emotions".

(Oliver)

“They gave me medication, because my doctor said what I suffered with was reactive depression. I got depressed when I lost someone. When I was, like, 20, three people died, an uncle died, my best friend died of leukaemia, and a girl who lived by me was murdered, and it affected me very much, this, all this death, all of a sudden. So, that was, I think, that was the first time I'd been put on medication. When I was 20. But the doctor said, after, like, 12 months of being... he weaned me off. And I was fine. And he was like, what you suffer with is reactive depression. And I thought, well, that makes absolute perfect sense. Of course, you know, you get low when you lose people, don't you? You know?”

(Cathy)

For half of the participants, this critical reappraisal extended to challenging the diagnosis itself. However, for some, retaining the diagnosis remained protective. Abigail described the diagnosis as a form of safeguard, suggesting that without “that banner” she worried others might lose awareness of her vulnerabilities and therefore become more at risk of relapse. Similarly, some participants described the diagnosis as reducing pressure to become fully “well” and gave them permission to view distress as something to live with rather than something they had failed to overcome. Daniel reflected on this:

“I suppose there's probably quite a bit of freedom or liberation from it. Because rather than this is something I'm battling, or this is something I've, I'm being treated for, it's just something I'm living with. And so there's no, well, there's less pressure to, well, ‘when are you going to get better from it?’ Because, I'm not, and I will go up as well as down as every other person on the planet does. You know we all have our ups and downs. It's just with my condition, I sometimes feel them and demonstrate them a bit more than others”.

(Daniel)

Alongside gaining different perspectives on their diagnosis, participants also described a shift in how recovery itself was understood. Their early hopes of a cure often shifted to a different understanding of what recovery meant to them. For Grace, she reflected upon a time whereby she believed she had “recovered”, however the presence of “spiralling” appeared to shape her perspective that you do not recover from BPD within the sense of it being a “cure”.

“I think I was a bit arrogant to say that I had recovered because I genuinely, I was in such a good space that I did feel recovered, and, you know, for a number of years, I had been. My sleep had been good, and I wasn't on medication, and I hadn't had any sort of depression. I mean, I'd had a couple of little mini blips. Which was seasonal, but, yeah, so as far as, you know, I felt at the time, I did feel recovered. But, I'd never say that again... I just spiralled... I don't think I was aggressive, but I had lots of flashbacks and things, and just went straight back to my childhood and trauma”.

(Grace)

Also, Abigail reflected on how she believed recovery in BPD involves accepting that there is a risk of having an “episode” and that this suggests how recovery involves the ongoing monitoring of the self.

“I think that you can be in recovery for it, like, in remission for cancer. I think in recovery is the same as remission. I think you can go a couple, you know, I think you're always going to be at risk of having an episode. That's how I see it. You know, I never feel safe that I'm not going to have an episode. If I'm upset, I don't think that I can drink alcohol comfortably enough, and safely enough, to say I don't have borderline personality disorder anymore. I still have to watch everything I do in life in general. And I don't think that's ever gonna change”.

(Abigail)

There was a consensus amongst all participants that their view of what recovery meant to them had shifted from being a cure to an ongoing commitment to understanding oneself and to living in ways in which align with their views of self-development. It also involved an acceptance of recovery requiring ongoing effort and an openness to adapting. There was also a belief held by many that the managing of the self became “easier” over time, as described by Oliver:

“I think you get to a place where you can manage it a lot more naturally. But there are very... I think the more you manage it naturally, it gets easier for a longer period of time, but every now and then, life will throw up a little situation where I think something can maybe spike. And, you know, maybe goes back to a trigger of some form, or whatever. But, again, once you've built that self-awareness, you're aware of that spike, you're aware of what you're managing. So it's easier to manage”.

(Oliver)

Further, Mark saw recovery as not having an endpoint, instead it was framed more accurately as a lifelong journey. Mark described this shift in understanding as:

“A personal journey of like discovery, where it became less about the illness and more about just trying to be generally healthier”.

(Mark)

Recovery was no longer understood as eliminating distress or becoming symptom-free, but as developing a greater understanding of the self. In addition, several participants believed that

there may be an underlying biological element to BPD which may mean that their brains function in a unique way:

“When you’ve been brought up in an environment where you’ve learned certain ways of communicating. Although you can practice and try to change some things. I feel like, in a way, they’re always sort of there with you... Yeah, maybe, like, also the intensity of emotions. I think it’s quite difficult to, completely change that. There’s, I don’t know too much about it, but for my perspective, I feel like there might be some sort of biological element to it, where your brain is functioning as... different way to other people, and I just don’t know if it really is that possible to change that, because it’s just within you”.

(Leah)

“Just like with autism, my brain just powers differently”.

(Daniel)

Participants repeatedly described recovery as involving coming to accept a continued vulnerability in relation to difficulties with regulating emotions, rather than expecting a cure. Abigail reflected:

“I don’t think you can be cured... it’s about being able to manage those emotions, and putting strategies in place to make sure that you don’t spiral”.

(Abigail)

Similarly, Grace explained:

“To find a life that is good enough. Doesn’t have to be perfect, and you, you know, to accept that you’re going to have a few steps back, and then a few steps forward. But I

think... It's a state of not being perpetually distressed. I think, you know, when you say I'm in good recovery, I'm not having crisis after crisis”.

(Grace)

Victoria also spoke to the ongoing presence of having days where she feels suicidal, and for her the meaning of recovery involved managing the emotions associated with this:

“But I still get days where I can wake up feeling absolutely suicidal and think, yeah, it's just not worth it anymore, or I just don't want to get up, I don't want to face another day. So, I wouldn't say I was totally cured, I would just say I can manage the emotions”.

(Victoria)

Further, a frequent viewpoint was challenging seemingly rigid ideals of what was thought to be “normal” and starting to develop more personally relevant definitions of what being well, or recovered, looks like for them. Daniel spoke to this notion:

“What is the goal of recovery, is it to help the person do the best they can with their diagnosis. Then I'm happy for the word recovery. That's that's what I'm doing. If if we as a society are thinking that recovery means, let's make Daniel normal, or let's cure him so that he is like every other 35 year old, well, tough because I'm not. I'm damaged. I'm working in my own way. And I wouldn't go back and change it, because this is, you know, this is where I've got to. Would have been nice if it was easier to get here, but I'm here now, and I think I'm better for it”.

(Daniel)

Participants accounts notably do not consider that emotional difficulties may not arise, and the meaning of what recovery is for them is not the absence of struggling with emotions but more so changing the way in which emotions are responded to. As such, recovery points to

living a life more knowingly, in which tolerating setbacks and distress is managed and emotional intensity is handled in such a way that it does not control the individual. Further, this reframing also involved an acceptance that aspects of the self may not fundamentally change, but could instead be understood and managed with greater compassion and different expectations. Daniel described this as:

“Giving myself permission... It’s okay to not achieve the same thing as other people... I’m still doing pretty well for me”.

(Daniel)

Changing their perspectives on the meaning of the diagnosis of BPD and what it subjectively means to be in recovery is also intrinsically linked to changing the ways in which they began to view themselves. Further to this point, Leah reflected upon her current perspective on recovery and how her view of recovery may indeed change in future, which suggests how reshaping the meaning of recovery has also been seen as potentially a lifelong phenomenon to navigate:

“I feel like it's an ongoing thing, and recovered is, like, very final... I don't think it's possible for it to be that, like, black or white. I think it's... there are, I feel like there's, like, traits within a person, if you've been brought up a certain way. It's like you have to self-manage those traits, and maybe it becomes easier in time to do that, but I feel like it's always there. Maybe I'll feel differently in, like, 20 years' time, and I'll feel like I'm completely recovered, but for now, I feel that's how I feel”.

(Leah)

4.3.2 *Becoming a Different Version of the Self*

Participants described recovery as involving not only changes in how they understood the diagnosis of BPD and recovery, but also a gradual transformation in how they experienced themselves, related to others and how they chose to live. For many, recovery was experienced as a reconstruction of self-identity in terms of how they came to see themselves as different from who they had once been. One way in which participants' identity shifted involved an increased capacity for self-reflection and awareness of thoughts, emotions, and behaviours, which participants described as previously inaccessible. Participants broadly spoke to no longer responding automatically to emotions and instead shared that they developed the skill of learning to pause and to reflect deliberately before responding to situations. Oliver reflected:

"I just kind of, like, started to really be aware and conscious of what I thought, and why did I think that, and why was I feeling that, and that just really sparks self awareness".

(Oliver)

Charlotte also reflected:

"I actually started to feel things, like, actually, like, rather than just, I feel good or I feel bad. It's daunting. It's like, branch out into, I feel anxious, or I feel, like, things that... because otherwise, before, it had just been, I feel bad, I'm going to restrict my food. That's not... I don't. I didn't, sort of, make any... I was too frightened of bad feelings. And sitting with negative feelings is so really hard".

(Charlotte)

As indicated, developing self-awareness, and more specifically in this context, a more nuanced understanding of one's emotional experiences, was often positioned as a foundational aspect of recovery which enabled participants to begin to make sense of emotional experiences that had previously felt overwhelming or automatic.

Most participants reflected on a gradual inclination to respond to their emotions more mindfully. The most commonly described defining feature that depicted the change that enabled responding to emotions differently was the developed ability to pause and to reflect before acting. Leah described her experiences of this:

"It was a lot of anger. And having no ability to prevent myself from getting to that place. I think, for me, it's still, I'm still capable of that happening. But I'm able to, like, reel it in, before it happens. That's sort of what recovery is for me, is, like, having the skills to do that... I sort of, like, go through what would happen in my head, like, I stop myself from saying something by visualising what consequences might look like, and I then sort of weigh the pros and cons of, oh, if I just reel it in. Although I want to get my point across, or, let that person know how upset I am. It's not worth it. That's sort of what I tell myself".

(Leah)

Alongside this reflective shift, participants described changes in how they related to their emotional experiences. It was depicted as learning to recognise triggers and learning to respond differently in situations that would have previously escalated into crisis, and experiencing this as evidence that they had changed as an individual. For Mark, his experience was starkly described:

"It is literally night and day... something that I would personally have taken quite personally, or would have gotten very upset about. I don't anymore".

(Mark)

These changes were often experienced as important markers of recovery, suggesting not the disappearance of emotional intensity, but a different relationship to it. Participants described becoming more able to tolerate distress and to prevent emotions from becoming all-consuming. This appeared to alter not only how participants managed emotional experiences, but how they experienced themselves. Rather than feeling governed by their emotions, participants largely described themselves as more reflective and in control. At the same time, this shift was not always experienced as linear. Some participants described new uncertainties that emerged alongside developing emotional awareness, including questioning whether their emotional responses were accurate or proportionate to the situation.

“Although I have these intense emotions, it's like, I have to... Yeah, it's a weird one now, because now I feel like I'm struggling with something completely different. It's like, oh, am I right about my emotions? Whereas before, I was like, I'm always right about my emotions. So, yeah, it's... it's... that's what I mean by it, it's definitely ongoing. You're never going to be in a place where you're, like, one hundred per cent perfect, but it's just not gonna happen”.

(Leah)

In this sense, recovery did not eliminate uncertainty for Leah, but it introduced different forms of ongoing self-development. Emotional change was therefore described less as mastery and more as an ongoing process of learning to relate differently to emotional experiences.

Participants also described an ongoing process of reconstructing their identity. Earlier accounts were often characterised by identities that were organised around illness or self-destructive coping. Some participants described deriving a sense of self-esteem through

harmful behaviours, whilst others recalled seeing themselves as fundamentally bad.

Charlotte reflected:

“I didn’t used to be able to say I was a good person, because I believed that I was... the worst person that had ever walked the planet”.

(Charlotte)

Charlotte also described having:

“No sense of self at all, except as an ill person”.

(Charlotte)

These accounts suggest that Charlotte’s earlier identity was organised around pathology, crisis or perceiving herself negatively. Recovery appeared to involve a gradual challenging of these perspectives. For instance, Charlotte reflected that now her perspective had shifted to seeing herself in a way in which she believes is more “realistic”:

“I think I’m more realistic when I, sort of talk about myself, or, you know, I can say that I’m good at this, or I struggle with that, or, I’ve got that sense of who I am, and I’m okay with it”.

(Charlotte)

For many, this process also involved letting go of aspects of the self that had once served a function but no longer aligned with who they were becoming or the person they wanted to be. They talked about letting go of coping strategies and relationships that had once felt necessary in the context of crisis or survival, but which no longer met their needs. Mark reflected:

“Anything that contributed or served me at that time doesn’t meet my need now as a changed person”.

(Mark)

Abigail also spoke to this, and emphasised prioritising living a lifestyle that prioritises her wellbeing:

“And I know not to go out now, and I stay at home. I don't expose myself to things that I know would have, would have sent me over the edge before. Or caused me to behave in that way. So I'm kind of, I don't, I think it's looking after yourself more as well. If I upset somebody by not going, unfortunately, that's just tough shit. Because I've got a reason for not to go. And if they can't understand that, then they're not a very good person, I don't need them in my life. And that's... I've got to look after myself now. I'm probably more so... I don't... I'm not a people pleaser anymore, if that kind of makes sense. I used to want to do everything for everybody, so I was always at the parties, I was always in a new outfit, I was always trying to look good, and now I'm like, I really don't care. I've got a bit of a different attitude, and this is the way it is, and it's kept me safe, and it's kept me out of hospital for 5 years now, and I'm gonna carry on being like this. And if people don't like it, it's just tough shit. They don't deserve a seat at my table”.

(Abigail)

This process often involved loss as well as growth. Several participants described grief when looking back on earlier versions of themselves, including sadness about lost time, missed opportunities, or years spent in distress. Despite this complexity, participants frequently described themselves in strikingly transformative terms, and they often emphasised the extent to which they no longer recognised their former selves. Oliver reflected:

“I feel like a completely different person, like, if I could go back to, say, that person that was just diagnosed and tell them that if I could even go back to before that, actually, like, after I left my parents, before my kids were born, and if I could show them the person that I am now, that is... it's... it's not upsetting in a... in a, like, sad way. But it is upsetting that I feel like I wish I knew what I knew now, like, back then, because... I would have had another 15 years”.

(Oliver)

Feeling like a different person was broadly experienced as a transformation of selfhood which involved reevaluating one's values, relationships, emotional responses, aspirations and ways of living. For some, this transformation involved actively constructing their identity through new experiences and relationships. Participants described trying new things, engaging in work, expressing opinions, building healthier relationships and allowing themselves to take up more space as part of discovering who they were beyond their diagnosis. Charlotte described:

“I've found my identity by trying things, and relationships with new people, and... allowing myself to take up more room”.

(Charlotte)

All participants also described a shift toward greater personal agency and responsibility. Whilst recognising the importance of support during crises, several described positioning themselves as active agents in ongoing change. For some, this transformation extended beyond the self into broader relational and social identities, with participants describing using their experiences to support others, particularly through peer support or advocacy. In these accounts, recovery involved not only becoming different for oneself, but occupying new relational positions as contributors and sources of hope. Helping others appeared to reflect a

broader shift from identities organised around crisis and receiving care toward identities rooted in connection.

4.3.3 Acknowledging Past Trauma

This category focuses on how participants made meaning and integrated their past experiences of trauma. Across participants' accounts, recovery involved a gradual process of acknowledging specific past experiences as traumatic, often alongside a parallel shift in how those experiences were understood and integrated into a broader sense of self. However, several participants described prolonged periods of not identifying with trauma at all, or actively resisting the idea that their experiences could be understood in that way. For some, trauma felt like a label that belonged to others rather than themselves, even in the presence of significant adversity. Darcie reflected:

“I was very, very anti-trauma as an idea for quite a long time. I just... I would not open any of those doors”.

(Darcie)

In this account, the idea of trauma itself is resisted or held at a distance. Experiences that had previously been disavowed had begun to be re-evaluated, which often occurred in the context of increased self-awareness which tended to transpire within a containing and consistent relationship through therapy. This was a non-linear process however, and some experiences that were viewed as traumatic were seen through a more critical lens. For instance, Cathy considered how aspects of trauma that she experienced in the past could be more accurately attributed to society as opposed to reflecting personal trauma that might need to be worked-through:

“I do accept that I had that trauma. I don't think... particularly if it shows itself... but I think that's society more than my condition”.

(Cathy)

This reflects a nuanced position in which trauma is acknowledged, but its ongoing emotional significance is understood as fluctuating, sometimes surfacing in particular contexts while remaining less visible in others. It also suggests that recognition of trauma is shaped not only internally, but through wider social meanings and expectations about what “counts” as trauma and how it should be experienced.

For some participants, this process involved confronting long-standing patterns of self-blame and shame. Experiences that had previously been interpreted as personal wrongdoing began to be re-understood as responses to adverse or traumatic circumstances. This shift often required a reworking of deeply held beliefs about responsibility and worth. For example, Darcie named this experience:

“There are other things that have happened to me that I know are traumatic, but I kind of buried [them], or didn't have enough self-esteem to think that it was anything other than my fault... I was quite adamant that I wasn't traumatised”.

(Darcie)

For Darcie, trauma was not believed to be initially absent, but actively unrecognised, which may have been shaped by internalising blame for her past experiences.

Several participants described experiencing anger toward parents or caregivers as they began to make sense of their relational histories. Oliver reflected on initially blaming his parents before recognising that blame alone did not create change for him:

“I sort of very quickly realised that blaming somebody else is not going to make it any better... I just needed to get on with it, and just start to put the work in”.

(Oliver)

This suggests that recovery did not involve rejecting the presence of emotional harm, but that it often required participants to move away from placing the responsibility solely onto caregivers in a way in which may have felt restrictive to starting to see the importance of one's own agency in their recovery. This movement toward recognition of past trauma often appeared to open space for changes in how participants related to emotional experiences that were often attached to them, such as anger or guilt. In addition, for some participants, making sense of trauma was closely linked to changes in how they viewed themselves, particularly regarding a reduction in self-directed blame and an increased capacity to hold more balanced or compassionate interpretations of past behaviour. Victoria reflected on this shift:

“Working on all the traumas that have happened... has changed how I feel about myself. Instead of feeling guilty all the time... I don't feel that it was my fault for everything that happened. It doesn't change all the different emotions that I feel, but I have a different outlook on myself”.

(Victoria)

Here, there is a clear distinction between the emotional experience and how the memories are interpreted. While emotions remain, the meaning attached to them and to past events shifted. This indicates that recovery involves a change in how difficult emotions are understood and situated within the self, at least within the context of trauma.

Several participants described “making peace” with the individuals that caused them harm, and Oliver had outlined how he began to empathise with those individuals which for him had led to him gaining different perspectives:

“When you find peace with them, and their actions towards you... you start to be able to look at things slightly differently”.

(Oliver)

Charlotte described a different process of acceptance whereby she described a movement to forgiving herself for things that she believes she has done in the past:

“Accepting that we are where we are, and we are who we are, and we do the best we can with what we’ve got... and forgive myself for... things that I did when I was poorly”.

(Charlotte)

Here, acceptance and forgiveness appear closely intertwined, which suggests that acknowledging trauma was not separate from reworking self-blame. Recovery involved not only recognising what had happened, but also renegotiating how responsibility was understood in relation to those events.

Alongside this, participants often spoke to a gradual process of making peace with anger related to both past and present experiences. This did not necessarily involve the absence of anger, but rather a change in its intensity or function. Importantly, this process was often described as still ongoing rather than complete.

“The latter years, say the last 20 years, I see aggression in someone, and I become extremely defensive very quickly, and that is the only thing that I can say is still... You know, kind of reactive to me. But I’ve spent the last, probably, 10 years or so, controlling that”.

(Cathy)

Several participants emphasised that trauma work was something that continued over time, sometimes with certain aspects remaining “buried” or not yet fully accessible. This suggests that acknowledgment of trauma was framed as part of an evolving and layered process. At the same time, participants often described a growing sense of compassion, both

toward themselves and toward others involved in their histories. This did not necessarily mean condoning harm or minimising its impact, but rather developing a more complex understanding of how and why certain behaviours or situations had unfolded. In this sense, compassion appeared to emerge alongside recognition, rather than replacing anger entirely. Charlotte captured this broader shift toward acceptance:

“Accepting that we are where we are... and we do the best we can with what we've got”.

(Charlotte)

Here, acceptance is about holding both the self and others within a more contextualised and less judgmental frame.

For some participants, this process of making peace with the past also involved reinterpreting earlier therapeutic experiences. Rather than seeing recovery as something that occurred within a single intervention or moment of insight, participants sometimes reflected on therapy as part of a longer developmental trajectory, where earlier experiences had laid the groundwork for later capacity to engage with trauma more directly. Daniel reflected:

“As an adult in his thirties I can now turn around and say that the therapy I had as a teenager... prepared me for the therapy when I was 25”.

(Daniel)

This suggests that making peace with trauma is not only retrospective, but also developmental, shaped across time through cumulative experiences of reflection and support.

4.4 Containment Becoming Possible Within Relational and Systemic Uncertainty

Participants described emotional containment as one of the most important aspects of recovery. They described it as something that was gradually made possible through

experiences of being emotionally held and understood by others, recognised within systems and no longer feeling completely alone with their distress. Importantly, it was not depicted as a fixed endpoint, as at the core of this experience was the awareness that relational and systemic containment remains fragile because relational safety unfolded within wider contexts of interpersonal and systemic instability. Experiencing containment within relationships and through systems was what facilitated participants to reshape their relationship to themselves and to the meaning of recovery, as described in the previous category.

4.4.1 Experiencing Relational Safety and Attunement

All twelve participants described a shift in how they related to other people but also how they began to experience others relating to them. This was depicted through moving from seemingly chronic feelings of aloneness and invalidation to having experiences that seemed corrective by having other people, sometimes close family or friends or sometimes professionals who show them that they are understood and believed in their experiences. For example, all participants spoke to experiencing feeling misunderstood by others, and for Darcie and Charlotte, they highlighted a sense of others initially failing to seek to understand them.

“I think people not being able to see beyond difficult behaviour as well, kind of sometimes taking it a bit at face value, when actually there's a hell of a lot more going on, like, often people are behaving the way they are, not because of the person in front of them, but because of stuff that's happened in the past. So, yeah, like, a lot of presumptions that my... like I mentioned with about the facial self-harm, like, that presumption that it was attention-seeking, was really damaging for a very long time, because actually what was happening for me was the total, total opposite, and that was so invalidating”.

(Darcie)

“Assumptions that you're manipulative, and assumptions that you're attention-seeking, and actually, you need to look underneath that, and... and the manipulation is a safety behaviour. It's not a thought through, I'm gonna get this person to do this by doing X, Y, and Z. It's survival behaviour. And I don't think that that's understood enough in the medical community that, that all of these things are survival behaviours”.

(Charlotte)

For Darcie and Charlotte, they experienced others misunderstanding them to be manipulative and attention-seeking, their experience was that of others seemingly not seeking to understand the intentions behind their behaviours, but instead appeared to make assumptions about the behaviours they saw at face value. For Cathy, she spoke to early experiences of abuse and spoke to an early experience of attempting to confide in her mother about what had happened, of which was met with physical chastisement and a lack of “empathy”.

“I did actually try telling my mum once, when I was abused. But because I was late home. The rule of thumb when I was a kid was get in before it's dark, and I got back late. And my tea had already been put out. And binned, because I wasn't there. So as soon as I came in, even though I was very distraught. Crying. The first thing my mum did was batter me and send me to bed with no tea. So, it was like, I don't trust people. I knew there was, it wasn't just men, it was people. I couldn't talk to my mum. My mum wouldn't listen. Even, you know, if I'd have sat down and explained to her, she had no, I don't know, empathy”.

(Cathy)

Grace also described experiences of not being heard, she explained that once when she confided in her psychiatrist, that she was accused of having false memories.

“When I had these flashbacks to abuse as a child, to various abuses, I, 30 years ago, my psychiatrist didn't want to go there and accused me of false memories, he was really unprofessional, and, used to swear at me, and used to say, people like you, I'm in therapy because of people like you, people who've got BPD, you're the worst people to treat, you're, he used to eff and blind at me, I mean, it was, it was unforgivable”.

(Grace)

Also, there was a recognition that others seemingly did not understand them and also did not know what to do. For example, Daniel spoke to his experiences in the workplace where he believed he was not being understood:

“It wasn't taken, perhaps, as, it wasn't looked into or given the same respect as if I had dyslexia, dyspraxia, autism, or a physical health condition... the impression I get is that they just don't quite know what to do”.

(Daniel)

Given these repeated previous experiences, having moments where others provided participants with experiences of being truly seen and understood, it was experienced as meaningful. Having experiences of being validated by others were described as turning points that led to a shift in participants' recovery. Importantly, these experiences were seldom shared within the context of receiving formal therapeutic interventions, but more often it was the seemingly smaller moments that other people demonstrated that showed participants that they were understood and being held in mind. Grace reflected on this:

“It’s those authentic moments where you have that connection that can really spur your recovery on... they can say something quite simple, but it can actually have really positive effects”.

(Grace)

Here, Grace positioned connection as an experience of being met by another person in a way that feels sincere. The significance lies less in what the other person has done and more on how the other person is experienced in a given interaction. Darcie echoes this sentiment in how she described valuing the sincerity of how she perceives her care coordinator:

“She’s not trying to over-please or over-impress anyone, she’s just trying to meet people where they’re at and get to understand them... she’s honest with me as well... she tells me if actually this thing you’re asking for is totally unreasonable, and I appreciate that because I know she’s not going to gaslight me or bullshit me”.

(Darcie)

Darcie’s perception of her care coordinator being honest and acting with integrity stood out for her. Furthermore, whilst participants described valuing experiencing validation, what mattered was the transparency of interactions as opposed to being unconditionally affirmed. This experience of having someone act with authenticity is what drove connection. As this formed in part, the foundation of which trust was developed with others. In addition, the quality of a therapeutic relationship was shared by Mark as a mechanism that enabled him to gain what he wanted to from therapy:

“It’s the relationship you have with that person that is the main... it’s the difference essentially between getting what you want out of it”.

(Mark)

This centres relational attunement as the active mechanism in which recovery or intervention related treatment becomes emotionally safe enough to engage with. Further to this point, Stephen shared an experience whereby he had received a personalised letter from staff members at a mental health charity that he was receiving support from, it depicted for Stephen a powerful sense of being recognised:

“Some of us had tears in our eye because the letters had been picked for you for that reason... I felt... they were hitting”.

(Stephen)

In this example, attunement is expressed through being understood as an individual within a group context. The emotional impact is located in the sense that one’s individuality has been noticed, held in mind and reflected back to them. As aforementioned, it was not solely professional relationships that were deemed important in shaping experiences of feeling relationally contained, but experiencing feeling truly understood by close family members was also emphasised as transformative in one’s recovery. Cathy expressed her connection to her father in the face of him being able to recognise her struggles, despite acknowledging his lack of expert knowledge of mental health:

“When I’ve sort of looked into BPD and what kind of issues we, people can have with having the disorder, it’s all, it’s all stuff my dad recognised in me years ago. And without having the knowledge of, a mental health worker or anything, he could see the struggles I had”.

(Cathy)

Further, this process did not involve a straightforward shift from feeling invalidated by others to then feeling completely contained however, and the shift in how participants

related to others often occurred gradually amidst having mixed experiences with others. For example, Stephen mentioned:

“I've been in and out of services all my life. Some good experiences, some bad experiences... I've always been told, talk to them. They're there to help, and that always went against me because then you doing that they just see it as you're willing, and you're not as bad as what they think you are”.

(Stephen)

There was a described sense of feeling contained by others most of the time, and all participants spoke to currently having at least one close person in their lives who they believed truly understood them. However, for all participants, there was still a held belief that feeling contained by services is not fixed and they were mindful of the reality of service constraints.

“Patience. That's a huge one. I'm having to be so patient with the system. I'm waiting for more therapy, and it's taking months and months. And that's really challenging for me, because I just want to crack on with it and get back to where I was, and everything moves so slowly in the system, in the community mental health system, with the psychology, you know, I know that, you know, they're short-staffed, and, they're having to do some training before they can deliver it. I know that, but when you're, you're desperate, and you're, bouncing in and out of crisis. It's hard to be, always be patient”.

(Grace)

At the core of this category is that recovery becomes possible through particular properties experienced within a relationship or interactions. Recovery was experienced as fundamentally relationally held and all participants shared how recovery occurred through the scaffolding of others, and within the context of felt connection with other people. Notably, it

was not the imparting of expert knowledge that facilitated connection, but it was an authentic sense of genuine human connection. These relational experiences were deemed important in close personal relationships and with professionals. A commonality between participants was that relational attunement was experienced as a human capacity to recognise one's emotional reality, rather than simply being seen from the perspective of a diagnostic or clinical perspective. For example, Stephen recalled his dialogue with a GP which contrasted with his earlier experience of feeling dismissed as a child:

"You never listened to me as a kid... but I'm going to shake your hand because you've listened to me".

(Stephen)

Previous experiences of Stephen feeling dismissed by his GP set an expectation for how he was anticipated to be perceived again at a later date, and experiencing the opposite, more validating experience, carried significant weight as it challenged previous expectations of how one is perceived.

However, the fragility of attuned care shone through in participants' narratives, and this tended to come about whilst participants were actively engaged in therapeutic treatment. Whilst many participants in hindsight reflected upon others showing a lack of attuned care, this was perceived in hindsight as unintentional or through a lack of understanding. However within the given context, this was in the moment perceived as dismissal. Victoria described an interaction that she had with a psychologist whilst she was in acute distress:

"I just feel so suicidal... and she went, well what did we learn on Monday?... and then she put the phone down on me".

(Victoria)

This excerpt illustrates a stark contrast between the expression of high emotional distress and the absence of emotional availability provided in response. This interaction shows how the absence of emotional containment in moments of crisis are experienced as disconnecting and therefore leaving individuals alone in a place of distress. Darcie also discussed a pattern that she had experienced amongst professionals of avoiding having conversations which were related to distressing emotional experiences, in particular, she noticed how professionals tended to avoid having conversations about self-harm:

“Nobody wanted to talk to me about it... they were just like go away and distract”.

(Darcie)

These experiences contrast hugely with Darcie’s more current experiences with her care coordinator where she feels able to openly share when she is experiencing urges that are considered as risky.

“Having the opportunity now to be able to talk about that, and, like, my care coordinator's been my care coordinator for 5 years, and I can, I can talk to, I can say now I have XYZ urges. Oh, feelings, or whatever, and I can say that to her, and be honest, and know that she's not gonna judge me, she's not gonna panic and, go and get me sectioned, or all of those things that were happening in the past, that actually she's gonna talk to me about it, and we're gonna process it, and we might end up getting to the point where it's like, actually, there is gonna be some harm here, but actually, how can we reduce that, and how can we learn from that? So, like, it happening doesn't mean that it's the end of the, it is not the end of the world. Sometimes there can be massive growth after that”.

(Darcie)

Both Victoria and Darcie's experiences suggest that when one's emotional experience is not heard and understood relationally, that participants may experience this as an unmet need and a disruption of trust that others can provide containment.

When participants had experienced feeling genuinely held and understood by others, it started to enable a noticing of relationship dynamics and a shift to prioritising relationships in which participants felt able to express themselves fully and authentically. There became a selectivity in participants in terms of who they wanted to maintain relationships with. For example, Darcie described moving from previously having many friends to prioritising certain relationships:

"I used to need to be friends with everything that walked past, like, I kind of was very much a people pleaser, but that led to a lot of very toxic relationships and friendships, and I've worked really hard in the last, like, two years or so to kind of, like, I guess, strip down my, close friends, friendship group. Instead of having lots of good-ish friends, I've got a couple of really, really, really good friends that I know I can depend on, and they're people that, are willing to take me in any format as well. Like, as in, like, whether it's a good day or a bad day".

(Darcie)

This highlights that relational attunement is not only about gaining connection, but also about withdrawing from relationships that undermine emotional safety. This shift in the perceived quality of relationships experienced by participants reflects a motivation to seek out and prioritise relationships in which feel authentic and genuinely attuned.

"I wouldn't mind meeting someone, but I also understand what I want in life, and also that means I understand what someone else has got to be able to kind of relate to, you know, and I'm yet to, I'm yet to find that".

(Oliver)

An increased recognition of the importance of reaching out for support from others compounded this shift in seeking better quality relationships. Participants increasingly identified the importance of communicating distress to trusted others in times of hardship.

“When I’ve had a bit of a hard time, I go straight to the doctor now. I don’t sit and dwell on it or go to the pub and spend all my money in the pub. I’m literally, right, I’ve got my, I know I’m gonna, I know I’m gonna be poorly, because I know that something might have happened, so if I’ve had a bereavement, or if I’ve had some bad news, I do talk about stuff a lot more as well”.

(Abigail)

“If I’m about to hit that struggle. Reaching out. If I don’t reach out, I know I’m gonna go down that long winding, not depressive, but the start of that depressive, I could hit that if I don’t ask for help, because if you don’t ask, you can’t get the help”.

(Stephen)

However, this uncertainty was not described as something that dissipates once containing relationships have been established. As such, Charlotte emphasised that there is a level of mistrust that can remain, which is often rooted in previously experienced relational trauma:

“I don’t trust people... it wasn’t just men, it was people”.

(Charlotte)

In this sense, relational safety is therefore not something that is achieved or reached as an outcome in recovery, but more accurately experienced as something that is cautiously reconstructed in the context of prior relational trauma or invalidation. Furthermore, relational safety does not replace distress or erase relational risk, but creates the conditions in which

participants can begin to risk openness and reflection within relationships that feel contained enough. Charlotte reflected on this:

“A lot of things that you, like, you believe. Or you think is just obviously true, or whatever, and you say it out loud with someone you trust, and you hear it out loud, and you can hear when something's not right, but you can only do that when you've got somebody you trust enough to open up with”.

(Charlotte)

Importantly, participants shared how having valued relationships with close people in their lives functioned as motivations to stay well. For some, relationships with specific family members were described as providing motivation for them to stay alive or to avoid harmful behaviours. For instance, Abigail reflected:

“I can't have these little people thinking they've lost their auntie”.

(Abigail)

In a similar vein, Mark felt motivated to recover within the context of his daughter:

“Finding out that I did have a daughter, was another motivating factor for me, because it was like. Well, I never, ever want her to have to experience what I did growing up as a kid”.

(Mark)

4.4.2 Trust Building Through Relational Consistency

Participants described a sense of felt trust in others through repeated experiences of feeling understood and contained emotionally. Whilst individual moments of attuned care were experienced as profoundly meaningful for participants, trust was experienced as earned over time through sustained and reliable interactions with others that provided them with

emotionally attuned experiences. As described in this subcategory, it was the development of predictability that others will be available and are capable of providing containment that enabled participants to risk ongoing engagement with others, and in part, precipitated the willingness to engage meaningfully in treatment. Further, this category outlines a distinct process of the accumulation of dependable responses from others that gradually challenge potential expectations of connection inevitably leading to abandonment. For participants, their reality was that previous experiences of support from mental health services were characterised by inconsistency, and the presence of this inconsistency eventually resulted in care being discontinued. Mark articulated this in terms of his experiences with psychological therapy, and he linked his experiences of inconsistency directly to experiences of abandonment:

“I'd start to get to know a counsellor, a therapist, whatever it might be, and then they would leave... and then you'd end up just being left in limbo. And really struggling with that... fear of abandonment... it would feel like abandonment”.

(Mark)

From Mark's perspective, inconsistency directly related to whether the professional was present or not, and in this case was not related to the quality of the relationship. He emphasised that service constraints or administrative issues can translate as relational inconsistency and abandonment. For Mark, each change or absence of staff member was not experienced purely as an isolated incident but rather as a real repeated experience of being abandoned by another person. On the other hand, for Mark, a later therapeutic experience that was seen as consistent profoundly challenged his previous experiences of therapy:

“The consistency and the continuity that I had with it... she was consistent with me... that continuity was like key for me, because I really built a relationship with her... Without her I wouldn't have, I don't think, seen it through”.

(Mark)

For Mark, the consistency he experienced with his therapist became grounds for him being able to build a relationship with her and follow-through with treatment. It shows how momentary acts of attunement alone do not suffice for meaningful change to occur, and that it is this in combination with the experience of having a consistent relationship that enables meaningful change to occur. For others, issues including staff members missing appointments, poor communication or unclear boundaries around contact perpetuated feelings of unpredictability in others. Darcie described repeated experiences of services failing to attend scheduled home visits or not informing her when staff were unavailable:

“I've had a care coordinator leave the service and not tell me... people who've gone on annual leave and not let you know... somebody is supposed to be coming on a home visit and just hasn't turned up”.

(Darcie)

As with Mark's experiences of abandonment with members of staff leaving, these experiences were not framed as minor service failures but perhaps more accurately as relational ruptures that undermined trust and reinforced expectations that others could not be relied upon.

Alongside professional relationships, participants also described the significance of consistency within personal relationships. Oliver reflected on the importance of a close friend who remained present even during acute crises. He experienced the presence of his long-term friend as calming in the midst of distress:

“He'll just turn up and... instantly, for some reason, he just makes me feel calm”.

(Oliver)

He expressed that the consistency of his relationship with his friend provided him with an embodied sense of containment. In a similar vein, Abigail described her parents' ongoing presence despite periods of relational strain and the perceived impact of her own behaviour. What became significant was not perfection in the relationship, but more so its consistency:

“I was an absolute nightmare... I don't know how my parents still want to talk to me. They've always been there, and I think that's now what makes me want to recover more”.

(Abigail)

In this account, relational continuity is directly linked to motivation for recovery. The sustained availability of others despite difficulty disconfirms expectations of abandonment and introduces the possibility that relationships can withstand hardship and emotional intensity.

For Darcie, the feeling of being able to reach out for help without being reprimanded or restricted actually reduced reliance on crisis contact:

“Knowing that when I reach out for help, she will respond... her being a bit more meeting me halfway has meant that I don't call on services as much, because I know it's there”.

(Darcie)

This suggests an important relational mechanism, in particular, that experiencing consistency in availability within relationships does not necessarily increase dependence, but that it can instead reduce anxiety-driven help-seeking by creating an internalised sense of availability.

The relationship therefore becomes a stable reference point rather than an uncertain resource that must be urgently accessed. Honesty and boundary clarity were also experienced as integral to consistency. Participants described valuing relationships in which communication was direct and predictable, even when this involved disagreement or limits being set. Rather than undermining trust, this clarity often strengthened it because it reduced ambiguity and prevented feared misattunements. Inconsistent or unclear communication, by contrast, was experienced as destabilising emotionally. At the same time, consistency was not experienced in a purely positive or straightforward way. Several participants noted that relational stability existed alongside broader systemic instability in their lives. Most participants shared concerns around service accessibility and, for Darcie specifically, systemic instability also included homelessness or fluctuating care arrangements. She explicitly situated difficulties within this broader context:

“Stability for me is a bit variable because I rely on care, and that's a very unstable thing... my decisions aren't my own, and that can be quite frustrating”.

(Darcie)

This highlights that trust-building through consistency does not occur in a vacuum. Even when individual relationships are stable, wider structural and systemic instability, as described by Darcie, can undermine the sense of security that those relationships are able to provide. As such, wider structural instability appeared to constrain the extent to which individual relational consistency could be internalised as safety, and it represented an ongoing tension.

4.4.3 Belonging Through Shared Experience

Participants expressed facing a movement from feeling alone in their experiences of distress to recognising that their experiences were shared and understood by others. The

emergence of a sense of belonging occurred most frequently once participants engaged in group-based therapeutic treatment and within online communities. It was in these spaces that participants encountered others with similar diagnoses and relational histories. However, this process involved more than being understood in an interpersonal sense or being supported or challenged by others. Precisely, it centred on the transformative impact of recognising similarity or seeing oneself in another. This identifying oneself in another disrupted long-held experiences of being different to others, or “being the naughty kid”, as described by Abigail. In group therapeutic contexts, this sense of shared experience was often described as immediate and striking. Emma reflected on the impact of being in a group where others appeared to recognise and understand her experiences without her having to explain herself:

“We had eight other people in my group who completely got it just completely understood what you were going through and why you might have said something or how, why you reacted that way. And it was such a safe space that you could call each other out on things, knowing that it was going to be OK. I mean, there was a lot of tension and shouting in that room sometimes and things did get a bit heated. But you knew that's kind of what you had to do”.

(Emma)

Similarly, Cathy commented on her own experiences of group therapy:

“But it was so beneficial. To, to sort of sit within a group and know that other people... when you can relate to other people with the same issues, and see that, you know... It's like, wow, it's good to know that you aren't alone, you know, and... It was... it was interesting, and certainly beneficial”.

(Cathy)

Although Emma's account includes elements of relational challenge, the central significance lies in the experience of shared recognition and being among others who "completely got it". The group becomes a space where behaviour that had previously been experienced as confusing or shameful for others could be understood as intelligible within a shared framework of distress. Even when the group environment was emotionally intense or conflictual, it was still experienced as containing because the underlying assumption of shared experience remained intact. However, belonging through shared experience was not always uniformly positive. Some participants described difficulties engaging in group therapy when differences in level of distress or stage of recovery disrupted their sense of belonging. In these cases, the presence of others with "worse" or more acute difficulties sometimes led to self-silencing or emotional inhibition, as described by Stephen:

"The last two times I had CBT, one was in a group, but we were all in different stages of our mental health journey. And I didn't feel like I could say stuff that I needed to say to get off my chest in the group. Because I was more concerned about how they, the people around me, would deal with it, because they were in a lot worse place than what I was. So it felt like I couldn't in that group session. I felt like I couldn't really get down to the nitty-gritty of why I was there. I was more there, supporting them with the stuff, if that makes sense".

(Stephen)

Stephen outlined how for him having this particular shared experience became complicated by relational comparison and responsibility toward others' distress. Rather than facilitating belonging, the group context temporarily positioned him as an outsider or caregiver, which limited his ability to access his own therapeutic needs. This highlights that belonging through

shared experience is not simply about co-presence, but about the perceived equivalence of experience and the freedom to occupy one's own place within the group.

Alongside formal therapeutic groups, participants also described the importance of seeking informal forms of shared experience. For some this included reading personal recovery stories and for others it was engaging with online communities. These forms of connection were often experienced as particularly powerful because they were not mediated by clinical authority but instead reflected lived experience in a peer-to-peer format that felt more relatable. Grace reflected upon her preference for reading others' accounts of survival and recovery:

"I quite like reading people's survival stories, and yeah, other people that have had similar diagnoses, it's really important to have those as role models. Yeah, it makes you feel less alone. Also, when you, you read... You think, oh, they felt the same, and, you know, or similar".

(Grace)

In Grace's experience, belonging is achieved through recognition across time and distance, where reading about others' experiences produced a reflective identification that reduces isolation. The emphasis is not on direct interaction, but on the recognition that subjective experiences are shared across others with similar histories. This form of belonging also introduces the idea of "role models", which implies that shared experience can also provide a developmental or aspirational dimension, where others' recovery becomes imaginable for the self.

Online communities were also described as significant spaces for this form of recognition. Participants highlighted the accessibility of online content created by individuals

with lived experience, particularly when it articulated emotional or cognitive experiences that felt difficult to express elsewhere. For instance, Emma explained the following:

“The online community is a really helpful, really helpful and there's an amazing guy online... he's he's a like world expert on BPD and he, he does some amazing pieces to camera, just some short pieces to camera about really kind of deep stuff that only somebody with BPD would get”.

(Emma)

For Emma, belonging was facilitated through digital spaces where shared language and shared emotional experiences are made visible and explicit. The phrase “only somebody with BPD would get” is particularly significant, as it reflects both the exclusivity and intimacy of shared experience. It suggests that belonging is not simply about being included, but about encountering a form of understanding that feels uniquely attuned to a specific lived reality. For some participants, the recognition of shared experience also functioned as a corrective to stigma and moral judgement. Many described long histories of being labelled as “difficult”, “disruptive”, or “bad”, particularly in relation to emotional or behavioural expressions of distress. Encountering others with similar patterns allowed these interpretations to be reframed as part of a broader pattern of human distress rather than individual moral failing. Abigail spoke to this notion:

“I think the only thing I can say is, is it was knowing that other people have got what I've got. I'm not the only person. It was, listening and thinking, oh my god, I do that, I do that, and being, like, not so isolated, because when you've got an illness and no one else understands it, you're deemed the bad person, you're deemed, oh my god, they're so naughty, they're so disruptive, oh, she's such a bitch. Not realising that it's not actually who I am, it's my illness”.

(Abigail)

This account illustrates how shared experience functions to shift understanding away from individualised blame and toward a more collective understanding of distress. Recognising similarities between her experiences and those of others enabled Abigail to reconsider previous experiences of judgement and stigma. Rather than viewing herself as inherently "bad", "disruptive" or fundamentally flawed, she began to understand these experiences within a broader context of emotional distress that was shared by others. In this sense, belonging through shared experience did more than reduce feelings of isolation; it also changed how participants understood themselves and the meaning they attached to their experiences.

However, Mark also highlighted that the possibility of belonging through shared experience is potentially narrowed by broader social and cultural stigma surrounding BPD. He described difficulties finding safe spaces in which to talk openly about his diagnosis, due to fear of judgement or misunderstanding. For instance, he discussed his reality of finding it difficult to find a space to share openly:

“The stigma is still quite... is still pretty bad, and I think that's a barrier in itself, not just like when you're trying to access services and stuff, but just generally trying to talk to people about it, because there's so much bad stuff out there. Trying to find a safe place to discuss it with somebody is really really difficult”.

(Mark)

This highlights that belonging through shared experience is not always readily available, as such, it is often constrained by stigmatising external narratives. As a result, the discovery of safe spaces becomes particularly meaningful, precisely because they are experienced by some as rare.

Participants also described initial apprehension about entering group-based or shared therapeutic environments, particularly when they involved exposure to others with similar difficulties. Over time, however, many described becoming more able to tolerate and eventually value these spaces, which suggests that once it is established that one can relate to others within the group, then this opens the door to feeling comfortable to engage with the collective experience. For example, Cathy shared:

“I was very apprehensive at first... sitting in a group with other people, discussing whatever. But after, like... obviously, the first couple of weeks was a bit... meh”.

(Cathy)

This reflects an important developmental process, specifically that belonging is not immediate, but that it often emerged through repeated exposure to shared spaces, as well as a developing tolerance of vulnerability in relation to others. Belonging through shared experience therefore appeared to function as a process through which isolation is disrupted and stigma is implicitly challenged. Through this process, participants moved from isolation toward connection, and from individualised shame toward a more collective and legitimised understanding of distress.

4.4.4 Others Holding Hope and Providing Challenge

Participants described recovery to be largely shaped by relationships in which others were able to hold hope and belief for them, this was felt to be especially impactful at times whereby they themselves felt unable to access feelings of hope for themselves. In some ways, this category embodies the combination of attuned and consistent relationships that participants begin to experience, but this extends to these relationships also encompassing support in terms of a maintained belief that one can and will be in a place of recovery. Further, recovery was often positioned as emerging through an ongoing dynamic of

experiencing hope as scaffolded by another and a gradual internalisation of this hope which develops into increased agency in recovery. Participants explained how specific individuals in their lives have communicated their belief that change for them was possible, even through moments of crises. This holding of hope was seen as meaningful as it represented a reminder that relational connection is possible even when you feel that you are not able to meet the expectations of those around you. Grace described the importance of having someone who could hold hope on her behalf during periods of severe distress:

“I’m not always good at having hope, but having somebody, like a support worker, who holds that hope for me when I’m really poorly. And... That’s really powerful, to know that somebody can see your strengths at moments when you’ve lost sight of them”.

(Grace)

Here, hope was a feeling that was described as not initially internally located but that is temporarily located within another person, and it functions as a stabilising relational resource that can be drawn upon when one is struggling to access self-belief, and for Grace, this is particularly relevant at times where she identifies as being poorly. For Grace, and for others, it is notable that this externally located hope carries an implicit expectation of future possibilities for change, which gradually becomes internalised over time.

In contrast, experiences of others lacking hope were often described as invalidating or damaging. For example, Stephen recalled an interaction with a clinician who communicated seemingly deterministic views about his future:

“He went straight off the bat he went you’ll never work again. You’ve had this all your life. You’ll never do this. You’ll never do that. You’ll never do that, and you’ll never do that. And he stuck his hands up like that and went, don’t get mad and attack me”.

(Stephen)

Here, the interaction was experienced as foreclosing possibility. Rather than expanding Stephen's sense of agency, it potentially led to a restricted sense of identity and reinforced any hopelessness that he may already have been feeling.

In addition, having others externally scaffold hope was experienced as providing participants with challenges. Importantly, this was experienced as hopeful only when provided by individuals who were perceived as containing and consistent. Participants often described more transformative experiences of challenge when it was delivered collaboratively and with an explicit stance of working with rather than on them. This was particularly evident in accounts where professionals invited participants into shared decision-making and positioned them as active agents in their own recovery process. Grace reflected on how experiencing this shift in stance fundamentally contributed to altering her engagement in her recovery:

"I can remember when the doctor first said to me, I'm working with you, and I thought. I'm... oh, and then... and then he's... he said, well, what do you think about your medication? Do you think we should... reduce it, or do you want to try this? And then I had much more ownership and investment in... in my own recovery, because I was given that, given that respect, and trust".

(Grace)

Further, Grace's viewpoint illustrates how responsibility becomes psychologically possible when it is scaffolded by relational trust and shared authority. Rather than responsibility being imposed, it was co-constructed in a way in which enabled a shift from passivity toward ownership and engagement. Importantly, this process was described as gradual and was often preceded by repeated experiences of others failing to demonstrate belief in their recovery,

meanwhile simultaneously imposing responsibility be taken in their recovery. Darcie depicted this experience from her perspective, whilst also describing how others scaffolding responsibility led the way for her to begin to take responsibility herself:

“I'd been told so many times before, you just need to take responsibility, like, it's really common for people to tell people with a BPD diagnosis, you know, you just need to go and distract, or you need to take responsibility for your actions, but then not actually offer people any support in doing that. Whereas on this unit, they... We were, we were, we were accepting responsibility for our actions, but we were given support to do that, and like, like. People were walking beside us in that journey”.

(Darcie)

Recovery in relation to developing responsibility therefore was not framed as complete self-sufficiency, but more closely as the gradual development of agency that is cultivated within a supportive relational context that can tolerate setbacks and inconsistency. In sum, others holding hope and providing challenge emerged as a relational process that enabled participants to move from feeling hopeless about the possibility of change toward greater agency and self-directed recovery. Darcie depicted this notion;

“And someone was like, you're... you did that. You were the only person that was responsible for you, like, you could have not turned up to those check-ins. You could have, like, but you did. And that was so empowering. That was so empowering, to realise, actually, I did have, I did have the ability to do that with the right support at that time, and that's sort of, like. And that was a really big turning point for me, in starting to, like, believe that I could change, knowing that I, you know, I had a long journey ahead of me, and I needed a lot of help to get there, but, like, that I... that I could change, that there could be something... there could be something different for

me in the future, that wasn't just death and being in psychiatric wards all the time. So yeah, that was a massive thing for me”.

(Darcie)

However, this was only possible when hope and challenge were integrated within emotionally attuned and consistent relationships. Without this integration, challenge risked being experienced as helpless, or even stigmatising. For instance, Stephen expressed this when he recounted an experience with a mental health crisis team:

“They say we can't help you. You've got personality disorder. Just go for a walk or have a bath. It's not helpful. There's such a big stigma around it”.

(Stephen)

Together, however, they functioned as a scaffolding process through which participants could begin to internalise belief in change, tolerate responsibility and engage more actively in their recovery. Abigail described this candidly:

*“You also need people around you to say, Abigail, do not have a drink. You don't need that. And I do, and as much as I rebelled against it at first, I'm like, don't f*cking tell me what I can and can't do. I know they've got my best interests at heart. And that has really helped... it's just about taking a bit of ownership and going, do I want to still be this person in 10 years' time”.*

(Abigail)

4.5 The Theoretical Model

The theoretical model (Figure 4) represents the processes of recovery in individuals who have received a diagnosis of BPD. It is depicted as an ongoing and relationally scaffolded process of developing a different relationship with oneself and to the meaning of

recovery. Participants did not describe recovery as becoming symptom-free or returning to a previous version of themselves. Rather, recovery involved becoming more critical about these initially held expectations, and involved a change of perspective about the meaning of recovery, which also involved a commitment to developing greater self-understanding, responding differently to distress and building a life that felt meaningful despite knowingly living with ongoing sensitivities to emotional distress.

At the foundation of the model is containment becoming possible within relational and systemic uncertainty. Participants described recovery as being scaffolded by experiences of relational safety and attunement, trust building through relational consistency, others holding hope and providing challenge and belonging through shared experience. Together, these processes created a sense of containment which enabled participants to develop the psychological processes involved in recovery, which included feeling less alone with experiences; valuing and seeking relationships seen as more authentic and fulfilling; having motivation to recover; developing hope and responsibility within one's own recovery. These processes in turn created the conditions from which individuals started to reshape their relationship to themselves and to the meaning of recovery. However, containment was never experienced as fully secure or permanent. Participants remained aware of the possibility of relational rupture, service discontinuity and wider systemic instability. For this reason, the lower category is represented by a hashed boundary within the model, to illustrate that containment was experienced as fragile and uncertain, yet sufficiently stable to support recovery processes.

Developing within this relationally scaffolded context is the overarching process of reshaping the relationship to the self and to the meaning of recovery. This overarching process includes three interconnected processes. Each of these processes contribute to this broader shift and represents pathways through which participants reshaped their relationship

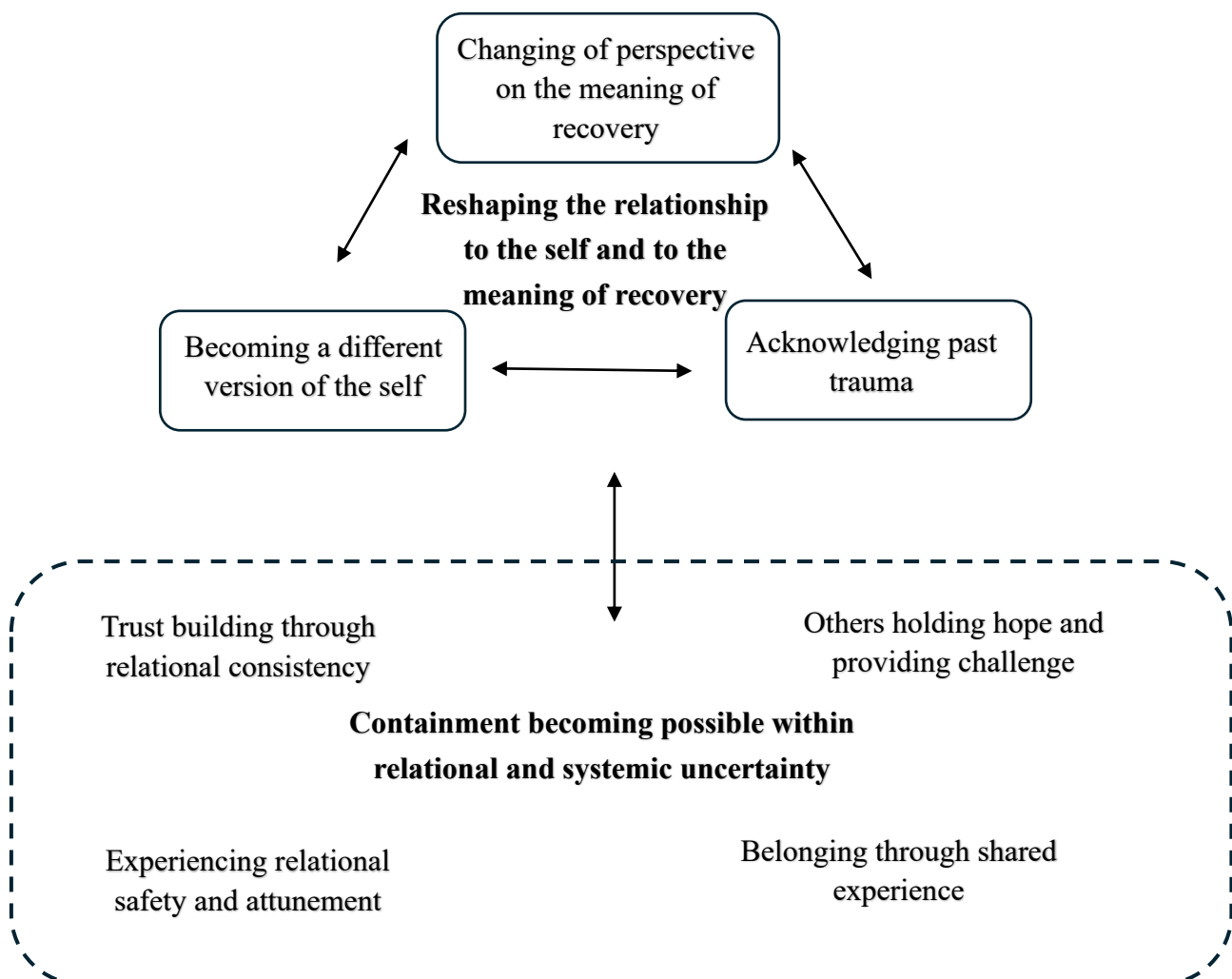
to themselves and to the meaning of recovery. The first, changing of perspective on the meaning of recovery, describes how participants moved from passively accepting diagnostic and recovery narratives towards developing their own understanding of distress, diagnosis and what recovery meant to them. The second, becoming a different version of the self, reflects participants' accounts of increased self-awareness, emotional understanding, personal agency and identity development. The third, acknowledging past trauma, captures the gradual process of recognising, integrating and making meaning of traumatic experiences, which was often accompanied by reduced self-blame and greater compassion towards themselves and others. These three processes are represented as distinct but interconnected because participants did not experience them as occurring in a fixed sequence. Instead, they were described as recursive and mutually influential. For example, developing a greater understanding of past trauma often influenced how participants viewed themselves, while changes in self-understanding created new opportunities to revisit and reinterpret past experiences. Similarly, shifts in how participants understood recovery frequently influenced their sense of identity and relationship to distress. The bidirectional arrows within the model therefore represent the recursive and mutually influential nature of these processes, illustrating how developments within one process often prompted changes within the others over time.

Although containment is represented as the foundation of the model, participants' experiences also suggested a reciprocal relationship between containment and reshaping the relationship to the self and to the meaning of recovery. As participants developed greater self-understanding, agency and self-compassion, they became increasingly able to seek out, utilise and maintain supportive relationships, communicate their needs more effectively and engage more meaningfully with support. In this way, containment initially enabled the development of these psychological recovery processes, but this also appeared to strengthen participants'

capacity to access and benefit from containing relationships. Recovery was therefore not experienced as a linear progression from containment to change, but as an ongoing and reciprocal process in which relational support and personal development continually influenced one another. This explains the bidirectional arrow from the lower to the upper part of the model.

Figure 4

Theoretical Model of the Grounded Theory



4.6 Chapter Summary

This chapter presented the findings of the constructivist grounded theory analysis which explored recovery processes in individuals who had received a diagnosis of BPD. The analysis identified a series of interrelated categories and subcategories that together formed a theoretical model of recovery as a relationally scaffolded, non-linear and ongoing process of reshaping the relationship to the self and to the meaning of recovery.

CHAPTER FIVE: DISCUSSION

5.1 Chapter Overview

This chapter begins by summarising the findings of the constructivist grounded theory of recovery processes in individuals who have received a diagnosis of BPD. Next, the findings are situated within the context of existing literature and psychological frameworks. The ways in which the findings either extend or contribute to existing knowledge within its application to recovery processes in individuals who have received the diagnosis are discussed. The discussion highlights how relationships function more than as supportive contexts within recovery. In particular, they are conceptualised within the analysis more specifically to facilitate recovery when they are characterised by specific qualities. The chapter also revisits the concept of ambivalence, as described in the systematic literature and meta-ethnography presented in Chapter 2. It is reframed as a meaningful response to identity change, relational and systemic uncertainty rather than a potential resistance to recovery. Finally, the chapter considers strengths, limitations and recommendations for future research before reaching the final conclusions of the thesis.

5.2 Summary of Findings

A theoretical model grounded in participant data was created from the findings of the constructivist grounded theory. The constructivist grounded theory explored the processes

involved in recovery in individuals who had received a diagnosis of BPD and who had identified themselves as in “recovery”. The model proposes that individuals experience an ongoing, lifelong process which involves both a reshaping of the relationship with the self and a reshaping of how they understand and relate to the meaning of recovery. The processes of recovery identified within this grounded theory involved movement through interconnected relational and intrapsychic processes. Also, the term “recovery” was initially understood by participants as a cure. However, through the process of redefining its meaning, it became less about symptom reduction or a return to a pre-morbid self, and more centred on a gradual process of psychological and relational change through which participants developed different ways of understanding themselves, relating to distress, making sense of the past and engaging with treatment over time. These processes were consistently described as being relationally scaffolded. Participants initially experienced hope, containment, self-understanding and agency through their relationships. These relational experiences gradually supported participants in developing their own sense of hope, containment, self-understanding, and agency, although these capacities continued to be reinforced through ongoing relationships. However, this did not mean they became permanently self-sufficient or no longer needed relationships. Recovery remained relationally scaffolded and ongoing. Recovery may therefore be understood within this analysis as a process in which relational experiences scaffold the development of intrapsychic resources that gradually begin to become integrated into an individual's sense of self.

5.3 Interpreting the Grounded Theory in Relation to Existing Literature

Before considering the findings in relation to the broader literature, it is important to situate the present grounded theory alongside the preceding systematic literature review and meta-ethnography presented in Chapter 2 of this thesis. The meta-ethnography conceptualised recovery as a non-linear and interconnected process involving self-growth, the repair and

reconnection of relationships and the experience of ambivalence towards change. The present grounded theory supports these ideas but develops them further by moving beyond a description of what recovery involves, to offer a process-based account of how recovery unfolds based on participants' experiences. Importantly, the grounded theory provides an interpretive framework through which previously identified components of recovery may be understood as connected parts of a wider process. In this thesis, this process is conceptualised as being underpinned by individuals gradually internalising relational experiences and ways of relating with others and themselves over time.

5.3.1 Containment Becoming Possible Within Relational and Systemic Uncertainty

Relationships as the Foundation for Intrapsychic Change. Existing recovery frameworks, including the Connectedness, Hope, Identity, Meaning in life and Empowerment (CHIME) framework (Leamy et al., 2011), identifies connectedness as an important component of recovery, while broader recovery literature has conceptualised recovery as socially embedded rather than solely intrapsychic (Borg & Davidson, 2008; Price-Robertson et al., 2017; Topor et al., 2011). The present findings support these perspectives but suggest that relationships may function as more than sources of support or contexts within which recovery occurs. For example, key intrapsychic processes including hope, self-belief, responsibility, agency, reflection, mentalising and pausing before responding appeared to develop initially within the context of relationships with others before becoming experienced as internal resources. This extends existing relational recovery literature by suggesting that relationships may not merely support recovery, but may be understood to shape the development of intrapsychic resources that become increasingly integrated into the self over time. Participants' accounts suggested that relationships could temporarily provide forms of emotional containment, reflection and hope that individuals were not yet able to sustain independently. Through repeated experiences of being understood and emotionally contained,

these functions appeared to become increasingly available as part of individuals' own psychological resources.

This aligns with psychodynamic concepts of internalisation, particularly Bion's (1962) idea that, in early development, a caregiver helps a child to manage overwhelming emotional experiences by receiving, holding and making sense of them on the child's behalf. In this view, the caregiver helps to transform raw, unprocessed emotional states into something more understandable and tolerable. Over time, through repeated experiences of being understood and emotionally contained in this way, the individual gradually develops their own capacity to carry out this reflective and regulatory function for themselves. Within the context of the present study's findings, others may temporarily help individuals to manage and make sense of overwhelming emotions, particularly at times when this felt difficult to do alone. Over time, these relational experiences appeared to contribute to the development of an increased internal capacity for reflection, emotional regulation and meaning-making.

Similarly, Winnicott's (1960) concept of the holding environment refers to the emotional and relational context provided by a caregiver or therapist. It describes a situation in which an individual experiences sufficient psychological safety to express and experience difficult or overwhelming emotions without becoming emotionally overwhelmed. It can be extended beyond its original developmental framing to suggest that therapeutic and peer relationships may provide a temporary external structure through which individuals can make sense of difficult emotions, experiences and aspects of themselves that may otherwise feel overwhelming. This form of holding can also be understood in terms of the psychological functions it enables, which aligns with Bion's (1962) notion that others may temporarily help to receive, contain and make sense of overwhelming emotional experiences until it becomes more tolerable. Importantly, however, the present findings indicate that this holding is not experienced as fully secure or static. As such, participants depicted containment as fragile and

occurring within ongoing relational and systemic uncertainty. This suggests that the development of more internalised psychological resources does not require perfect or stable environments, but sufficiently consistent relational experiences in which these reflective and regulatory functions are repeatedly available. From an attachment perspective (Bowlby, 1969), this process may be understood as the progressive internalisation of a secure base. This refers to a consistent, reliable relationship in which an individual experiences safety and support which allows them to explore emotions and experiences with increasing confidence. Bowlby (1969) proposed that over time, repeated experiences of responsiveness and attunement enables individuals to begin to access internal representations of safety and stability without often requiring direct interpersonal reassurance.

Mentalising as an Internalised Relational Process. Importantly, this mechanism also resonates with mentalisation-based theory (Fonagy & Bateman, 2008), in which the development of reflective processes emerge through interactions in which mental states are named and held in mind by another. Mentalisation refers to the capacity to understand behaviour in terms of underlying thoughts, feelings, intentions, and perspectives, both in oneself and in others (Fonagy & Bateman, 2008). The findings of the current grounded theory suggest that recovery may involve the development of this capacity through experiencing others as mentalising them; for example, being understood in ways that go beyond surface-level interpretations of behaviour and instead reflect an appreciation of their emotional and relational context. This appeared to support participants in beginning to view their own responses from alternative perspectives, including recognising how their reactions might be understood or experienced by others. Over repeated experiences of being mentalised by others, this process seemed to facilitate a gradual relocation of mentalising from an interpersonal experience to an intrapersonal capacity. In other words, the ability to understand

one's own mind may first be experienced as something done with another, before becoming something the person can more reliably do alone.

Hope and Belonging as Relationally Mediated Processes. Participants also described a process whereby hope was initially located within others before gradually becoming internalised over time. This finding aligns with recovery literature which identifies hope as a central component of recovery (Leamy et al., 2011) and with suggestions that individuals may initially rely upon others to maintain belief in the possibility of change when they are unable to do so themselves (Tore Sælør et al., 2014). The present findings extend this literature by illustrating a developmental process through which externally held hope appeared to become gradually transformed into greater self-agency and ownership of recovery. Participants often described others' belief in them as powerful, as it demonstrated trust and the emergence of a new perspective regarding change being possible. This suggests that hope may first emerge interpersonally before becoming internalised.

The importance of belonging through shared experience further supports previous findings regarding the value of peer relationships in recovery. Mead and Copeland (2000) argued that mutuality and shared understanding can challenge isolation and facilitate empowerment. Likewise, participants in the present study often described group interventions and contact with others who shared similar experiences to them to reduce feelings of isolation and shame. This process also seemed to enable the challenging of deficit-based narratives of understanding distress and provided a sense of normalisation of their experiences. However, the findings suggest that shared experience offered more than social support alone. Recognising aspects of themselves in others appeared to facilitate a reshaping of identity and meaning, which allowed participants to move from viewing themselves as uniquely flawed toward understanding their experiences within a broader shared human context.

Reframing Ambivalence as Lived Uncertainty. Previous qualitative literature has described recovery in relation to BPD to be characterised by ambivalence (Katsakou et al., 2012). However, the present grounded theory suggests a different interpretation. Participants did not describe uncertainty about whether they wanted recovery or change. Rather, their concerns were rooted in lived experiences of mistrust and invalidation within relationships, alongside fears of relapse and uncertainty about future access to support. This suggests that what has previously been conceptualised as ambivalence to change may be better understood as understandable responses to relational and systemic conditions of uncertainty. Recovery therefore involved developing new ways of relating to distress and learning to tolerate uncertainty about the future, the self and relationships. In this sense, containment may be understood as the development of sufficient psychological and relational resources to continue engaging in recovery despite ongoing uncertainty. Consistent with the systematic literature review and meta-ethnography presented in Chapter 2, uncertainty remained a persistent feature of recovery, but the present grounded theory suggests it is grounded in relational and systemic contexts rather than an internal conflict about change, or recovery, in and of itself.

5.3.2 Reshaping the Relationship to the Self and to the Meaning of Recovery

Recovery as an Evolving Process Rather Than a Cure. Previous literature has described recovery in BPD to be defined as non-linear and characterised by setbacks (Ng et al., 2019), but the present study extends this by exploring how this process of meaning-making unfolded. Participants consistently rejected notions of recovery as a return to a previous or “normal” self. Instead, they described an ongoing process which expectedly involves setbacks and adaptation. There also appeared to be a gradual shift toward becoming more aligned with accepting oneself and the presence of ongoing differences. This supports broader personal recovery literature, which emphasises recovery as living a meaningful life

despite ongoing vulnerability rather than achieving complete symptom reduction (Slade, 2009). Notably however, the present findings suggest that this understanding of recovery was not typically present from the outset. In fact, participants often described initially seeking recovery in the sense of a cure or complete resolution of their difficulties before gradually developing a different perspective on what recovery meant to them. Recovery therefore appeared to involve changes in relational and psychological functioning, and also a transformation in how recovery itself was understood. In this sense, reflecting upon and revising the meaning of recovery may constitute an important recovery process in its own right.

Participants also described recovery as involving a fundamental shift in how they related to emotional distress. Importantly, recovery was not characterised by the elimination of difficult emotions. However, it was about developing greater awareness and tolerance of emotional experiences. Participants often described becoming more reflective, recognising their triggers, pausing before acting on emotions and responding differently to situations that may previously have resulted in a crisis. This finding closely aligns with Linehan's (1993) biosocial theory of BPD, which conceptualises emotional dysregulation as a core feature. Linehan (1993) identified the development of emotional awareness and regulation skills as central to recovery. Participants also recounted earlier experiences of responding automatically to overwhelming emotional states and that they later developed greater capacity to observe, understand and to respond to emotions differently. This suggests that recovery may involve altering one's relationship with emotional experiences rather than eliminating emotional sensitivity itself. In addition, participants in the current study emphasised an acceptance that experiencing emotions more intensely than others was something experienced as unique and innate to them, and therefore not something to be changed, but more so something to be effectively managed and adapted to. Interestingly, the current findings also

resonate strongly with acceptance and commitment therapy literature. Hayes et al., (2006) argued that psychological wellbeing is facilitated through changing one's relationship with difficult thoughts and feelings, not by trying to avoid or get rid of them. Participants repeatedly described recovery as learning to live alongside difficult emotions, accepting setbacks and developing strategies that prevented distress from dominating their lives. This suggests that recovery may also be conceptualised as an increasing flexibility in responding to emotional experiences rather than achieving a state of complete emotional stability. These findings may also be understood through mentalisation-based perspectives. Fonagy and Bateman (2008) proposed that difficulties in mentalising are central to BPD, particularly during emotionally intense and interpersonal situations, and that treatment should support the development and maintenance of reflective functioning. Participants in the present study described developing greater curiosity about their emotions, often by asking themselves why they felt certain ways and reflecting on previous responses that felt automatic. These accounts closely resemble descriptions of increased mentalising capacity. The present findings therefore suggest that one aspect of recovery may involve developing a more reflective relationship with internal experiences.

Reshaping Identity. One of the most prominent findings within the present grounded theory was that recovery involved becoming a different version of the self. Participants described recovery as a gradual reconstruction of identity, which entailed an increased self-awareness, changes in the ways they viewed themselves, changes or closer alignment with their values and relationships and the development of greater agency. This identity reconstruction was also reflected in participants' interpersonal lives. As they developed greater self-understanding and agency, they described becoming more discerning about the relationships they maintained. For instance, many participants described actively seeking relationships that they experienced as genuine, authentic and emotionally containing while

distancing themselves from relationships which were believed to be invalidating or unhelpful. This finding closely aligns with previous qualitative studies of recovery in BPD, which have identified identity change as a fundamental component of recovery. For example, Katsakou et al., (2012) found that participants described recovery as becoming a different person and developing a more coherent sense of self. More broadly, these findings support recovery literature which conceptualises recovery as a process of rebuilding selfhood. Further, Slade (2009) argued that recovery involves developing a positive sense of identity beyond psychiatric symptoms. Consistent with these accounts, participants in the present study described moving from identities which centred around crisis and pathology towards more nuanced understandings of themselves, which often looked like defining themselves through personal values, relationships, interests and aspirations rather than diagnostic labels alone. A key process underpinning this identity reconstruction appeared to be relational confirmation. Participants' accounts suggested that shifts in the way they understood and related to themselves were not consolidated internally in isolation, but required repeated experiences of being seen differently by others. In this sense, identity change was not only an intrapsychic process but also an intersubjective one, in which alternative self-concepts were mirrored back through relationships which were characterised by attunement and consistency. These relational experiences appeared to provide evidence against previously dominant identity narratives, which gradually supported the stabilisation of emerging self-concepts.

The findings also resonate strongly with the Identity component of the CHIME framework (Leamy et al., 2011), which highlights the importance of developing a positive sense of self during recovery. The present study adds further detail to this literature by illustrating how identity transformation may unfold over time. Participants described becoming somebody new through ongoing processes of reflection and relational connection. Recovery therefore appeared concerned with constructing an evolving sense of self that could

incorporate past experiences without being completely defined by them. Importantly, the present findings suggest that identity reconstruction involved the construction of a newer identity whilst simultaneously holding in mind how one defined themselves previously. Previously defined versions of the self were not always discarded, but were described as reference points to how far they have come but also reminders that older versions of themselves are still present and cannot be erased. Therefore, identity reconstruction may be better conceptualised as an ongoing negotiation between emerging self-narratives and previously dominant narratives held about the self. As will be mentioned within the following section, reshaping one's identity also appeared to be intrinsically linked to how participants reshaped their relationship to trauma.

Reshaping One's Relationship to Trauma. A further key finding concerned participants' gradual process of acknowledging and beginning to make peace with past trauma. They did not describe trauma work as a discrete stage of recovery, but more of an ongoing process of reconsidering self-blame and developing new ways of understanding the impact of those experiences on their lives. This finding from the present grounded theory aligns closely with Herman's (2015) three-stage model of trauma recovery, which proposed that recovery from trauma involves the interconnected processes of establishing safety, remembrance and mourning and reconnection. Participants' descriptions in the current study reflected elements of each stage, particularly the importance of developing sufficient relational safety before revisiting traumatic experiences. Specifically, reshaping the relationship with one's trauma appeared in the present data to be less about constructing a definitive or complete account of the past and more about an ongoing process of reconstructing meaning. Participants often shared that previous traumatic experiences prior to recovery were frequently understood through lenses of self-blame. Over time, however, the same experiences came to be interpreted within broader relational, developmental and

contextual frameworks. Therefore, what appeared to change within participants' accounts was the psychological meaning attached to the content of the memory and its position within the individual's understanding of the self. In this respect, the grounded theory developed in this study extends Herman's (2015) model by suggesting that remembrance and mourning may involve the development of a coherent trauma narrative and an ongoing process of reinterpretation and meaning reconstruction that continues indefinitely throughout recovery. Importantly, these shifts in meaning were rarely described as occurring in isolation within participants' accounts. Instead, participants described how alternative understandings of their experiences were first introduced and validated within relationships before gradually becoming their own. Specifically, new meanings were often initially co-constructed within therapeutic, peer or other significant relationships before becoming increasingly available as internally generated ways of understanding experiences. Furthermore, whilst Herman's model emphasises the importance of relationships in establishing safety and facilitating recovery, the present grounded theory suggests that participants experienced relationships as central to the ongoing construction and internalisation of new meanings throughout the recovery process, rather than serving primarily as a context within which trauma work occurs. Notably, participants rarely described the process of understanding and working-through trauma as achieving a complete resolution. As such, many acknowledged that aspects of their traumatic experiences remained difficult to fully process, and many participants acknowledged that elements of their past trauma remained unprocessed. However, this was not generally experienced as evidence of failed recovery. Instead, it reflected an acceptance that recovery remains ongoing and that relationships with traumatic experiences continue to evolve over time. Trauma therefore appeared to become something that could be acknowledged, understood and held differently, as opposed to something that required a complete resolution.

This finding also supports trauma literature which proposes that trauma can have an impact on how an individual views themselves and others. For example, Van der Kolk (2014) argued that trauma can fundamentally shape how individuals experience themselves, their bodies and their relationships. Briere and Scott (2015) suggested that trauma recovery often involves reattributing responsibility and developing a more compassionate view of the self. For instance, they advocated for the use of cognitive-behavioural therapeutic approaches to challenge beliefs and to replace them with more accurate representations of the self. Participants in the current study closely reflected this shift, particularly in moving from self-blaming interpretations towards more contextualised understandings of their experiences. Importantly, these changes appeared inseparable from the broader process of identity reconstruction described earlier. As participants revised the meaning of traumatic experiences, they simultaneously revised the meanings they placed on themselves. Reshaping the relationship with trauma therefore did not function as an isolated therapeutic task, but as one mechanism through which identity change was enacted. Reinterpreting trauma as something that had happened to them, and for some, the understanding that their trauma may reflect broader societal views rather than something that defined them, appeared to enable the development of more nuanced and compassionate understandings of the self.

5.4 Strengths and Limitations

5.4.1 Methodological Strengths

Recruitment via online platforms enabled the inclusion of participants from a range of geographical locations across the UK, which likely enhanced the contextual diversity of the sample. This was particularly valuable given known variability in service provision and treatment pathways dependent on locality (Maconick et al., 2021). Unlike much of the existing research, which has explored recovery within specific treatment settings or programmes, recruitment was not limited to individuals who were currently receiving

treatment or who had recently completed treatment. Instead, participants represented a range of treatment experiences and pathways as described in their interviews, which also included differing levels of engagement with services over time. This exploration of recovery processes beyond the context of any single intervention or service model may have facilitated the identification of recovery processes that were relevant across diverse treatment experiences. The geographical breadth of the sample further allowed for exploration of how recovery processes are experienced across different service contexts operating within distinct systemic structures. This variation supported the development of more conceptually robust analytic categories by enabling consideration of both shared and contextually inflected aspects of recovery. Had recruitment been limited to a single locality or treatment context, the analysis may have been more constrained by local service configurations and less able to explore the extent to which recovery processes were consistent or variable across different systems of care.

5.4.2 Methodological Limitations

A limitation of the present study relates to the cultural homogeneity of the sample, which consisted exclusively of White British participants. As a result, the grounded theory is primarily reflective of recovery experiences situated within a UK, White, Western and predominantly NHS-based mental health context. Recovery processes are likely to be in part culturally shaped based on norms around expressions of distress, ways of relating with others, including those in positions of authority, to name a few. Consequently, it remains unclear whether the present model of recovery is transferable to individuals from more ethnically and culturally diverse backgrounds. This includes the proposed process through which individuals gradually develop different ways of understanding themselves and others through relational experiences. In particular, the central emphasis within the grounded theory on the internalisation of relationally derived intrapsychic resources may reflect culturally specific

emphasises of autonomy and individuation that are more characteristic of Western psychological frameworks. In more collectivist cultural contexts, where identity may be more relationally or community embedded, similar processes may be experienced differently or may not be conceptualised in the same intrapsychic terms. Additionally, the meaning and experience of a diagnosis of BPD are themselves culturally situated within Western psychiatric systems. Alternative cultural frameworks may locate distress within spiritual or social explanatory models for example, which may shape both engagement with services and narratives of recovery in ways not captured within the present sample. A study in the systematic literature review outlined in Chapter 2 demonstrated this cultural difference in how individuals diagnosed with BPD related to others within their recovery. Specifically, Sarwendah et al., (2022) found that in an Indonesian context, individuals' spiritual faith served a stabilising relational function within recovery. As such, the findings should be understood as culturally situated.

The iterative process of initial coding generated a large number of potential analytic directions, which required decisions to be made regarding which codes were developed further into focused codes and subsequent categories. This process necessarily involved prioritisation, whereby certain analytic pathways were developed in greater depth while others were not pursued in order to produce a coherent and conceptually integrated analysis. While such reduction is inherent within constructivist grounded theory methodology, it also means that alternative analytic directions may not have been fully developed or may have been set aside during the analytic process. As a result, the final theoretical account represents one of several possible interpretations of the data, shaped by the analytic choices made throughout coding and category development.

5.4.3 Reflexivity

As a Trainee Clinical Psychologist at the University of Essex, I approached the research from a particular epistemological and professional position that inevitably shaped both the generation and interpretation of data. My clinical training orientated me towards attending to psychological, relational and intrapsychic processes within participants' accounts of recovery, which inevitably influenced not only the aspects of narratives that appeared salient to me, but also the follow-up questions posed during interviews and the interpretative decisions made throughout the analysis. My training within clinical psychology may also reflect broader professional discourses that privilege psychological formulations of distress and recovery, which potentially shaped both what was attended to within participants' accounts and how these experiences were interpreted. In addition, my professional identity may have privileged certain understandings of recovery over others by potentially foregrounding individual meaning-making and emotional processes whilst comparatively backgrounding broader socio-political influences. Researchers from alternative disciplinary or professional backgrounds may therefore have attended to different dimensions of participants' experiences and generated different analytic interpretations. Reflexive engagement through memos was maintained throughout the study in an attempt to critically examine how my assumptions and clinical experiences shaped the research process and the construction of meaning within the analysis, although it is important to note that the complete removal of potential unconscious biases is unlikely to occur through this process.

My own assumptions regarding the meaning and nature of recovery inevitably shaped the research process and influenced methodological decision-making from the outset. Prior to undertaking the study, I had limited understanding of what recovery might look like for individuals diagnosed with BPD, and was particularly interested in the topic because recovery narratives often appeared less foregrounded within both the literature and clinical

practice from my personal and professional experience. Through previous clinical experiences working with individuals diagnosed with BPD, I had been exposed to clinical narratives relating to those with a diagnosis of BPD which seemed characterised by hopelessness and stigma. Consequently, the possibility of recovery had not been widely explored within my own clinical experience, which initially contributed to an implicit assumption that recovery may represent a distinct turning point or form of “cure”. In hindsight, this assumption may have been shaped by working within primarily medical-model teams that tend to privilege biomedical forms of treatment and align more closely with cure-based understandings of recovery (Anthony, 1993; Slade, 2009). Reflexive consideration of these assumptions throughout the planning and conduct of the study highlighted the importance of adopting a methodology which was capable of exploring recovery as an evolving process rather than presupposing a particular outcome or endpoint. These assumptions appeared to shape my early methodological thinking, including an initial inclination towards using interpretative phenomenological analysis, as I anticipated participants may describe identifiable “before” and “after” recovery experiences. However, my decision to adopt constructivist grounded theory reflected a desire to explore recovery as a process and to remain open to how participants themselves understood and experienced recovery over time. Ongoing reflexive engagement throughout the study required the continued examination of my assumptions, particularly as participants’ accounts consistently described recovery as non-linear and ongoing rather than as a fixed state or endpoint. In this sense, the iterative and process-oriented nature of constructivist grounded theory proved particularly well suited to capturing the evolving and relational dimensions of recovery. Retrospectively, reliance on my earlier assumptions may have risked oversimplifying recovery processes by conceptualising recovery as a singular transformative event rather than

an ongoing negotiation of relational containment and reshaping of one's relationship to themselves and to the meaning of recovery itself.

In addition, participants may also have positioned me as a mental health professional associated with psychiatric systems, psychological services and diagnostic practices, which may have influenced both what was disclosed within interviews and how experiences were shared. Participants may have assumed a degree of shared understanding regarding mental health services, and the diagnosis itself, which may have influenced what was emphasised, omitted, or taken as implicitly understood within interviews. At times, participants spoke positively about psychologists or asked questions relating to clinical practice and service experiences, which suggests that my professional identity influenced the relational dynamics of the interview process. Equally, participants may have moderated criticism of services or professionals due to perceiving me as aligned with clinical systems. These interactions highlighted how participants' accounts were constructed within a particular interpersonal and institutional context, rather than existing independently of the researcher-participant relationship.

5.5 Clinical Implications

Recommendations to the ways in which care and treatment is approached in the UK for individuals who have received a diagnosis of BPD were created upon the generation of the theoretical model presented in the current study. Below are seven recommendations:

- Clinicians may benefit from seeing the diagnosis of BPD not as a final explanation of an individual's difficulties, but more as an ongoing way of making sense of their experiences that can be revisited over time. The findings suggest that individuals often go on to understand their distress in multiple ways, including in relation to trauma, neurodevelopmental differences and difficult

relational experiences. A trauma-informed and formulation-based approach can support this by encouraging clinicians to build a more complete picture of the person, rather than relying on a single diagnostic explanation. In practice, this means actively exploring what sense the person themselves makes of their diagnosis and inviting discussions that involve alternative explanations for their difficulties. Also, it is important to being open to revising this understanding over time. This may help ensure that the diagnosis does not narrow an individual's understanding of themselves, but instead supports instillation of hope and personal agency as well as developing a personally meaningful way of understanding distress.

- The findings highlight that diagnostic labels can be experienced as both validating and potentially stigmatising. While the diagnosis may provide access to support and offer a shared language, it may also inadvertently reinforce stigma or even communicate reduced expectations involving possibilities of change. Clinicians should therefore communicate diagnoses in a way that emphasises hope in the possibility of change and in which also communicates an individual's personal strengths. Doing so can help avoid communicating deficit-focused narratives which may serve to perpetuate potential feelings of hopelessness and shame.
- Ongoing and consistent relationships with clinicians or services appears to support individuals in developing emotional regulation and reflective thinking skills, which can over time become internalised and used more independently. Services should therefore prioritise consistency in therapeutic relationships wherever possible and minimise unnecessary ruptures in care. Particular attention should be given to transitions such as discharge, which participants often experienced as emotionally destabilising. Planned endings, relationally held transitions, and

where appropriate, brief or intermittent follow-up contact may help support consolidation of skills learnt during treatment and reduce experiences of abandonment or relational uncertainty.

- The findings suggest that risk behaviours and crisis states may be better understood as moments of relational and emotional distress rather than solely indicators of individual pathology or treatment failure. From this perspective, clinical responses should prioritise understanding the relational meaning of distress. This can be achieved by maintaining connection during times of crises, and prioritising repairing ruptures in the therapeutic relationship. This implies a shift away from exclusively behavioural focused responses towards approaches that emphasise reflection and meaning-making.
- Participants described significant value in being able to express distressing experiences such as suicidality and self-harm within relationships characterised by containment. Clinicians should be supported to remain emotionally present and reflective in the face of distress, rather than responding primarily through distancing or service withdrawal. This includes sitting with difficult emotional material and offering validation. It also includes engaging collaboratively with distress in ways that support reflection and learning rather than shame or isolation.
- The findings suggest that individuals who have received a BPD diagnosis and identify as being in recovery acknowledge that emotional intensity is something that is innate to them, and for some, the ongoing presence of risk was experienced as realistic. Therefore, expectations around treatment should be in line with these lived experiences of the reality of recovery, that being a lifelong journey and not something to be achieved, per se.

- The findings suggest that recovery is supported by relational experiences that provide hope, containment, and guidance, which gradually scaffolds the development of individuals' own capacity to hold hope, contain distress and engage in recovery with increasing agency. Clinicians should therefore aim to balance support with the careful scaffolding of autonomy by ensuring that responsibility is neither prematurely withdrawn nor over-relied upon externally. Supportive relationships may help individuals develop reflective capacity and emotional regulation, particularly when these functions are not yet easily accessed internally. Over time, this may involve a gradual shift from external support to internalised resources, while maintaining relational availability where needed.

5.6 Recommendations for Future Research

Future research should further explore the social, cultural, political and spiritual dimensions of recovery, which were not actively examined within the present study. While the current grounded theory highlighted the importance of relational processes, it remains primarily situated within psychological and service-based contexts. Future work could therefore examine how factors such as socioeconomic inequality, gendered expectations, cultural meanings of distress, and access to community resources shape recovery experiences and trajectories. In particular, research is needed to understand how recovery is constructed outside of mental health services, including within families, peer communities, cultural identity frameworks and non-clinical support systems. This could also include exploring how people who have received a diagnosis of BPD make sense of their experiences without using recovery terminology, particularly among individuals who do not identify as “recovered” or “in recovery”, in order to better understand how recovery-related processes are described outside of a recovery framework. Additionally, spirituality may represent an important but underexplored dimension of recovery. Future qualitative research could investigate how

spiritual beliefs, existential frameworks, or non-clinical forms of meaning-making, for instance philosophical worldviews or nature-based practices or even holistic medicinal practices may contribute to experiences of hope, containment and identity reconstruction. This would help broaden current understandings of recovery beyond psychologically and diagnostically defined frameworks and ensure that models of recovery are not unintentionally limited to Western clinical epistemologies.

5.7 Conclusions

This constructivist grounded theory offers a novel conceptualisation of recovery processes in individuals who have received a diagnosis of BPD from a UK perspective. It conceptualised recovery processes to involve a relationally scaffolded reshaping of the relationship to the self and to the meaning of recovery itself. Previous literature has identified the importance of hope, connectedness, identity and meaning-making within recovery (Leamy et al., 2011). The present study suggests that these processes in individuals who have received a diagnosis of BPD may be linked through a broader developmental process. As opposed to relationships functioning solely as supportive contexts, the findings suggest that experiences such as being emotionally understood, experiencing containment, validation and the communication of hope may function as active developmental processes. Through repeated and emotionally salient relational experiences, these functions appear to support the development of capacities for self-reflection, emotional regulation, identity coherence and agency. Within this model, relationships do not merely facilitate recovery, but constitute the developmental medium through which internal psychological resources such as hope and self-belief are first co-constructed in interactions with others and then gradually become available to individuals more independently. This process is iterative and non-linear and is characterised by movement between reliance on external relational containment and increasing use of emerging internal resources. These findings build on those identified within

the preceding meta-ethnography in Chapter 2, which conceptualised recovery as a non-linear and relational process involving self-growth, the repairing and reconnecting of relationships and ambivalence towards change. In this sense, the present grounded theory adds further detail to these processes by elaborating on how they may unfold over time. Internal intrapsychic processes such as hope, agency and self-reflection may not function as separate components of recovery but as interrelated experiences that develop through repeated relational interactions.

The findings also suggest that the meaning of recovery shifted from idealisations of a cure towards an ongoing and non-linear process of reshaping relationships with the self, distress, trauma and recovery itself. Identity reconstruction emerged as a central feature of this process, and it closely intertwined with the development of the ability to tolerate and manage difficult emotional experiences. What has often been described in previous literature as ambivalence towards recovery appeared, in the present study, to reflect realistic concerns regarding the possibility of future setbacks, particularly within contexts of relational and systemic uncertainty. Rather than indicating resistance to recovery, this reframing positions uncertainty as an intrinsic and meaningful feature of recovery processes.

In conclusion, the findings suggest that effective clinical practice is likely to be relationally active as well as encouraging the development of skills. Clinicians may function as temporary external co-regulators of emotions, meaning and hope, and, over time, consistent and attuned relational experiences may support the development of these capacities within the individual. In turn, this may contribute to the development of greater reflective capacity, emotional regulation skills and a developing sense of identity. Overall, recovery may be understood as a process through which individuals gradually develop new ways of relating to themselves and their experiences through repeated experiences of containment, connection, challenge and meaning-making. Hence, the grounded theory proposes that

recovery unfolds through a dynamic process whereby relational experiences repeatedly scaffold new emotional and interpersonal experiences, which become increasingly integrated into the individual's sense of self and support evolving ways of relating to distress, identity and the meaning of recovery. Recovery is therefore not a destination to be reached, but an ongoing process of becoming.

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Appendices

Appendix A:

Quality Appraisal of Included Studies Using the CASP Checklist

Table A1

Quality Appraisal of Included Studies Using the CASP Checklist

Author and year	1. Aims	2. Qualitative methodology	3. Research design	4. Recruitment	5. Data collection	6. Relationship	7. Ethical issues	8. Data analysis	9. Findings	10. Value
Donald et al., (2017)	✓	✓	✓	✓	✓	×	×	✓	✓	✓
Katsakou et al., (2012)	✓	✓	✓	✓	✓	?	✓	✓	✓	✓
Kverme et al., (2019)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Larivière et al., (2015)	✓	✓	✓	?	✓	×	✓	✓	✓	✓
Liljedahl et al., (2023)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓
Mooney et al., (2023)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓
Sarwendah et al., (2022)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓

Note. ✓ signifies this criteria was met; × signifies this criteria was not met; ? signifies that there was not enough evidence provided to assess this criteria. Full questions from the CASP; (1) Was there a clear statement of the aims of the research?, (2) Is a qualitative methodology appropriate? (3) Was the research design appropriate to address the aims of the research? (4) Was the recruitment strategy appropriate to the aims of the research? (5) Was the data collected in a way that addressed the research issue? (6) Has the relationship between researcher and participants been adequately considered? (7) Have ethical issues been taken into consideration? (8) Was the data analysis sufficiently rigorous? (9) Is there a clear statement of findings? (10) How valuable is the research?

Appendix B:

First and Second Order Constructs

Table B1

First-Order and Second-Order Constructs in Donald et al., (2017)

First-order constructs	Second-order constructs
“I don’t know if the word recovery is realistic. It might be for some people”. “I really do want to recover because of all the rubbish that I go through because of it [BPD]. But, at the same time, recovery is detracted a bit by the fact that I don’t really know what it looks like”. “I think [...] yeah, I think it’s possible. For myself anyway [...] and for a lot of others, I’m sure they can [...] change, yeah”. “[...] scares the living daylights out of me because I’ve never been anyone without mental illness [...] I’ve had mental illness since I was seven, so I don’t know what I’m going to do once I’ve recovered. I don’t even know who I would be”.	Positive change as “risky” but possible
“In general, I think that people who are seeking recovery need to be aware that in reality they are probably going to have to go through a lot of stuff in order to get it. Umm, there are a lot of barriers there that they need to get through and they are probably going to get treated like sh*t before they get anywhere good”.	Positive change is difficult but possible through constant hard work
“Until you actually hear things spoken or even with other clients not just the [names agency] staff but listening to others, it sort of reinforces or you come to a realisation”. “My relationship with my ex-partner and my kids were the biggest thing for this. Like I don’t think I would’ve cared half as much about myself or the outcome of my life if I didn’t have them in my life, if you know what I mean”.	Support from others
“I know initially early on I was probably in denial; that was probably a big hurdle that I had to get over and get through. Umm, yeah I don’t know aside from acceptance, it covers so much, it is such a big thing. First it was accepting the diagnosis”.	Acceptance of the need for change
“One of the positive changes that I have already seen is that I have stopped blaming myself. For so many years I had thought that it was just me being silly or clingy or difficult to deal with, but the positive changes that I can now see it is not me, like I am separate from BPD and those were just the symptoms showing up at the time, it wasn’t about me particularly”.	Work on past trauma without blaming oneself
“Through the start of my recovery I found myself being curious and it was doing [names group] that what I was learning and what was being taught [...]. Umm, yeah it was more curiosity”.	Curiosity about oneself
“I grew up and I’m like, ‘things are hard for me, why is that?’ And I’d slowly go, ‘Yeah, when I do that, it doesn’t work out’. So I sort of had to re-learn some things [...] It’s not, you know, not about the world molding to you”.	Reflection on one’s behaviour

Table B2*First-Order and Second-Order Constructs in Katsakou et al., (2012)*

First-order constructs	Second-order constructs
“I feel more confident. I keep on doing something and then thinking ‘well I wouldn’t have done that last year’. I’m stronger in myself, with relationships, with anything. Even when I might be talking on the phone with somebody who I don’t want to talk to, like a salesman, and then stopping them in between, whereas before I would let them rant on until the end and I’d probably sign up to what they wanted me to”.	Accepting self and building self-confidence
“I just want to be able to... like if I’m miserable then I’m just down, I’m not wanting to die kind of thing. And then if I’m happy I’m just cheerful, not kind of flying off the walls like I’ve taken drugs; just to feel normal emotions”.	Taking control of emotions, mood and negative thinking
“I’m not a very mindful person, the way I was brought up, so I couldn’t really take on board how other people were affected by what I was doing, or how other people are feeling. It kind of became a problem between me and my eldest son, because I kind of put a barrier up whenever he wanted to express himself, because I wouldn’t understand what he’s trying to say. Whereas now we are always expressing ourselves, always talking about emotions and how we feel”.	Improving relationships
“I still haven’t managed to get back to work and I can’t see friends, I’ve been cut off because I’ve stopped working. Not having a job means being financially dependent and just affects your self-esteem, like knowing you haven’t really got the confidence to go out”.	Practical achievements and employment
“Stopping self-harming was one of my goals... It got to the point where it was a thing as an addiction. The moment I felt even the slightest bit of stress I was cutting, so even I knew it escalated and I needed... I don’t think I necessarily wanted to stop but I wanted to control it, ultimately it stopped”.	Reducing suicidality, self-harming and other symptoms
“I’m not different to before I started treatment. I’m just fat... I’m just blowing up. I just seem so ugly, I actually feel it, I look at myself and I go, what the hell have I become?” “I sort of deal with one thing but then the other problem will escalate... like when I used to take cannabis, I cut down on my drink but smoke more cannabis; I didn’t have cannabis, I’d smoke more fags, so it’s always something is replaced...”	No progress has been made
“I can go through periods. Yesterday was relatively ok, today is ok so far. But before, consistently, I had a period where I couldn’t actually leave the house and I was very dissatisfied and self-hating... So it’s difficult to actually trust the times when I am feeling alright”.	Recovery fluctuating
“I think it’s still there, so as to recovering... I actually don’t see it as before and after, you can have a diagnosis of depression and then move through that depressive phase... it feels a bit more like who I am... But I’m aware, I try to keep on top of [borderline traits], I’m quite reflective in myself, I am feeling significantly more peaceful in myself, happier, I function better, day-to-day stuff I’m better at, I’m managing my own home, although there is still aspects that I struggle with greatly”.	Able to deal with things in a better way but not (fully) recovered
“I think I have recovered from BPD. Although I know I still find myself having the same panicky reactions to things, it’s just that I can rationalise with myself more easily now. I can still overreact to situations, but the difference is I know I’m doing it. And I know that I can do something about it”.	Recovered
“DBT helped, but it didn’t answer all of my questions. It didn’t help me to work things through myself, it didn’t help me to achieve my goals really... I was trying to get over my divorce and also my relationship with my mum and men, and I was trying to work through it but it was all about other things, it was about self-harming, it was about mindfulness...”	Tension in balancing personal goals of recovery versus service targets
“I can’t imagine not having BPD. I don’t remember a time in my life when I didn’t feel this way. So recovery, cure... no, I don’t think so. Learning how to deal with it, I’m very positive about... I don’t think it will every go away. I’d have to have a personality transplant for that to happen... I’m not entirely sure I want to actually let go of certain aspects of me. I like the fact that I’m a compassionate human being. I don’t want to be	Problems with the word ‘recovery’. The term recovery implies a dichotomous classification of

this involved with people's emotions, but I wouldn't want to not care. And that wouldn't be me. I'd much rather learn how to deal with it than have it taken out of me".

problems, suggesting that people either have problems or they are fully recovered.

Table B3*First-Order and Second-Order Constructs in Kverme et al., (2019)*

First-order constructs	Second-order constructs
"I am like others and others are like me".	Moving toward connectedness
"(...) It's like building a house, first you need stability in your daily life, work and somewhere to live, that becomes that steady foundation the house can be built on. Then you need a ladder, I'm on that ladder and the psychologist is giving me the tools so I don't have to go up and down on that ladder, getting the tools, cause then I go down emotionally, if you think about it that way. Then I can be up there, growing, building and when the walls are up, and the roof is up that's the year that have passed in treatment. Then the house is finished, but it's never actually finished, I have to continuously work on it you know (...) but then it's not such a big job that I need that ladder, then I don't need the carpenters showing me how to use the tools, then I know how to use them myself".	Learning to hold one's own
"I feel like she sees me, even if it really hurts. When I left I felt like a really bad person, I'm just bad at being a person I thought, I can't accomplish anything. And then I sent my therapist a text. You know it's just that, with my old therapist I couldn't reach him by mail, text, nothing. There was no way of communicating with him until the next session (...) So I was really upset and sent her a message on the way home, and I got this answer that really calmed me down. So then I felt like maybe it wasn't so bad. She said that 'Yes we all get blown off, it is not just you, we all get rejected' (...) That makes it more human you know, so then I felt I could relax and go on living".	Needing honesty and genuine mutuality
"Group therapy probably helped me the most, cause then I met people who struggled with the same... as I felt I was the only one, in the whole world, who struggled with. Then suddenly I meet people with exactly the same thoughts and emotions as me. So that probably helped the most".	Daring to belong
"To be satisfied with the little steps I take, or to me they are really big steps but to others they might be: 'Really is that a problem?' I just have to be proud of what I accomplish. I have to try, and if I fail, well that's okay too".	Making a room for recovery

Table B4*First-Order and Second-Order Constructs in Larivière et al., (2015)*

First-order constructs	Second-order constructs
“Journey”, “Progress/improvement”, “accomplishment”, “acceptance”, “being functional”, “confidence in oneself”, “learning”, “rebuilding oneself”, “having a normal life”, “being actively involved in the therapy”, “feeling good about yourself”, “being able to control thoughts and emotions”, “healing from childhood wounds”.	The concept of recovery for women with BPD: Not consensually the best term to name their experience
“When I feel something negative or, you know, frustration or sorrow, now I don’t wait anymore... You know, before, I wouldn’t talk about it at all, I would keep it inside and at some point it accumulates. [...] So now I address it more”.	Better emotional management
“Now, with the therapy, I feel that... I exist. So if I exist interiorly, I can exist exteriorly, with the others. That I have my place” ... “To assert myself in what I am, what I think”.	Asserting oneself
“Before, (my mother) would call me and wanted to die. [...] and I would take it upon my shoulders. This would pull me down and I’d go back to the starting point. Then I said, at some point: No. I cannot live like this anymore. I have lived my whole childhood undergoing this. I live for myself now”.	Definition oneself/individuation
“Now I can put (the child inside of me) aside and I say to myself, you know: This is past, this is when I was young, but you know we cannot change it, we can only improve what we have now”.	Letting go of the past
“In my perspective, I can work it out. There is little blue sky but I can make it... Don’t look back... don’t give up”.	Having hope for the future
-	Exploring other ways of seeing life
-	Biting into life again
-	Having confidence in self and others
“I had no friends, I had nothing. I made them run away. Now I have plenty and it’s fun”.	Having healthy relationships
“Now I try to look good, I take care of myself, I’m on a diet [...], I wear makeup. You know, I think I show myself off”.	Taking care of oneself
“I would like to play piano... play music, sing... I could join a choir... I could get back to dancing. [...] I’m involved, I commit myself more, and I want to be involved in my housing cooperative”.	Being involved in a meaningful role and/or activities
“I kept my job, this is something new for me. Because usually, it was like... I get in a new place, I am fired. [...] This is the first time I stay at my job, I even had a raise, it was the first time of my life	Having and maintaining a job
“Completing the therapy because I had the chance to do it. I could have said no but I wanted so much to become, become a person that is a pleasant person to live with”.	Carrying out a project until the end
-	Taking responsibilities
“I have a lot of friends, I like to be surrounded, I have my family, it’s important for me. All those things really help me, that I have a network of support, to spend time with them, have fun”.	Support from families and friends
“I try to give myself the right to be less tough on myself. And I think that, with time, I accepted many things [...] that I didn’t accept at all. This helped me a lot. [...] (I accepted) my intensity, or certain traits that I have [...]”.	Knowing about BPD
“The services at the hospital are what helped me the most. Today, I can live, I can breathe, I do not have my desire to die anymore. It’s because of them because they were there when I needed them”.	Appropriate and useful help from health services and community organisations,

	particularly the program for BPD
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Table B5*First-Order and Second-Order Constructs in Liljedahl et al., (2023)*

First-order constructs	Second-order constructs
“...in the beginning it was kind of a lot that I felt I wanted to do it [stay free from self-harm] for my boyfriend... Because we moved in together and then it was, it was a good thing, like, having someone close”.	Family or close people helped recovery and to create a life worth living
“I probably do not want to say 100% recovered but I still think I am very close. So, if I am going to take it as a percentage, I probably actually want to say that I am enough, aah, 90% recovered”. “I definitely see myself as a person who has recovered from mental illness and so on. But... I do not see mental illness as a static condition, so... I do not think it is so relevant to talk about it from the aspect of whether you have been diagnosed or what symptoms you have... That is not what is interesting to me... When I look from the inside, I see myself as, uh, more resilient. So, I would describe as well as my recovery, as that I have more resilience to face what life gives me, whether it is mental illness or other challenges in life”.	Identify as recovered
“I see myself as healthy. Completely... It means that I am no longer in any way, maybe an exaggeration, but controlled by feeling bad. That I am not governed by anxiety, that I am not governed by anything else that bothers me in either mood or what I do or do not do, what I eat or do not eat or anything like that, knowing that I can have a bad day but it's a bad day, I do not have to hurt myself for it, I do not have to act on it...”	Identify as healthy and beyond
“So it has taken a very long time to rebuild a feeling that the world, that is, - not naïve but still with some kind of nuance – that the world is pretty good and that others want me quite well and such. That at least there are some who want me well and that there are nice things in life, has taken me a long time to, to feel... I worked hugely hugely hugely, very long and a lot. Not just me, my, my poor psychologists and therapists too... to dare to trust”.	Becoming well is a long process

Table B6*First-Order and Second-Order Constructs in Mooney et al., (2023)*

First-order constructs	Second-order constructs
“It took me a couple of years to kind of believe it, or agree, which kind of made it a bit harder to get treatment or anything, [...] I just didn’t want to believe that I was mentally ill [...]” “It’s like an internal battle... do I really want to recover or do I really just want to kill myself...”	Psychological barriers
“I’ve gone through four GPs, one minute they’re ok and next minute they’ve seen my history and run for the hills [...]”	Unhelpful health service experiences
“I was working and then I went on sick leave because I became really unwell, and then they offered me a payout [...] we’re just going to pay you to go away [...]”	Maladaptive coping strategies
“(psychoeducation) [...] it has definitely helped me cos I believe in knowledge as power and being able to be informed on tricks and skills on what to do [...]”	What works in therapy
“Having a balanced lifestyle and diet is important to me...” “It’s a mixture... family, friends, current GP, therapist, kid’s helpline... it’s kinda all finally falling into place”.	Factors outside of therapy
“... being able to feel like you’re taking control of your life and that you have got this”. “The (turning) point was when I acknowledged they (therapists) knew better... you need to commit to... buying into this process”.	Recovery-focused mindset
“I’m better at removing myself and letting myself feel”. “I do feel change... not drastic... everything slowed down”.	An imperceptible gradual shift towards slowing down
“I’m more comfortable with myself and don’t have to put on a show”.	Acceptance
“I’m more excited for the future than I was”. “I believe that you just learn to cope and then the coping gets easier becomes like a reflex like some of these skills already are... I don’t think it ever goes away... you just learn to cope with it and then the coping gets easier and easier”.	Imagining a better life

Table B7*First-Order and Second-Order Constructs in Sarwendah et al., (2022)*

First-order constructs	Second-order constructs
"I cannot handle this with myself, that's it. I need help from a professional". "What is certain is that I don't accept it (with the diagnosis of BPD). First time, eeehm, first time hearing. And the second one was not accepted, because eeehm the self-diagnosis effect is possible, huh. So it's like, "Oh there's depression too" like that. So it's like, I, I feel like I'm depressed".	Seek professional help and prevent the effects of self-diagnosis
"The biggest support from my wife. My wife provides motivation and helps to rise from adversity. This support is very helpful in BPD recovery". "So what's more, for example, the nurse knows, oh, this needs to be calmed down like that. The thing is, once, there was also the feeling, the nurse just wanted to hurry up like that. Or there is also a nurse who, sits, relaxes like that and really... eeehhmm... helps to cool down".	Support system from family, close people, community and mental health workers
"... ah I feel that my self is different, I'm like, I'm confused with myself, who am I? what am i? I'm confused about my identity. Especially when I found out I was BPD, it was mental problem, right? Wow, so I'm not like normal people". "I'm having a hard time, um, I can't recognizing the emotions. Because most of what I felt is empty. Empty, sometimes his emotions go up and down..." "So from there (remembering the past), from there until S had thoughts of committing suicide like that. Until, you want to harm yourself, want, want, just want to destroy yourself like that".	It's hard to understand and love myself
"Then, those related to dating, that's it. Frequently changing partners. Which means, you know, umm... at first I was really happy. Very happy. You know, huh.. you know it's gone, don't know ah. I don't want it anymore, already". "Well dominate (in relationships). You have to do what I want. Then, I just want it like this, I don't need attention, I don't need anything. But I'm, um, scared, I have a fear of being left behind". "If I'm honest at work, yes, I often get angry like that, that's the type. And if, for example, I don't like it, I can just do that, just dare to leave, even though I don't have a new job yet, that's what it is. So actually from my work experience, I was said to be a jumping bug, so often..."	Difficult to build stable relationships with others
"That, I actually avoided the incident of wanting to commit suicide, for example, wanting to hurt, wanting to be angry. That can be resolved with regular worship, going to the mosque, praying dhuha, remembrance, and so on. That's the solution, if we get sick with BPD, we just let it go, yes, in the end, we end up hurting ourselves and committing suicide". "To kill myself, I don't. God willing, no. Because in Islam it's not allowed, that's how it is to commit suicide. Suicide is, yes, fades all our charities, that's how it is. In the end, we are not grateful for ourselves. And that's the point we are least grateful for. By the grace of Allah. That's the first. The point is, religion and Allah, Allah is it". ".... I planted it in my mind. that I have to fend for myself. With that good thought I am now trying to cultivate a sense of self-respect. so that people outside cannot judge my life.... life will go well if we believe in ourselves."	A journey to find a peaceful life

“Because I just changed schools, I happened to change places of residence, so I changed schools. It was bullied, as a new kid. It’s said..... When I talk to Mama, Mama just laughs like that. It’s like thinking, oh, what the heck, that’s the thing, it’s a trivial thing”.	The most painful experiences come from the closest people
“There is the system, like every time it is controlled. That’s a different doctor. So it’s like, in my opinion, okay, control, but every time you tell a story, it’s like you have to, if you go there, you have to keep telling stories. It’s like being repeated again and again”.	Experience in accessing mental health services

Appendix C:

Participant Information Sheet

Participant Information Sheet

Project Title:

Exploring processes of recovery in borderline personality disorder: lived experience perspectives

My name is Lauren Gibbs and I am a Trainee Clinical Psychologist undertaking a Doctorate in Clinical Psychology in the School of Health and Social Care at the University of Essex. I would like to invite you to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

Recovery processes in borderline personality disorder (BPD) are poorly understood. The present study aims to understand processes of recovery in BPD from the perspectives of those who identify as being in recovery or as recovered from BPD. Understanding perspectives on the processes involved in reaching a place of recovery is fundamental for enhancing our understanding of how to foster positive outcomes for people living with the diagnosis. Your contributions during the interview process contributes to the research aims of developing our understanding of processes involved in BPD recovery.

This study is a doctoral research project in relation to completion of the Doctorate in Clinical Psychology programme at the University of Essex.

Why have I been invited to participate?

If you meet all of the inclusion criteria, namely, the criteria listed in the left-hand column in the table on the following page, then you are eligible to participate in the study. This research aims to recruit a total of 15 people.

<i>Inclusion criteria</i>	<i>Exclusion criteria</i>
To have a current or historical primary formal diagnosis of Borderline Personality Disorder (also known as Emotionally Unstable Personality Disorder)	No formal diagnosis of BPD and/ or have other/ another primary mental health diagnosis
Identify as either in recovery or recovered from BPD	Identify as being acutely unwell with BPD
Willing to participate in an interview about your lived experiences of BPD	Not willing to attend an interview to discuss your lived experiences of BPD
Currently living in the UK	Living outside of the UK
English speaking	Does not speak English
Aged 30 or over	Under the age of 30
Able to recall past experiences	Has a memory/ cognitive impairment severe enough to inhibit ability to recall past experiences
Not currently acutely experiencing psychosis	Currently experiencing acute psychosis
Able to commit to not using alcohol or illicit substances at least 24 hours prior to interview	Is dependent on illicit substance(s)/ alcohol and unable to commit to abstinence from substances at least 24 hours prior to interview
Consent to have your interview recorded	Do not consent to have your interview recorded
Has access to a smart device such as a mobile phone, laptop, tablet or personal computer with access to the internet to access interview.	No access to a smart device and/ or no access to the internet to access an interview.
Able to sit for around an hour to attend the interview in a quiet space	Unable to sit for an hour in a quiet space to attend an interview

Do I have to take part?

It is up to you to decide whether or not you wish to take part in this research study. If you do decide to take part you will be asked to provide written consent. You are free to withdraw at any time, without giving a reason. Withdrawal will have no impact on your employment or any support services you may have involvement with. If you choose to withdraw from the study, all of your personal information will be permanently deleted.

If you wish to withdraw from the study, you will be required to email the researcher quoting your designated participant number (assigned at random by the researcher) which will be

provided to you in an email once written consent to participate in the study is received. The researcher's email is lg23457@essex.ac.uk

What will happen to me if I take part?

On receipt of signed consent, the researcher will contact you to arrange a date and time for an interview. The study will consist of one interview lasting approximately 60 minutes which will take place via video call on the online platform, Zoom. Once a mutually agreed date and time for an interview has been arranged, the researcher will email you with a Zoom link to attend the interview. Attached to this email will be instructions on how to use Zoom, for your convenience, should you require this. The researcher will be using a University of Essex Zoom account to conduct interviews.

The interview will involve the researcher asking you questions about your personal experiences of recovery as somebody with lived experience of borderline personality disorder. The first set of questions will explore what it means to be in recovery or recovered from BPD from a lived experience perspective; the second set of questions will focus on what has contributed to being in recovery or recovered from BPD; the third set of questions will explore the processes involved in reaching and maintaining recovery in BPD and finally, the last set of questions will focus on exploring barriers to reaching recovery in BPD. At the end of the interview, you will be given the opportunity to add additional information that you feel is appropriate and given the chance to ask questions. The interview will be recorded, for the purposes of transcription and data analysis.

What are the possible disadvantages and risks of taking part?

The interview is expected to take up at least one hour of your time. The topic of discussing experiences related to recovery could bring up difficult emotions. In order to safeguard the effects of this, we will mutually agree on a plan to address any emotional difficulties that may occur during the interview. Time will be taken prior to the interview to explore what you find to be effective in regulating your emotions when experiencing distress. During the interview at any point if you feel emotionally distressed, you are welcome to either on camera or off camera engage in your chosen emotion regulation strategy. On return back to the interview, if you choose to return, you will be asked for verbal consent to continue with the interview.

Should you wish to receive support following the interview, please refer to the list of National support services in the table below.

Support service and contact details	Type of support provided
Harmless harmless.org.uk	User-led organisation that supports people who self-harm, and their friends and family.
The National Association for People Abused in Childhood (NAPAC) 0808 801 0331 support@napac.org.uk napac.org.uk	Supports adult survivors of any form of childhood abuse.
NHS UK nhs.uk	Information about health problems and treatments, including details of local NHS services in England.
NHS 111, Option 2	Mental health telephone support for when you are experiencing a mental health crisis.
NHS 999	Emergency services support
Papyrus – HopeLineUK 0800 068 41 41 07860039967 (text) pat@papyrus-uk.org papyrus-uk.org	Confidential support for under-35s at risk of suicide and others who are concerned about them. Open 24 hours, 7 days a week.
Samaritans 116 123 (freephone) jo@samaritans.org samaritans.org	Samaritans are open 24/7 for anyone who needs to talk. You can visit some Samaritans branches in person .
Shout 85258 (text SHOUT) giveusashout.org	Confidential 24/7 text service offering support if you're in crisis and need immediate help.
Hub of Hope hubofhope.co.uk	The Hub of Hope is the UK's leading mental health support database. It is provided by national mental health charity, Chasing the Stigma, and brings local, national, peer, community, charity, private and NHS mental health support and services together in one place for the first time.

What are the possible benefits of taking part?

Your contributions during the interview process will contribute to the research aims of developing our understanding of processes involved in BPD recovery.

What information will be collected and how will it be stored?

A signed consent form will be collected from you. Your name on the consent form will be replaced with an assigned participant number. An interview recording will also be collected, this is for transcription purposes only. The recording will be saved with the file name of your participant number. A participant number will be assigned to you to ensure anonymity of your data, while ensuring a way to identify your data in the event that you choose to withdraw from the study. Interview transcripts will be anonymised with a pseudonym chosen at random. During the write-up of the research, the same pseudonym will be used to describe your data. Your identifiable data will be securely stored and accessible only to the members of the research team directly involved in the project.

What is the legal basis for using the data and who is the Data Controller?

The legal basis for processing your data will involve the receipt of your written consent. The Data Controller is the University of Essex and the contact is, University Information Assurance Manager (dpo@essex.ac.uk).

What should I do if I want to take part?

Please read this information sheet carefully. Once you have read this information sheet, find the consent form attached to your invitation email. In order to participate in the study, please sign the consent form and return it to me via email: lg23457@essex.ac.uk. Once I have received your completed consent form, I will contact you to arrange an interview.

When the researcher has received sufficient data, an email will be sent to you to inform you that the researcher is no longer accepting participants for the study.

What will happen to the results of the research study?

It is anticipated that the results of the research study will be published in an academic journal. Results will be anonymised and you will not be identifiable in any written report. Your data will be used to support other research in the future, and may be shared anonymously with other researchers.

Following completion of the research, you are welcome to request a copy of the written research, or, if you would prefer, a shortened version will be available to you. To request a copy, please email the researcher on lg23457@essex.ac.uk.

Who is funding the research?

This research is part of a doctoral thesis and will not require funding.

Who has reviewed the study?

The University of Essex Ethics Sub-Committee 1 has reviewed and approved this study.

Concerns and Complaints

If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact either the researcher, Lauren Gibbs, or the research supervisors, Dr Frances Blumenfeld and Dr Rachel Marrow, using the contact details below. If you are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the researcher, please contact the departmental Director of Research in the School of Health and Social Care, Dr Antonella Trotta (email: atrott@essex.ac.uk). If you are still not satisfied, please contact the University of Essex Research Integrity Manager, Mantalena Sotiriadou (email: ms21994@essex.ac.uk). Please include the ERAMS reference which can be found at the foot of this page.

Name of the Researcher/Research Team Members

Researcher: Lauren Gibbs

lg23457@essex.ac.uk

Research supervisors:

Dr Frances Blumenfeld

fblume@essex.ac.uk

Dr Rachel Marrow

rachel.marrow@essex.ac.uk

Appendix D:

Recruitment Poster

PARTICIPANTS NEEDED

EXPLORING PROCESSES OF RECOVERY IN BORDERLINE PERSONALITY DISORDER: LIVED EXPERIENCE PERSPECTIVES

University of Essex

IF YOU...

- Have a current or historical primary diagnosis of borderline personality disorder (also known as emotionally unstable personality disorder)
- Identify as either in recovery or recovered from borderline personality disorder
- Are aged 30 or over
- Are not currently experiencing acute symptoms of psychosis

THEN YOU ARE INVITED TO TAKE PART...

In a research study which is exploring processes of recovery in borderline personality disorder. It will involve taking part in an online interview to share your experiences of recovery.

I'M INTERESTED, HOW DO I GET INVOLVED?

Researcher: Lauren Gibbs
Trainee Clinical Psychologist
Email: lg23457@essex.ac.uk

Email me on lg23457@essex.ac.uk to let me know that you are interested or if you have any questions.

I don't meet those criteria but I want to support this research... Please share with anyone that you think may be interested and/ or share on social media!

THIS STUDY HAS BEEN REVIEWED AND APPROVED BY THE UNIVERSITY OF ESSEX ETHICS SUB-COMMITTEE 1
 ERAMS REFERENCE: ETH2324-1098

Appendix E:**Initial Interview Schedule**

1. What does it mean to you to be in recovery or recovered from borderline personality disorder?

Prompts: emotions, relationships, age, connection, community, identity, term 'recovery'

2. What has contributed to you being in recovery or recovered from borderline personality disorder?

Prompts: relationships, treatment, professionals, motivation

3. What are the processes involved in reaching and maintaining recovery?

Prompts: consistency, support, relationships, treatment

4. What were the barriers to reaching recovery?

Prompts: professionals, communication, language, stigma, relationships, services, connections

Appendix F:

Participant Consent Form

Consent Form

Title of the Project: Exploring processes of recovery in borderline personality disorder:
lived experience perspectives

Research Team:

Researcher: Lauren Gibbs

Research Supervisor: Dr Frances Blumenfeld

Research Supervisor: Dr Rachel Marrow

Please initial box

1. **I confirm that I** have read and understand the Information Sheet dated 09.08.2024 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that any data collected up to the point of my withdrawal will be destroyed.
3. I understand that, due to the sensitive nature of the research topic, questions asked during the interview may create emotional distress. I confirm that, with the support of a collaborative protocol being followed with the researcher, and details of services which provide free emotional support following participation, I am comfortable with participating in this study.
4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained.
5. I understand that my fully anonymised data will be used for data analysis purposes, and may be published in a research journal.

6. I understand that the data collected about me will be used to support other research in the future, and may be shared anonymously with other researchers.

☐

7. I agree to take part in the above study.

☐

Participant Name

Date

Participant Signature

Researcher Name

Date

Researcher Signature

Appendix G:

Example Interview Transcript at the Initial Coding Stage

Participant Pseudonym: Mark

Key: I= Interviewer (grey background), P= Participant (white background)

Note. References to potentially identifiable information is redacted using a black background.

Speaker	Transcript	Initial Codes
I	Okay, so first of all, I just want to ask you quite broadly, [REDACTED], what does it mean to you to be in recovery from BPD, or if you call it BPD or EUPD, or...	
P	Yeah, I don't know, because I I do tend to refer to it in a, in a, in a professional capacity, I tend to refer to it as EUPD. But when I'm talking to somebody I know about it, I refer to it as BPD. Yeah, it's it's a funny one, because I think like, oh. I used to advocate quite a lot for for people in general with BPD. However, it's it's really interesting, because you've caught me at a bit of a funny time in my life where I don't really, I find it more difficult to do now, because I don't tend to find myself struggling with the kind of the symptoms enough to be... I think, last as I think... Personally, if I was put in front of a psychiatrist now, at this stage of my life, I probably wouldn't get the diagnosis, because I don't sort of meet a lot of the criteria, but that's taken years and years of of work. So it's it's an ongoing process for me, anyway, and I don't think I would never I would never say that I'm recovered. I would never say that. I would I would ever, and I don't think I ever will, sort of kind of fully recover from it. I think it's always gonna be an ongoing journey if you like. A lot of people that you speak to generally will say that they don't. There's no cure. There's no this, no, that. And I've spent quite a lot of time kind of advocating for actually you, you can get better from it. But like this doesn't, at this stage in my life. I don't really feel like I meet the criteria so much and as such I don't tend to advocate for it as much anymore. So I'm at a bit of a personal crossroads with it myself at the minute. But yeah, it's a it's a difficult one, because, like, when I was younger before I got my diagnosis in 2019, and I was 28, I think,	Hesitating about meaning of diagnostic label Referring to EUPD in professional capacity Advocating for people with BPD Feeling at a different point in life Finding it difficult to advocate for BPD due to not relating anymore Struggling less with symptoms of BPD Feeling distant from diagnosis Taking years of work to distance from diagnosis Rejecting idea of being fully recovered Rejecting idea of ever fully recovering Being an ongoing journey Comparing self to others on a journey Rejecting idea of a cure Advocating getting better Emphasising not identifying with diagnosis Being in conflict with identifying with diagnosis Rejecting idea of ever being recovered Clarifying not ever being fully recovered Naming recovery as an ongoing journey Comparing own recovery to others Confirming how other people also believe there is no cure Advocating about getting better from it despite other views Believing no longer identifying with diagnosis Advocating for diagnosis less due to not identifying with it

	when I got the diagno-. Yeah, 28 when I got the diagnosis. But I've been unwell for years before that. And I've been diagnosed, clinically depressed. General anxiety disorder. OCD. When when I was a lot younger and had lots of problems with substances and alcohol, I'm when I got the diagnosis. It was a bit of a it was kind of like a bit of a Eureka moment. Where a lot of the sort of behaviours and things like that that I'd previously exhibited sort of suddenly kind of made sense and I knew growing up as we're getting older with it that it wasn't just depression or anxiety, or OCD. Or whatever, or ADHD was another one that was sort of loosely thrown about. But yeah, it kind of makes sense, and to get the diagnosis was was pivotal for me, and actually being able to then get the right help and actually get into recovery. So even though I've probably had it most of my life and the recovery journey for me only started actually, when I got a diagnosis, and the diagnosis then helped provide the framework that I needed for the recovery journey. So I was very, very lucky with my with my initial recovery when I got my diagnosis. Much more fortunate than a lot of other people. And I probably wouldn't get the same level of care and treatment now because the funding is just not there where, where I am in the the [REDACTED] that covers the area in which I live. But yeah, for me, the diagnosis was like the turning point because it was like, right? Okay, now, I know actually what is wrong with me and what I need to do to kind of try and fix it.	Describing difficult relationship with diagnosis currently Confirming when diagnosis was received Being unwell for years before receiving diagnosis Receiving diagnoses of anxiety and depression Struggling with alcohol and substance misuse when young Receiving diagnosis being a eureka moment Receiving diagnosis put behaviours into perspective Always knowing there was more to it than depression, anxiety or OCD Having ADHD proposed Receiving diagnosis was pivotal Receiving diagnosis was key to accessing treatment Receiving diagnosis led to recovery Acknowledging having BPD for most of life Believing that recovery began once diagnosis was given Believing that the diagnosis provided a framework for recovery to be based on Feeling lucky about initial recovery Feeling more fortunate than others Believing that he would receive less treatment nowadays Believing funding for services is inadequate Receiving diagnosis being turning point Receiving diagnosis provided pragmatic clarification Problem-solving perspective to diagnosis
I	So I'm hearing that getting the BPD diagnosis may have been a massive light bulb moment that enabled things to make more sense, and that actually prompted your recovery journey. And I'm hearing from what you said before, that maybe the word recovery or recovered is maybe not appropriate, and it's more of a journey?	

P	Yeah, I wouldn't. I would never say recovered. I think like, with a lot of things like, if you speak to people who have had problems with alcohol and other substances. It's very similar in terms of the, you know they never, they're always in recovery. They're constantly in recovery. Once you've once you've been on that journey there's relapses and things like that. But you you're never kind of fully recovered, regardless of if you've been abstinent for years and years and years, a recovering addict would still tell you they are in recovery, not recovered. And I feel like it's the same with the same with BPD. Because it's essentially like learned behaviours as a way of dealing with complex trauma from like a very early age. It's difficult to. I think, unlearn all of those unhealthy behaviours. If that makes sense, I think you just have to kind of it becomes a part of who you are. But I think. Yeah, yeah, it's a funny one. I'm still, I'm like, I said, I'm at this. I'm at this really unusual stage of my journey at the minute, anyway, which I was, which is why I was really keen to get involved when you reached out. Because it was like, yeah, like, I don't feel like I identify with it as much anymore. Which is probably a good thing, you know. It's a sign of it is a sign of recovery. But I just think it will be a like an ongoing thing, I think. Instead of looking at it as like a an illness, that I needed to get a cure, for it was like, actually like a prompt to working on myself. It was like once I started trying to change the behaviours and stuff with the treatment, that I'll go into in a bit, it suddenly took on its own like. It was its own. It was like its own entity, and it became something different. It became like a personal journey of like discovery, of like self awareness, where it became less about the illness and more about just trying to be a generally healthier perversion of myself. Emotionally. So yeah, it was a. It's been a a really interesting journey.	Rejecting idea of being recovered Comparing BPD recovery to that of an ex-substance user who is in constant recovery Believing in inevitable relapses Even if abstinent long-term, like an addict you are in recovery Saying addicts in recovery would not say they are recovered Believing full recovery is not possible, like a recovering addict Rejecting full recovery from BPD due to learned behaviours Coping with complex trauma Coping from an early age Being difficult to unlearn unhealthy behaviours Behaviours becoming part of your identity Hesitating about stage in life Struggling to articulate current stage Being keen to engage in research Identifying with diagnosis less Believing it is good to not identify with diagnosis Identifying less with diagnosis being a sign of recovery Believing it is an ongoing journey Changing perspective of BPD as an illness to be cured from Having diagnosis being a prompt to work on myself Reflecting on beginning to try to change behaviours Starting to change behaviours started something Changing from just changing behaviours Becoming a journey of self-discovery Becoming less about the illness Trying to become a healthier version of the self Recovery not being a straightforward journey
I	I wonder, you sort of say you're in a different part of your journey at the moment, and I'm wondering if there was a time where you may have thought about things differently?	

P	When I when I first got the diagnosis. I I didn't know anything about it. And I did the worst thing possible, and I googled it. And the stuff that I was seeing online was was just shocking. I mean, you've probably seen it yourself. There is some really really bad press out there about people with BPD. And I remember one of the first things I actually came across when I started doing my own research was a book that I found that I can't remember the name of the book now, but the book was about how to manage somebody with BPD. As opposed to how to manage it yourself. It was a book written from some, like, a, like a third person saying how they essentially like survived somebody with BPD and that was kind of like the first thing that I saw after I got my diagnosis. And I thought, Oh, my God, like. Yeah, and I didn't wanna, I didn't wanna kind of be associated with with that. But I think the main, the main. It was horrible. It was. It was it. Yeah. It made me feel like I was crazy. Because I I like I knew there were definitely and I was very aware that I had very unhealthy coping mechanisms and behaviours. I was. I was very aware of that. But I didn't know how or why it was happening. Why, I was the way that I was. That's why getting the diagnosis, I think, was so important. But initially, yeah, it was, it was a bit of a shock. When I saw everything that I read online, I was thinking, God, am I nuts? Am I crazy? Am I this bad person that people seem to just make out? You know, the classic sort of negative traits that people sort of tend to emphasise is manipulative, narcissistic. All this sort of stuff. And I was like, Oh, God like. But it was I didn't like. I refused to let it become that for me. I didn't want it to be about about like. And I, the more research I did into it and stuff, the more I realised that like, yeah, unfortunately, it's like when I say to other, I say to other people, it's like living in survival mode constantly, and when you're in survival mode you'll do and say anything that you need to, or anything that you, anything that you you can to to get by, or to get any kind of validation, or whatever it is you need. Which is why I think people perceive it as sort of manipulative and stuff sometimes. But yeah, yeah, it was. It was a shock at first, at but once I sort of accepted it. That was like the big	Being unaware of diagnosis initially Reflecting on Googling diagnosis Seeing shocking things online about diagnosis Believing interview is aware of shocking content online Awareness of stigma online Remembering first things reading about diagnosis Finding a book to manage someone with BPD Failing to initially find support online Finding narrative about someone surviving someone else with BPD Being first thing seeing after diagnosis Shocking to see this Not wanting to be associated with diagnosis Feeling like I was crazy Being self-aware Being aware of unhealthy coping strategies and behaviours Unknowing as to why I behaved the way I did Getting diagnosis helped with understanding behaviours Seeing things online and questioning sanity Asking whether I am a bad person Questioning whether what others say are true Questioning whether I am manipulative or have other traits Describing sense of dread Refusing to become the stereotype Researching into BPD Realising that I'm living in constant survival mode Reflecting on acting to get needs met Reflecting on acting for validation
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	thing for me was like, okay, I need to just sort of if I'm going to get better. I need to just kind of lean into it and go go all in and and and try and make the positive changes that I know I need to make.	Accepting that acting on survival strategies can be perceived as manipulative Seeing stereotypes initially being a shock Accepting diagnosis being pivotal Thinking about getting better Believing in leaning into diagnosis in order to get better Putting in all effort to make changes Awareness of needing to make changes
I	And what was that like? Sort of, you know, going through a process of accepting. And also as you say, leaning into the diagnosis and making the changes, what was that like?	
P	It was difficult at the time. It's stirred up a lot of stuff from the past which specifically like around my parents. And like the upbringing I had. I think initially, my emotions were probably a bit all over the place, anyway, but I actually ended up sort of growing to resent my parents a little bit because of it. and I think at first I probably blamed them for it. But after a short period of time I sort of very quickly realised that blaming somebody else is not going to make it any better, is it? It's not gonna so I'm gonna change anything. I just needed to get on with it, and just start to put the work in, to make those changes.	Accepting diagnosis being difficult Accepting diagnosis meant acknowledging things in the past Acknowledging role of parents Reflecting on role of upbringing Reflecting about emotions being all over the place Growing to resent parents for diagnosis Initially blaming parents for diagnosis Quickly realising that blaming others will not change anything Prioritising getting on with putting the work in to make changes
I	Thanks for sharing that. And I'm just thinking back as well to sort of going back to sort of the sort of term recovery, and it being a journey, and I'm wondering, I know you say that you don't believe you could ever fully recover, so I'm wondering if you have maybe a more appropriate term for that? Or how you would describe where you're at.	
P	I don't know. I can't think of another word that I would use, the one I always, the word I always end up back at is journey. It's just this ongoing journey of self-development. And like I said, it's it's become less about getting better from an illness and more about just trying to just being more self-aware and develop personally as a more rounded, emotionally intelligent person.	Journey being appropriate Being less about getting better from illness and more about self awareness Becoming a more rounded emotionally intelligent person
I	So aside from things you've just mentioned, what things have contributed to your journey?	

P	Oh, my God! That's very broad, because. I think I had to word it, I think. Do you mean kind of the recovery journey, as in from the point in which I kind of accepted, that I needed to be in recovery or kind of like before that sort of the contributing factors. That kind of got me to the point where I was diagnosed, and began treatment.	Being a point of acceptance of recovery being needed
I	I'd say both. If you could maybe start where feels most appropriate. But yeah, I'd be very interested in sort of both, the kind of, the whole journey.	
P	I'm I think. Well, going right back to the very beginning. I think I know why I ended up the way that I was because essentially my parents were my mother is a very angry person, and she's not very. She just has no maternal instincts, and my father was military. So he was in the army. Very military mindset from an era where mental health issues just weren't a thing. But that said he, not that he's ever seen anybody about it, or ever had an official diagnosis. But, I'm pretty sure that he does suffer with PTSD. As a result of his time in the army and being at war. But he's very emotionally closed off, and obviously there was quite a lot of time growing up as a kid when I needed him. But he wasn't there physically and emotionally, because he was literally in another country fighting a war. So I feel like that's probably the combination of having the that's like two complete extremes that we're not nurturing in any way, shape or form, probably contributed to the the illness manifesting itself at quite an early age, I would have thought. But then, yeah, I think the unhealthy behaviours that I developed as a result of needing some kind of validation, some sort of feeling of love in my life. That's why I turned to drugs and alcohol and stuff when I was quite young as well as a way of trying to like. I think initially, I was trying to fit in somewhere with a group of people that I probably shouldn't have been. And I'm just in a constant search for some sort of validation, some sort of feeling like I was wanted or a part of something or yeah, but and then, unfortunately, that became a bit of a vicious cycle. And I went through a spate of overdose attempts and things like that which kind of just fed back into the narrative that I was a chaotic	Reflecting on why I am how I am Attributing the self to parents Describing an angry mother Describing mother as lacking maternal instincts Describing father as military Describing military mindset Describing era where mental health wasn't acknowledged Believing that father has PTSD Thinking about impact of army on father's mental health Describing father as emotionally distant Believing father was absent Acknowledging literal physical distance with father Believing that not being nurtured by parents Believing that impact from parents resulted in manifestation of BPD from early age Developing unhealthy behaviours to gain validation Wanting to feel love Turning to drugs and alcohol for search of love Wanting to belong to a group Knowing I shouldn't have been with certain people Being in constant search for validation Wanting to feel wanted and part of something

person, that was just basically a troublemaker, and kind of got myself a bit of a reputation for being that kind of person. As I said, where the the the negative behaviour just fed into that constantly. Yeah, I don't really know what else to say about that. Because I'm. I worked in a very, very very stressful kind of high intensity job. Which actually kind of kept me quite grounded for a long time. I was working stupid hours. And I was very successful, actually, at what I did. And I kind of thrived off that. Really it was a very chaotic. I worked in the [REDACTED] industry for a very long time. And it's very stressful. It's very chaotic. Lots of pressure. Lots of targets. And I kind of buzzed off that because I was getting the kind of recognition and sh*t like I was getting the the awards and all this sort of stuff like and going traveling around different countries in Europe. And all this sort of stuff, and and like that, that was like a big big thing for me getting noticed. I guess it was at the time. That's how it was. It was like, okay, my, like, like, I'm I'm being that my contributions to like work at the time were being recognised all over the place, you know, like in the news, and I was getting these certificates and trophies and all sorts of stuff. And it kind of made me buzz. That was a time where I was actually fairly stable for some time, because I was kind of getting all that that I needed. But then, when I lost, I didn't lose the job. I was essentially I was headhunted for another, same brand, but a different franchise. And it turned out to probably be the worst decision I ever made in my career. But yeah, when I lost that, things started to go south pretty quick. But my ex-partner was not very supportive in any way, shape or form with it. She knew about it from. She knew that there was something wrong, that I wasn't. Mentally I wasn't very well for a long time, but when I got the diagnosis she just sort of was like. I don't want to know. You know what I mean. It was kind of yeah, that was really difficult, because she kind of didn't want to accept that I think we've been together probably a few years when I got the diagnosis, and she didn't really want to accept the maybe because of the bad press that was around. I don't know. She didn't want to accept that. I had this particular illness, so she was actually offered a carer's assessment. When	Search for validation becoming a cycle of overdose attempts Behaving in ways that reinforced narrative of being chaotic Being labelled a troublemaker Behaving in negative ways that reinforced a narrative Struggling to elaborate further Previously working in stressful job Being in a stressful job felt grounding temporarily Working excessively Being successful at work Thriving off of work success Reflecting about job being chaotic Working in a stressful environment long-term Enjoying the validation of awards at work Getting perks at work from being successful Getting noticed felt meaningful Reflecting on being recognised widely Getting a buzz from being noticed and receiving awards Being stable when feeling validated at work Validation fulfilling a need Rejecting idea of losing a job Being sought by another franchise Changing jobs being worst decision in career Losing job led to thing going south quickly Ex-partner being unsupportive Ex-partner being aware of poor mental health Ex-partner being dismissive of diagnosis
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	I got diagnosed because I was that ill, or was that unwell that they they asked her if she wanted to do if she wanted to do a carer's assessment to look after me, and she refused. But yeah, I felt like that could have been a a bit of a contributing factor as well, because it kind of in terms of like post diagnosis and the recovery journey, because to then be almost sort of rejected because of it. Was. It was a bit of a do or die moment for me where it was like. I need to pull myself up with my bootstraps. Otherwise I am. I will die, and I was convinced, because I I never. It's really weird. I never thought I was going to make it past 30, because I'd be dead. I'd have killed myself, or I would have died from drink or drugs overdose I don't know. So So like hitting 30 was actually quite like a massive deal for me. When that happened I ended up having a big party with my mates and things like that, because it was a bit of a like at this point on it was. It was a bit of a celebration kind of like how far I was coming. I was like God, I never thought I was going to make it this far, and then it was like. What now? You know, like I never. When I was younger I never paid into a pension. I never put money away in my savings. I never nothing, because I was just like I'll be dead. I won't, you know. It's not gonna, it won't matter. I might as well try and enjoy it while I can. And yeah, so yeah, I don't know, really, if that, there's so much to go into.	Being difficult for ex-partner to reject diagnosis Rejecting diagnosis felt like a rejection of the self Questioning whether ex-partner dismissed diagnosis due to stigma Describing ex-partner being offered a carer's assessment Being diagnosed due to being very unwell Ex-partner refusing carer's assessment Ex-partner rejecting diagnosis and support contributing to journey Being rejected by partner due to diagnosis Being rejecting by partner due to diagnosis was a pivotal moment Realising the need to put in effort myself Realising I need to put in work or I will die Reflecting on previous thoughts about fatality Aging being meaningful Reminiscing on partly to celebrate birthday Celebrating being able to live life this far Not believing in living this long Not investing in future when young Not saving financially when young Not investing in future due to belief that I will be dead Believing that the future does not matter Believing to enjoy life while I can
I	No, no, that's great. I'm interested in learning what's helped you so far in your journey. So some people may talk about therapy or support groups, or they might talk about key relationships that have, you know, really helped them. I just wonder if there's anything in particular that helped you in your journey?	

P	Yeah, there was. When I was referred back into secondary care services in 2019. I had a care Coordinator called the well, I won't say her name, but anyway, she was. She was great and she linked me in with the psychologist who carried out the initial formulation. I'm and I actually started dialectical behavioural therapy one-to-one with the psychologist before I got the diagnosis. I think the formulation assessment was done. Kind of like the April time. Something like that, I think, has started. I know probably a bit before that, and maybe I started. March started. DBT. Which was one to one with a psychologist every week. And yeah. And then I got a diagnosis kind of like, part way into the treatment. Because I had the the formulation initially instead. But she was. She was amazing. She was really, really good. She was really patient with me. She was really I'm she was incredible. And the the thing about it was the the consistency and the continuity that I had with it, because previously in other. In primary care, and previously in secondary care services. For years I've been in and out all the way from [REDACTED] child, and adolescent services right the way up to into adult care services, primary secondary services. One of the things I really struggled with, which I think again, you're probably quite well aware yourself that a lot of people symptoms of BPD report like a fear of abandonment is quite a big one. It certainly was for me, and unfortunately I would I I would be in their service, and I'd start to get to know a counsellor, a therapist, whatever it might be, and then they would leave. They'd leave the service. They'd move on. They, whatever they'd go off sick was quite a common one, and then you'd end up just being left in limbo. And really struggling with that. What perceived fear of abandonment and the actual abandonment, it would feel like abandonment. So the thing that really really helped me with my psychologist was that she was consistent with me, con-. You know that that continuity was like key for me, because I've really built a relationship with it like a really really good helping relationship she was. She	Reflecting on care coordinator Having a great care coordinator Being referred to psychology Having an initial formulation Starting individual DBT before having diagnosis Remembering when DBT started Having individual DBT with a psychologist Receiving diagnosis part-way through treatment Receiving psychological formulation in place of diagnosis initially Believing psychologist was patient with me Emphasising competency of psychologist Valuing consistency and continuity of DBT Reflecting on long history of engagement with mental health services Referring to awareness of interviewer Reflecting on fear of abandonment being a significant factor Reflecting on getting comfortable with therapists Reflecting on therapists leaving once feeling comfortable Therapists going off sick being common Being left in limbo in services Struggling with feeling abandoned when left in limbo Having a consistent psychologist helped Having built a helping relationship with psychologist

was amazing. Without her I wouldn't have. I don't think I'd have seen it through. I'm sure you again. You'll be aware. You know, I had to sign a contract when I started my DBT therapy. To say, oh, you know I was going to commit to. I was going to give it everything that I could and whatnot. But I was sceptical, because, as I said previously, up until that point I've been let down so much by other services because of staffing issues, funding issues, sickness, whatever it was. I get just I get a couple of months in. I just get comfortable with a new counsellor, and it was like right they're leaving, all right. And it happened, I had EMDR therapy. Just started that with somebody, and then they left, and it was just like that's probably well over a dozen different therapists and counsellors and stuff before I met my psychologist who she was great. And we we did a lot of the DBT skills themselves was actually, some of them are game changers, for how I reframe certain things in my head. Like the distress tolerance stuff was quite good, but it was the emotional regulation stuff that, like really really helped. There were like a lot of skills that to this day I still do use radical acceptance, opposite action. Some of the distressed skills, the tip skills and things like that. But it was putting it into practice. So like it wasn't like. And I say this to everyone because I do. I do preach about it to people. They think that not that, especially nowadays. I don't think people don't ever seem to get offered DBT. Instead, they can tend to get offered like a group life skill session. Which doesn't work. Trust me, it doesn't work because there's no emphasis on you as an individual to put the work in in that group setting, and I know that because I went and I worked in secondary care services for the [REDACTED] for about 10 months. And one of my jobs as a peer support worker was to work alongside the psychologist to deliver group life skills. Yeah, and it was co-produced, but it was still not from a lived experience perspective. But anyway, I digress on a bit of a tangent there. But it was putting the skills into practice. And I say that to everyone it's not just a case of like with counselling the counselling. And some of the psychotherapy stuff is quite a subconscious process almost where it's like you kind of. Don't realise that the cogs are turning, and especially	Attributing treatment completion to psychologist Having to sign a contract prior to DBT Feeling sceptical about completing DBT Feeling sceptical due to being let down consistently by services Being let down by staffing, sickness and funding issues Just when starting to get comfortable the therapist would leave Reflecting on therapist leaving once starting EMDR Losing count of the number of therapists Having therapists before being allocated a psychologist Believing in the effectiveness of DBT skills Skills being effective for reframing situations Emotional regulation module being useful Continuing to use certain DBT skills Putting the skills into practice made a difference Preaching to others Believing that people do not get offered DBT nowadays Rejecting effectiveness of life skills groups Groups lacking focus on you as an individual Groups lacking emphasis on you individually putting in work Observing effectiveness of groups being offered Talking about experience co-delivering life skills groups
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with things like EMDR, where it's almost completely subconscious like you don't. You're not aware that your brain's processing all this stuff as it's happening. But what with DBT and CBT is that you've you've like you've got to practice it. That is literally a case of like having to try and rewire your own brain, and the only way to do that is to just practice the new skills over and over and over and over again. And I guess at the very beginning I didn't really. I didn't really. I didn't really take it on board. At first, at I don't think. Took a while, and probably a good couple of months in ended up having a chat with my psychologist. And it was like, look, you need to be practicing this stuff like, it's not just a case of like sitting in the room for an hour, and it's going to go in, and it's going to change your life and like you need to take what I'm telling you. And then for the next week, you need to go and practice it and practice it and practice it and come back next week. And yeah, so that was something that like I had to do a bit of work on, and that sort of ended up when I started to see the benefits of it was something that I preached quite a lot to other people around like it's not. There's no way that anyone else can do the work for you. You've literally have got to do it yourself. You have to got you've got to. You've got to make the changes. So I needed a bit of a kick up the backside at the beginning, I think, for sure. But then, when I started to genuinely see some benefits of it, I was like, Wow, okay. And I'm convinced to this day that the the DBT that I had saved my life. I do think I do genuinely think that because if I hadn't had that that level of intensity and treat in the treatment I don't think I would have. I don't think I'd have taken it as maybe not so seriously. I just think I might maybe not have been as motivated to make the change that I knew deep down I needed to.

Co-produced groups not effectively incorporating lived experience perspectives
Putting skills into practice was meaningful

Acknowledging that some therapies involve subconscious processes
Acknowledging that some therapies may involve not always being consciously aware of changes, like EMDR
Some therapies meaning you're not aware about processing information
Being aware of the need to consciously practice strategies in CBT and DBT
Taking accountability to rewire your own brain
Continually practicing new skills to rewire your brain
Initially not realising the need to take ownership
Taking a while for the perspective shift
Having direct conversation with psychologist about expectations
Being advised to practice skills as opposed to being passive in therapy
Being told that attending therapy alone will not change your life
Being told expectations to practice skills

Having to put in work to practice skills
Starting to see benefits once skills were practised
Telling others that benefits will be seen once skills are practiced
Knowing that nobody can do the work for you
Knowing to take responsibility to do the work yourself
Needing to make changes myself
Needing a firm prompt to begin taking responsibility

Being impressed when seeing benefits of DBT
Believing that DBT saved my life

Believing that the intensity of treatment made it effective

		Having the intensity of treatment helped with motivation to make changes Always knowing the need to make changes
I	So it sounds like having that sort of intense one to one support and treatment, and having that good relationship as well and consistently...-	
P	The relationship. She was very, very understanding. She was very patient, she understood she understood the symptoms very well generally, but she she understood how they affected me as a person. And yeah, it was that one to one understanding was the, it was the helping relationships, the relationship I had with her that that was the key difference, I think. Which is then what essentially inspired me to change my career. That's why. Then I ended up leaving [REDACTED] trade. After I got ill I got my diagnosis, and now I've moved on and I I've moved into like peer support roles. My first one was in the [REDACTED], as I said, with a [REDACTED] where I was essentially bridging the gap. One of the things that I struggled with for quite a long time with it was because I was always in between services primary and secondary care services the primary care services would offer. I mean, I was lucky to get EMDR from primary care services at one point, but it was mainly just counselling and stuff psychotherapy. But then I'd have a lapse, a relapse, whatever you, whatever you want to call it. And then I'd end up getting escalated up to secondary care services. And then I'd go through some treatment, and then I'd be discharged and stuff. It wasn't until I had that one to one DBT. But I kept falling into this gap where there's kind of this void for people with BPD, because some people particularly high functioning, and I've always been high functioning with it always. You fall into this gap. There's like this void where you sort of fall in between services. And the problem I was having is that I was told I was too complex for primary care services after a certain point. But that I'm a stable. I was too stable to essentially be referred on into secondary care services, or to be admitted. And to be fair, I think, even in the in the whole. In the whole journey, from start to finish, I think I've actually only ever been sectioned got a 136 once, and	Having a very understanding psychologist Being treated in a way that showed patience Psychologist understanding symptoms Feeling understood by psychologist who knew how symptoms affected me as a person Having a one-to-one personable understanding of me The helping relationship being the key Having a helping relationship with psychologist inspired a career change Changing career to peer support Describing first peer support role Role involving bridging a service gap Struggling with always being in-between services Being in-between primary and secondary care services Feeling lucky to receive EMDR from primary care Only receiving counselling or psychotherapy Struggling to know what to call a relapse Being escalated to secondary care following a relapse Receiving one-to-one DBT seemed to stop the cycle of being stuck in-between services Falling into a service void Identifying as being high functioning Being told I was too complex for primary care but too stable for secondary care

	that was it. Because of a suicide attempt. But yeah, I forgot where I was going with that now.	Being sectioned once due to a suicide attempt Losing train of thought after mentioning suicide attempt
I	No, it's okay. I suppose, just keeping on the theme of sort of what helped you in your journey, I'm curious as well how you talk about, you know, being better versus sort of unwell before, you know, you started making positive changes. I'm, I suppose what I'm getting at is what is the difference? So how do you know now, for example, that maybe you don't fit the diagnosis, or that maybe you're in a better place than when you were before?	
P	Like what has changed main-. The main thing, the two main things is my tolerance to distress generally, and stress in general. I used to. If I got particularly stressed, get very overwhelmed, and I tend to spiral, and I return to the drink and the drugs to try and help alleviate the symptoms. I don't do that anymore. And the other thing is the general emotional regulation where it was chaos I used. I used to describe it. And I remember the moment that my care coordinator referred me to a psychologist about it, because I remember saying to her that it was like I was constantly in conflict with myself, and how I worded it to her was like it was like I had two parrots, one on each shoulder, and the one of them would like say good things and whatnot and talk in my ear. But the other one was like all negative stuff, and it was like. and I was like in this car. And I remember when I explained it like that to her. There was like this epiphany moment where she went. Okay, I'm gonna refer you onto this blah blah blah. And then that's when she said to me, I think that you may have borderline personality disorder. And it was from me telling her that about the kind of the inner conflict that was the the point in which she said, like she's not, you know, she said. I'm not qualified to make that diagnosis. I'm not. That's not my job, but it sounds very much like that's what it is. Which is. Then what prompted the formulation assessment. And then subsequently, the DBT. And the and the diagnosis. But I was the the inner conflict was always exacerbated by the actual, by the emotions I was feeling, which was like a roller coaster constantly. And my mood would change within seconds. And it wasn't always bad, because it was. There were	Tolerance to distress has changed Tolerance to stress has changed Previously getting stressed would lead to a spiral Previously relying on drink and drugs Not currently relying on drink and drugs No longer feeling chaos with regulating emotions Remembering moment when I was referred to psychology Explaining feeling in constant conflict with myself Explaining experience to care coordinator using a metaphor Remembering explaining myself in a car Remembering care coordinator having an epiphany moment of understanding me Care coordinator suggesting I have BPD Having a tentative label after describing my inner conflict Experience of care coordinator staying within remit of job Being heard and understood by care coordinator led to effective treatment and diagnosis

	obviously there were moments where, like it was that it was, it would be torture because I'd go from. I could go from absolutely feeling on top of the world to literally. I want to be dead in a matter of seconds. So I spent a lot of time on regulating the emotions. Which helped sort of calm me down generally, I think. But that now like when I look back now I don't tend to get, and I hate using this word, but I still don't really know of another word to use instead, but like situations that might have previously triggered me. Don't anymore. And it's as simple as that. For me. It's night and day. It's it's it's it's it is literally night and day, something that I would personally have taken quite personally, or would have gotten very upset about. I don't. I don't anymore. And I'm I just know that that's a sign that I've worked hard enough on myself that I've my I can be more in control of my emotions, and it's literally as simple as that for me. There aren't. There? Aren't any other. You know this. It's not as nuanced as as some other people tend to make out it is literally a case of I know I can manage my emotions more healthily, and that's the the bottom line of it, really in terms of like because of that. I have more of the inner peace. And do you know what I mean?	Having an inner conflict made worse by a roller coaster of emotions Shifting moods within seconds Shifting moods not always bad but was torturous Going from feeling on top of the world to wanting to die in seconds Awareness of shifting moods led to spending more time on regulating emotions Rejecting the word triggered Reflecting that previous situations that would be triggering no longer are Noticing not becoming upset by things or taking things personally anymore Not becoming upset by things that would have upset me before being a sign of having worked hard enough on myself Being more in control of my emotions Rejecting idea of emotions being complex as others may suggest Being able to manage emotions more healthily results in me having inner peace, or calm Checking for interviewer's understanding
I	Yeah. Regulating your emotions sort of generally managing them. Your emotions when they do arise. It's been a massive factor in your journey. And maybe that's how you know that you're well, and you've made progress. Yeah, and sort of things that maybe used to trigger you no longer do. And that's due to sort of all of the work that you've put in, in terms of your work with DBT, and that was 2019, wasn't it?	
P	So I'm 34 now, I got got the diagnosis when I was 28, just before I was 29. So yeah, 2019, like five and a half years, something like that.	Receiving diagnosis almost six years ago
I	Okay, okay. So you mentioned that you went through the DBT, with the psychologist-	
P	Yeah, I think I think I started it in the like the March time. Something like that. And it it went	

on every week right up until the end of that year. And then I think I was discharged from services. Yeah, it might have been the very end of 2019, or very, very beginning of 2020, I think. But essentially, when I completed the DBT kind of the course that she put out for me with this weeks and weeks of therapy. Essentially, it was a case of like, you've kind of, you've got the skills now. And I was just discharged like, okay, cool, off you go. Kind of thing, and you know. But I know, like I was saying before about this sort of void that people fall into where particularly people who are very high functioning with it fall into this gap where you don't meet the criteria for either primary or secondary care services and you end up falling into this like ether, where you just cannot get any support. And I did end up actually having a relapse a couple of years later, and I tried to re-access services and was basically just told there's nothing we can offer you. There's nothing we can do for you. There's nothing, that's it. You've had DBT, so you're essentially cured. You're far too complex with primary care services. We don't deal with anything like that now, in primary services. So it has to be a secondary service thing. And that was another key kind of moment for me in my life, because I thought, well, like there's plenty of other people I know, like me, that are high functioning with it that can't access the support either. And I kind of took it upon myself to try, and maybe I was a bit naive about this, I think, looking back, I probably was. But I thought, you know what I want to be the change that I want to see. So I was unemployed for some time after I left the [REDACTED] and decided to do some CPD stuff and just trying how I'm going to get. I'm going to get a job in mental health. I want to help other people. And I did, and I got the job. I got the job in a in a community mental health team. For a [REDACTED] by me, I loved it, and part of my job was to bridge the gap between the two services, so I was quite happy to take referrals in primary and secondary care, and I would do community work with these people. Group work, one-to-one stuff. And yeah. I knew that there were a lot of people that were in the gap that I was stuck in and peer support is. It's quite unique in that. It's very reciprocal. It's a mutual kind of	Receiving DBT weekly for about nine months Being discharged following completion of DBT Being discharged after a significant time of weekly therapy Being left alone once skills were acquired Falling back into a void after completing DBT Identifying as high functioning and not meeting service criteria Being unable to access support due to not meeting service criteria Being unable to receive support ending up in relapsing Being told there is no support to offer due to completing DBT Being told I am cured due to receiving DBT Being rejected by services prompting a key moment of insight Realising that there are others in the same position who cannot access services Wanting to change how high functioning people struggle to access support Taking responsibility for this personally Taking responsibility to gain employment in the mental health field Wanting to help other people Wanting a job and achieving it Enjoying being able to bridge the service gap in new role
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relationship. So it helped me as well because I was. That was kind of like my niche. I sort of everyone knew in the service that I was from a lived experience background with BPD, and it was kind of like, like, I said I was very open about it and adjusted to everyone you know, anyone that you know of with BPD, EUPD. I'll take them on because I wanna like I felt on this like mission to try and save the world. But yeah, unfortunately, it was a shame, really, because it didn't last very long, because there was a situation at work where, long story short, I mean, I left there in [REDACTED] last year, and going through an employment tribunal at the minute for discrimination and harassment, which there's a [REDACTED] trial listed for [REDACTED]. So it's a bit bittersweet. And yeah, that that being in a situation where I couldn't access the services, knowing that there was people like me out there was like another key defining moment for me to start my career in health and social care, basically because I knew so many people were struggling in the same situation that I was in. And I was fortunate enough to be in a at that time. Then I could actually make a bit of a difference. But unfortunately not every [REDACTED]. In well, in England, as a model that fully embraces lived experience as a practice. I was. I was working in a community team in [REDACTED], and I was the first peer support worker they'd ever had. In [REDACTED] 2022, but the model in terms of like the organisational structure with management just does not support lived experience, practice. And I've seen so many people come and go through that service now because they weren't getting supported with their own mental health. They weren't getting supervision enough, or whatever. And it was. Yeah. And as I said, there was a lot of discrimination, there was a lot of yeah. So I had to leave. I left, and I went kind of private into like charities and stuff like that. But yeah, again, I digress a little bit there. But just being aware of the challenges that other people were facing when I knew for a fact, they were. Because I've been there.	Completing a variety of work with people Knowing that there are lots of people stuck in the same service gap that I was Finding peer support to be reciprocal and relational Peer support helping me as I was an expert Everyone recognising my role On a mission to transform care Feeling a loss that the role did not last long Being discriminated against and harassed at work Perceiving peer support role as bittersweet Relating to others in a similar position motivated a career in mental health field Knowing that other people experience the same struggles that I have Feeling fortunate to have made a difference Believing not all [REDACTED] fully support and embrace the lived experience model Reflecting on being a services' first peer support worker Organisational barriers to embracing lived experience in practice Noticing other peer support workers leaving due to insufficient support in the role
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		Leaving peer support role due to discrimination Leaving [REDACTED] to work privately Understanding other people's struggles in a similar situation to me
I	And do you think any of those issues were kind of related to like to? You know, you having a diagnosis.	
P	Which issues the ones at work or?	
I	Yeah, yeah, it's okay if you don't want to go into it. But I just wonder if you think it is related to the diagnosis?	
P	I feel. Unfortunately, I was targeted by somebody because they knew I was vulnerable. So yes, unfortunately it did. It probably was the probably, was the initial reason for the way that the situation panned out. But again, I think because of that, it's an it's it was another motivating factor. Once the dust settled for me to to stand up for myself and not let not let it happen to other people. So hence the employment tribunal and the case against them. But yeah, unfortunately, I think it was. I think I was targeted because I had a because I was vulnerable because I was an ex service user, because I was from a lived experience background. But but yeah, I can't say too much about it at the minute, anyway. But yeah.	Being targeted by a colleague due to being vulnerable Diagnosis being initial reason why I was targeted at work Being discriminated at work motivated to assert myself and others to prevent it happening to others Having escalated it to a tribunal Being targeted due to being an ex-service user
I	Yeah, that's okay. So in terms of work now, are you working at the moment you sort of mentioned that you went into private-.	
P	Yeah. Yeah. So I'm working. I still work in like in like, kind of the more private sector I'm I'm still work alongside the [REDACTED]. But I'm still doing peer support stuff. Slightly different in the role that I'm in now. In fact, I'm just about to move on into another role. I've just been offered a new position in a in a service. But yeah, I still do peer support one to one stuff. But I kind of ended up going off on a bit of a different path the way that it took me because it was essentially asked to come into this role that I've been doing for just over a year. Now it's not quite what I was doing or what I thought I was going to be doing, which was the specifically mental health stuff. Specifically, peer support one-to-one with other people with personality disorders. But it's still a it's still a lived	Continuing to currently work in peer support Moving on to another role Having ended up going down a different career path Job not being as expected

	experience role, and it's still supporting other people. So yeah, I'm trying to get. I'm trying to like, come full circle and end up back in a mental health role. I just don't know how it's gonna look yet. But yeah.	Wanting to work completely within a mental health role Unsure about what mental health career will look like in future
I	Okay. So sticking on the, for now the topic of kind of the kind of positive things that have helped you in your journey. We've covered DBT, and how that's helped you quite a lot and the impact that key relationships have had. And even in a bittersweet way, this experience with the job. But it's kind of helped you sort of, you know, feel a bit more motivated to maybe stand up for yourself-.	
P	Yeah.	
I	Advocate for yourself more.	
P	And to make sure that it doesn't happen to other people that that was like the key driving point thing for me with the initial when I first started in this kind of line of work, was that bridging, that gap between the services, primary and secondary services to meet the needs of people that were like me, that were falling into this void and basically just being neglected by all these services. And it was like, I know how that feels. I don't want other people to have to go through that. How can I make a difference? And it's just kind of gone from there, really, and as a bit of a passion project for me personally to try and help other people like that. And I, said I, I spent a long time advocating. I was doing interviews similar to this. I was doing podcasts. I did. I've done some training videos for some local council. I've done loads of stuff, loads of stuff. I've written a book and all this sort of stuff that I want to like, share my experiences to try and help other people, because like I still have therapy. Now. I still see a therapist now, and I've seen her for on and off for a couple of years now and again. Very good relationship with her. because that is the key thing, and it's the same in peer support. It's like the the relationship you have with that person is is the main it's the difference essentially between getting what you want out of it, and not because just that. Yeah, I don't know what it is. But yeah, no, I. Still, I still, I still have therapy once every couple of weeks to just stay on top of it. I say to people so like one of the things that I've done that I've	Wanting to work in mental health being driven by a motivation to bridge the gap in mental health services to help others in a similar situation to me Wanting to meet the needs of people like me Wanting to meet needs of those being neglected by services Wanting to prevent other people from feeling neglected by services as I can identify with the feeling Wanting to know how to make a difference Wanting to help others being out of passion Investing time in advocating for people with BPD Engaging in multiple avenues to advocate for people with BPD Having written a book Wanting to share experiences to help others Continuing to have therapy Having therapy long-term Having a good relationship with therapist Having a good relationship being facilitator to getting what you want out of treatment

	talked about in quite some detail before to talk about. It is like reading. So I talk about these negative thoughts. And I do used to suffer with negative automatic thoughts a lot. Not so much. Now we've done a lot of work. But I say to people, it's like weeds in a garden, right? So those negative thoughts that that crop up are like weeds in your flower beds. And if you leave it for too long, it becomes overgrown, and it almost becomes unmanageable. You think, God, how how am I gonna how am I going to deal with this? So it's a process. It's like it's a process of just constantly just trying to like address it as and when it's happening, so it's just weeding it as and when you need to, rather than waiting, and then trying to like, tackle it all in one go so that's kind of the like. The analogy that I use for maintaining like a healthy mind if that makes sense but it applies to everything. It's not just not just BPD.	Continuing to have therapy to maintain Doing a lot of reading Talking about negative thoughts Previously suffering with negative automatic thoughts frequently Not having negative thoughts as much due to doing a lot of work on it Describing metaphor for negative thoughts Describing a process of addressing negative thoughts as they arise as opposed to leaving them until they are difficult to manage Using an analogy to maintain a healthy mind Acknowledging that maintaining a healthy mind applies to everyone and not just people with BPD
I	Yeah, that's a really lovely analogy. I haven't heard that before.	
P	Yeah, I find it quite therapeutic. I used to love gardening, anyway. So I I do. I find I switch off. And then, yeah, as I said, it just sort of became its own analogy for me where and like that's how I say it to other people now is that like you've got to kind of maintain it. You can't wait until you get to like crisis point. And then I mean, it's this, it's this process, this constant process. It's an ongoing journey. Blah blah.	Noticing that analogy fits with personal interest in gardening Being connected to the analogy Sharing analogy with others Explaining to manage negative thoughts before they get to a crisis point Explaining a constant proactive process
I	No, no, that's great. Okay, so I guess I'm wondering, so, some people might talk about sort of you know what helps to kind of maintain their journey. Recovery journey. Some people sort of talk about kind of key relationships in their life. I know you've sort of spoken about your therapist as well. Maybe your psychologist before. I wonder if there's anybody who's key in your life at the moment.	

P	Yeah, I mean my I've got. I've got a daughter. Whose, whose five. But it's a it's complicated. It's very, very, very complicated situation, but she's kind of like a big motivation for me. Because, I think it was hard for me. I never wanted kids when I grew when I was growing up because I didn't want I didn't. I felt like I didn't want. If I had a kid and I was anything like my parents. They were going to grow up to be like me, and they were going to grow up in this emotional turmoil constantly, and and then end up like me. But then, since finding out that I did have a daughter, was another motivating factor for me, because it was like. Well, I never, ever want her to have to experience what I did growing up as a kid. So she's kind of like a bit of a bit of a motivation for me I've got. I've got a partner who's very supportive. Whose known about it from from day one and then sort of tries to understand it. And my friends like I let them know, like I let people know. And I talked to a lot of other people with BPD, EUPD. But just since I started sharing more about it, particularly like online and stuff like that, like it attracted quite a bit of attention. And I guess again it kind of it's a bit like that peer support where it's that mutuality between somebody with shared lived experiences where it's kind of like rather than preaching to people about. Well, this works that works blah blah and try this and do that. It's kind of more two-way. It's not like a one-sided thing. Do you know what I mean? And there's no sort of power, imbalance, or anything like that. So it's kind of the approach that adopt with all of it, really. But yeah. I think the relationships that I've had with people since I've been open about it, and I must admit it's difficult, because I've had to. I cut a lot of people off. So when I got when I started to get better. I realised that the people that were in my life previously had been contributing to the person I was before, that I didn't particularly like. For example, now, and I haven't for about three years. I don't have a relationship with my own parents. I haven't spoke to them for three years, because and it's not that I blame them anymore. But I just I know them and I don't. I don't want that kind of negative impact or that negative trying to think of another word to to describe it. But it's just that general negativity	Daughter being a significant motivation Relationship to daughter being complicated in some way Reflecting about previously not wanting kids Not wanting kids because not wanting them to be like me Not wanting kids to grow up in emotional turmoil and end up like me Feeling responsibility for child's wellbeing Finding out I have a daughter being motivation Being motivated to give daughter a difference experience growing up Currently have a supportive partner Partner always known about diagnosis Open about diagnosis to friends Talking openly to people about BPD diagnosis Talking to other people with BPD Sharing information about BPD online attracted attention Benefitting from peer support online with others with a similar experience with BPD Valuing the mutual relationship with peer support as opposed to an imbalance in power dynamic being advised what to do Acknowledging the lack of power imbalance with peer support Being difficult to cut people off Realising that certain relationships contributed to who I was before Not liking the person I was before Sharing that there is no relationship with parents now
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	like, I just don't need that in my life not now like I feel like. I'm a totally different person now. So I feel like anything that previously served me in another life, where I was very chaotic and very unwell, and very emotionally poorly. Anything that contributed or served me at that time doesn't meet my need now as a changed person, and what that's meant is, I've had to cut people off, old friendships and things like that with people that not particularly healthy, toxic relationships that are at the time I probably thrived on. But now I wouldn't. Now I don't, because I'm not that chaotic, emotionally immature kind of person anymore. So it was like quite a big moment where I ended up cutting off all my old friends, my family and starting over, really, because I just didn't feel like I was that person anymore, like I'd grown and changed to a point where. Yeah, they just weren't gonna fit in with how I wanted my new life to be. Do you know what I mean, so I have to make some pretty big changes, but it was for the best.	Not spoken to parents in three years Acknowledging that cutting off relationship with parents is not due to blame Struggling to find a work to describe why the relationships were cut off Cutting off negative relationship with parents Feeling like a completely different person now Believing that anything that previously served me no longer does Reflecting on previously being chaotic and emotionally poorly Anything that previously met my needs or served me no longer does Being a changed person and not having needs met in the same ways as before Having to cut relationships with friends which were unhealthy Recognising that I would have previously thrived on unhealthy relationships Currently not identifying as chaotic and emotionally immature Being significant to cut off relationships and having to start over Realising that certain relationships were not compatible with how I wanted my life to be Having to make big changes for the best
I	Yeah, okay, thanks for sharing that, [REDACTED].	
P	It's okay.	
I	I'm just mindful of time. It's five past five. So it's completely up to you. What we can do is we can have probably a couple more questions left, so it's up to you. We can push through, or you can have a 5, 10 minute break, or or we can rearrange. I don't know what your schedule is looking like?	
P	But if you've got, if you've got time, I'm happy to just let's crack on and get it done?	
I	Yeah. Okay. So I suppose thinking about the last set of questions I wanted to think about was anything, and I'm aware that a lot of these questions interlink. So you know, I might have touched on quite a few things already. But I'm interested in sort of some of the sort of barriers that have come up throughout your journey, and	

	maybe things that might, you know that haven't that you haven't experienced as helpful.	
P	Yeah, I think the first thing I would say is that again I've I've mentioned it, I think, in pretty much. Every kind of set of questions is that gap between the services you can actually access, which was a big issue. Because as I said, you can't kind of be treated in primary care, setting anymore in a lot of [REDACTED]. But once you've kind of done DBT, in a secondary care setting, it's kind of like, well, where do you go after that? It's been difficult since I did. I didn't. And I you know I'm very aware that anything could happen that could cause a potential relapse. And, as I said, it did did happen a couple of years ago.	Emphasising that recovery is related to the gap in accessing services Gap in services being an issue Cannot be treated effectively in primary care services Acknowledging limited access to support once DBT is completed Not knowing where to turn to once DBT is completed Feeling left on your own once DBT completed Feeling alone and vulnerable to relapse without further support
I	Isn't that interesting, though? How you said, you know, once you've sort of had DBT you know, professionals might say, Okay, well, what next? You know you've had that-.	
P	That's yeah. And I think because that did happen to me, it was kind of like, Okay, well, if no one else is going to help. I've kind of got to take matters into my own hands. So what can I do to maintain my mental health? I said. It's a bit of a situation of like a do or die moment where it's kind of like I've gotta I've got. I'm gonna I've got to do this myself, because no one else is gonna do it for me. But I had to go through hell to get to that point where I was able to sort of pick myself up and do that. A lot of other people maybe, aren't quite as resilient, or I don't know. Yeah. It was a difficult one. Trying to access services itself is a barrier, and I'll give you an example as well. Of the kind of level of stigma within the [REDACTED], where so not the specific service that I was working in. But still in the same in the [REDACTED] and one of my colleagues. They were in MDT and a referral came through for somebody with EUPD, and there were two nurses, and they flipped a coin to see who was going to take the referral. I didn't witness this myself. I was told by a colleague who joined after I did that. Neither of them wanted to deal with this patient because or service user, because it was a EUPD. And oh, they're chaotic. They're crazy blah blah. And they would flip a coin to decide who would take the patient on onto their caseload which I just thought was completely disgusting. But I feel like it's	Acknowledging that services will not provide help Having to take responsibility to make changes Having to figure out alone how to maintain mental health Being a do or die moment Noticing that I have to do it myself because no one is going to do it for me Having to go through suffering to reach a point of helping myself Questioning whether other people are as resilient Trying to access services being a barrier Providing an example of observed stigma in services Nurses flipping a coin to decide who was going to take referral for EUPD patient Being informed of stigma by colleagues early on in role Neither nurse wanted to work with a patient due to their diagnosis of EUPD

	difficult for me now, because, like I said, I don't, I don't. I don't identify with the with BPD. Anymore as like a an illness as such. So those behaviours that were historic to me that that probably were classic really symptoms of of BPD. I kind of don't feel like I want to be sharing that side of my life anymore, because I've kind of moved over to a point where, like, I've just completely left it behind. And I'm always. Little bit with certain things emotionally, maybe. But for a long time I was like, yeah, I was this crazy, chaotic person that was drinking and doing drugs, and was promiscuous and all the rest of it. But now I've got to the stage in the recovery journey where it's like, okay. I don't even want to be associated with the person that I once was, because, like, I've moved on so far, and I've got rid of my old life completely like, I don't want to have to remind myself that I was like that. I want to just focus on moving forward and getting more and more mentally. Well, stable, healthy, whatever you want to say. But I think, like the stigma is still quite. Is still pretty bad, and I think that's a barrier in itself, not just like when you're trying to access services and stuff, but just generally trying to talk to people about it, because there's so much bad stuff out there. Trying to find a safe place to discuss it with somebody is really really difficult. I think that was probably the main, the main barrier for me. I think over the course of trying to get diagnosed, and then, even after. But I had a relapse. Yeah.	Feeling disgusted by stigma in mental health professionals Being difficult due to not identifying with the diagnosis Rejecting identifying with BPD as an illness Not wanting to share side of life that were symptomatic of EUPD Completely leaving behind the person I was with EUPD Describing previous self as chaotic and crazy Acknowledging previous promiscuity Stage of recovery where I don't want to be associated with the old me Having removed aspects of old life completely Not wanting to remind myself of my old behaviours Focusing now on moving forward and more mentally healthy Noticing bad stigma and being a barrier to accessing services Stigma being a barrier when wanting to talk to people about BPD Acknowledging negative information online about BPD Finding a safe space to talk about BPD is difficult Being difficult to talk about being a main barrier to before during and after diagnosis
I	Okay. I wonder if maybe the the stigma, you know, there's such a huge stigma, you know, around BPD, and I wonder if that in itself maybe influences your thoughts, on maybe not kind of wanting to associate with the diagnosis anymore?	
P	Yeah, I think I think it does. But I don't think it's because of the characteristics of the illness. I think it it is, but it's more to do with me personally. How I've moved on, and how I how I am as a person now is is this is miles away	Characteristics of BPD as an illness not being why I want to distance myself from it Being removed from identifying with diagnosis due to being so far

	from how I used to be, which was those characteristic behaviours. And I wasn't ashamed of the stigma when I was very open about it for years. From virtually from the moment I got the diagnosis very shortly after, until very recently, the stigma. I was never ashamed of the stigma. I was quite. I just owned it. I was never embarrassed about it. It was just. It is what it is. I just think I think some people are definitely and like, I know, some people have reached out to me since I came out of my diagnosis, who I would never in a million years would have thought people I knew from school and people who I actually have worked alongside. There's one in particular who's actually she. I think she's already contacted you. I worked alongside her in a previous job. I had absolutely no idea that she had BPD. And then she saw the stuff that I was doing online. And she reached out to me. And and we talk now. And yeah, I think she's dropped you an email to to get in touch with you about about this. But I think so many people, so many people just go silent because they're so scared of the stigma. I just thought sod it like, I'm just gonna own it. Because if if you. It's the only way to break this thing with that, isn't, it is to talk about it and normalise it and try. And you know, I think when you don't talk about it and stuff, it feeds back into that kind of oh, it's that's what feeds into the stigma, isn't it? So? I've always been open. But, like I said, it's more for me now about how I just I just don't. I don't like to remind myself really of the person I used to be as much anymore. I'd rather focus on where I'm going, not where I've been.	removed from the person I was, which was the characteristic behaviours Being openly unashamed of the stigma Owning the diagnosis Awareness of other people being embarrassed of diagnosis Being open about diagnosis led to others reaching out to connect who surprisingly also had the diagnosis Knowing people from school and work with BPD Working alongside someone and unaware of their BPD diagnosis Being reached out to connect based on shared diagnosis Believing that many people go silent due to the stigma Believing that the only way to make change was to own it and normalise it Believing that not talking about BPD feeds into the stigma Always being open to talking about BPD Not wanting to remind myself of the person I used to be Preferring to focus on developing and being future oriented
I	No, I hear that. Okay. So thinking about the sorts of questions that I had in mind. I think I've pretty much covered everything now. So I suppose, sort of thinking about from your perspective. I wonder if there's anything that you'd like to add, or anything you feel like you haven't had a chance to speak about. That, you feel may be important in terms of your experiences of recovery, good or bad, or somewhere in-between?	

P	No, no, I think actually I was. I was once I was. I became quite open about it. I, after the initial fear of reading all the stuff online immediately after getting the diagnosis. Was generally met with quite positive with quite a positive outlook. I was quite open about it on things like Instagram and stuff like that. And so I did these podcasts and stuff like that. And actually, all the feedback was good. It was all positive, but it was because it was from people that needed to hear it. You'd still get the odd, the odd comment from people who don't understand or just ignorant to ignorant to it. But yeah, I just think people should be talking about it more and trying to trying to break the stigma.	Being open about diagnosis after initial fear of reading about diagnosis online Being mostly met with positive feedback on social media Positive feedback online led to confidence to doing podcasts Receiving positive feedback Positive feedback being meaningful because it was from people that needed to hear it Noticing comments by people who lack understanding Believing people should talk about BPD more to break the stigma
I	Yeah, no, that's brilliant. Have you got any questions for me? At this point.	
P	I don't think so, [REDACTED]. I think I'm quite happy with everything. If you are.	
I	Perfect. Okay, then, [REDACTED], I just want to say you've been absolutely brilliant. This has been really great. Yeah. And again, thank you so much for your time.	
P	So it's a privilege to be able to be a part in it like. So thank you very much, because I've although I've done various other things in the past with like the the raising, awareness and stuff. I've never been able to contribute to something like this properly before, and I've done. I have, in the sense that I've shared and delivered my experiences within the [REDACTED] and other settings. But to actually contribute to research like this. This is something I've never had the opportunity to do. So thank you.	Having engaged in various avenues to advocate and raise awareness Being grateful to contribute to research

Appendix H:

Examples Showing the Development of Focused Codes From Initial Codes

Figure H1

Example of Focused Codes Being Drafted Through the Annotation of a Sample of Initial Codes

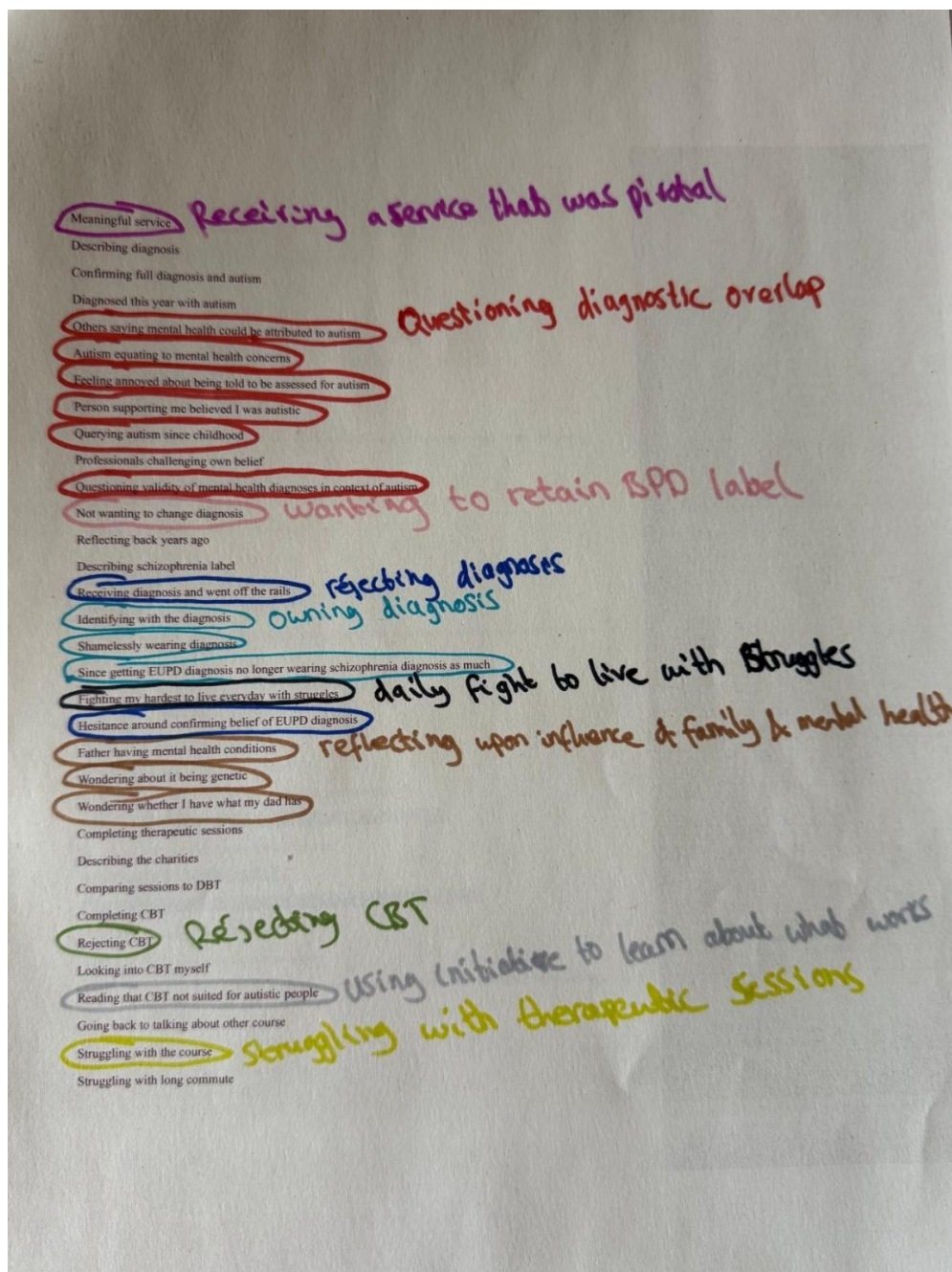


Figure H2

Example of Focused Codes Being Drafted Through the Annotation of a Sample of Initial Codes

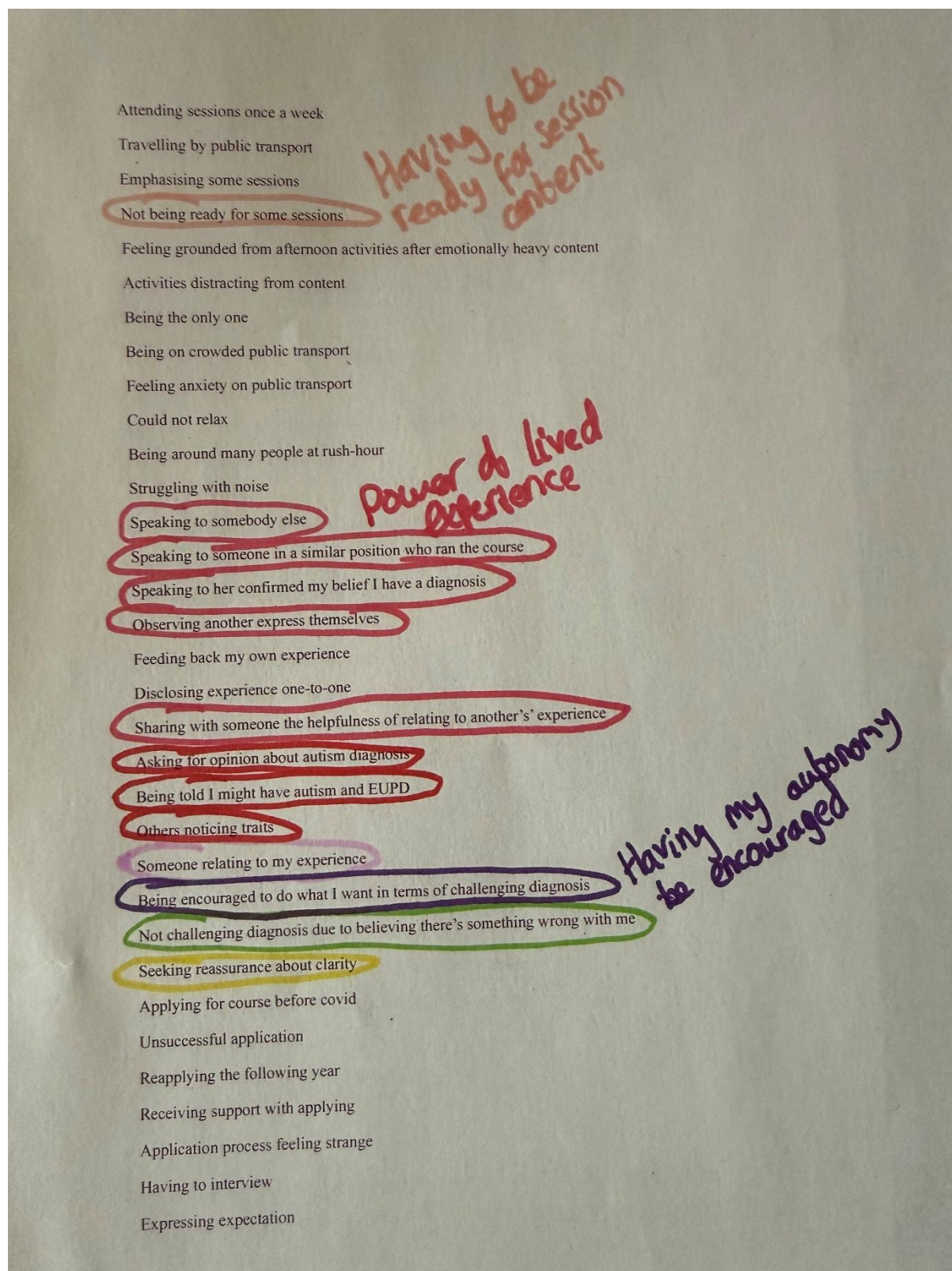
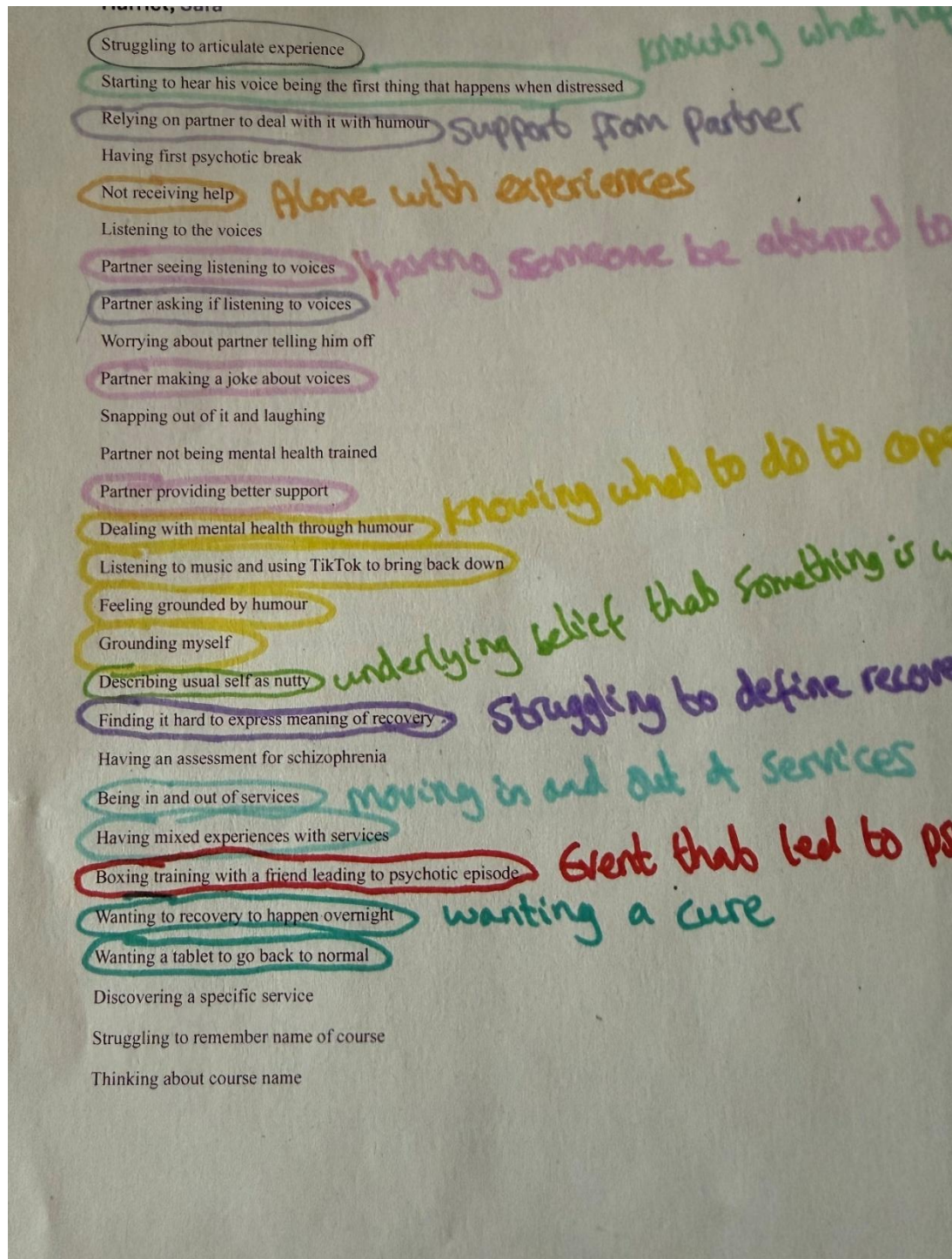


Figure H3

Example of Focused Codes Being Drafted Through the Annotation of a Sample of Initial Codes



Appendix I:

Example Diagrams Exploring and Refining Relationships Between Categories and Subcategories

Figure I1

Diagram Drawn to Illustrate Continuums Between Potential Categories and Subcategories During the Analysis Stage

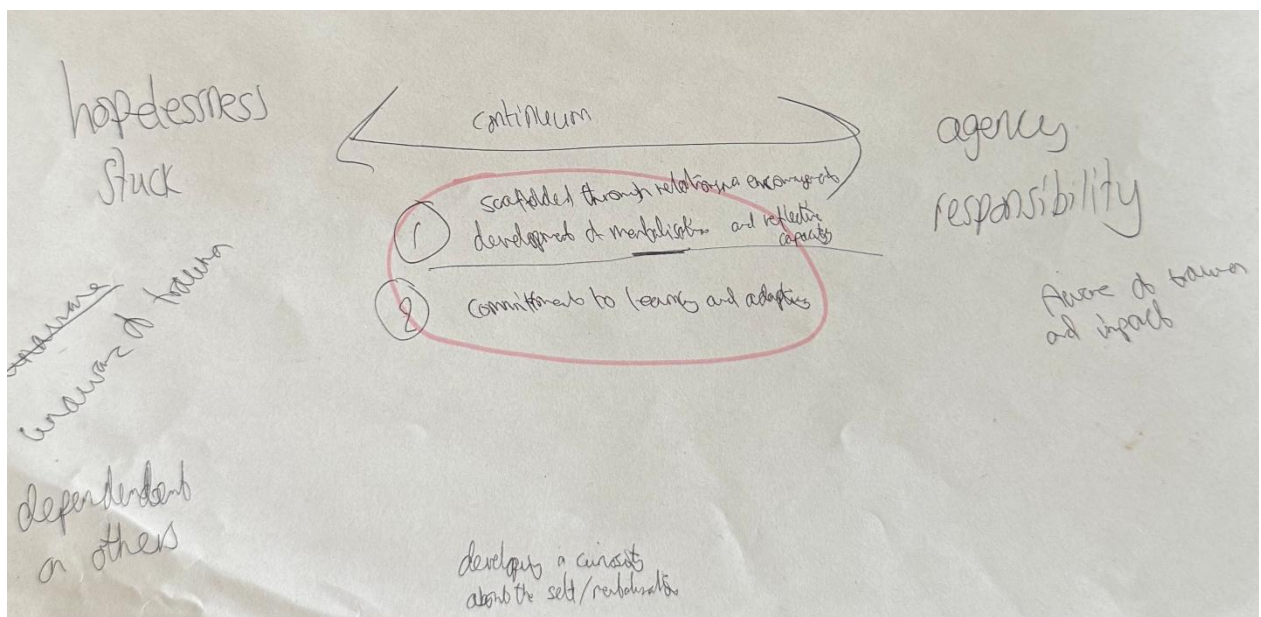


Figure I2

Diagram Drawn to Illustrate Continuums Between Potential Categories and Subcategories During the Analysis Stage

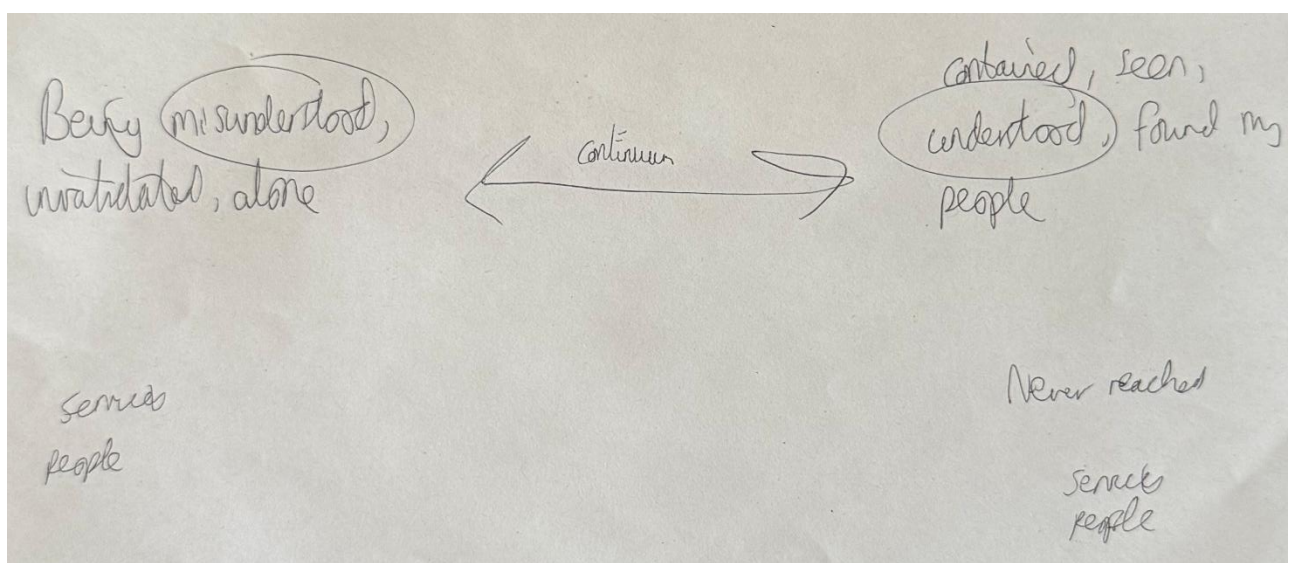


Figure I3

Diagram Drawn to Illustrate Continuums Between Potential Categories and Subcategories During the Analysis Stage

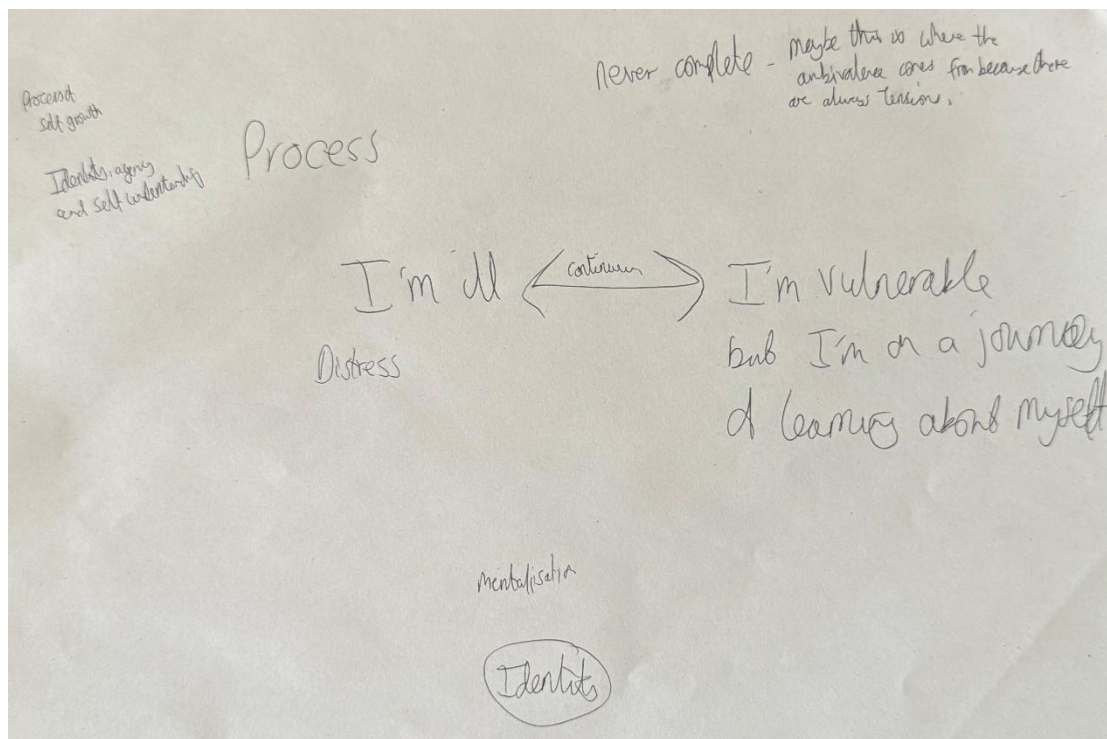
**Figure I4**

Diagram Drawn to Illustrate Continuums Between Potential Categories and Subcategories During the Analysis Stage

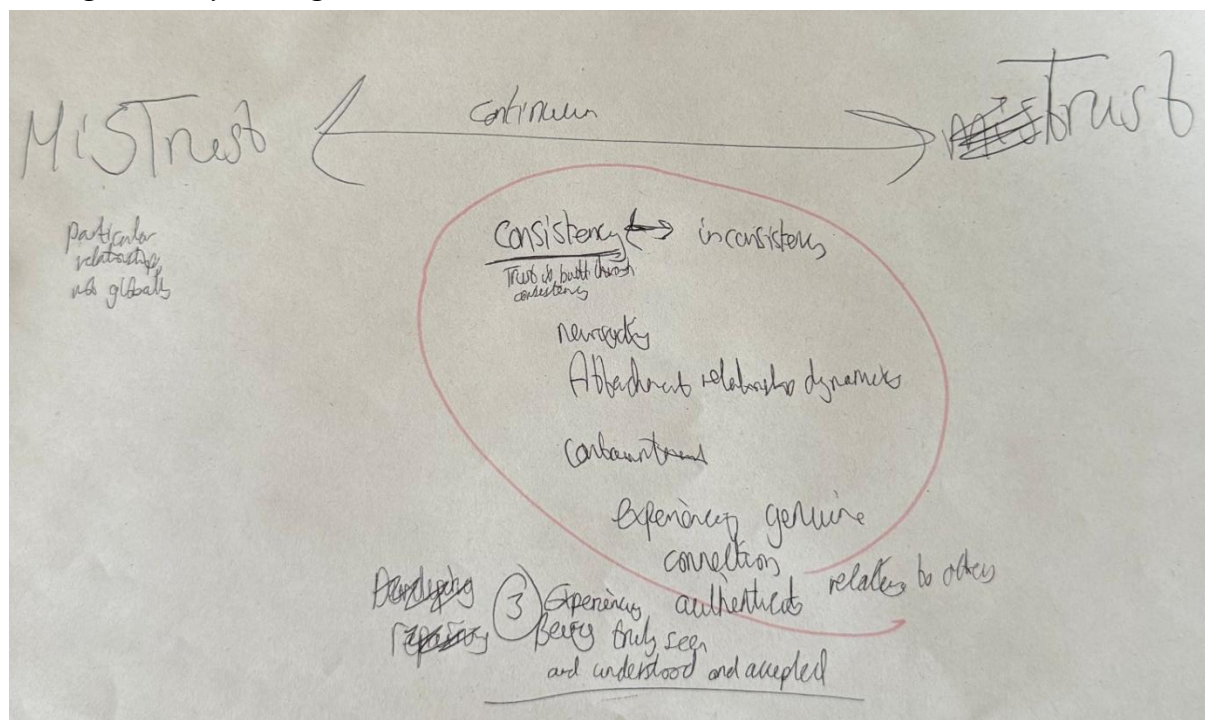


Figure I5

Example of Early Diagramming to Conceptualise Links Between Codes, Categories and Subcategories

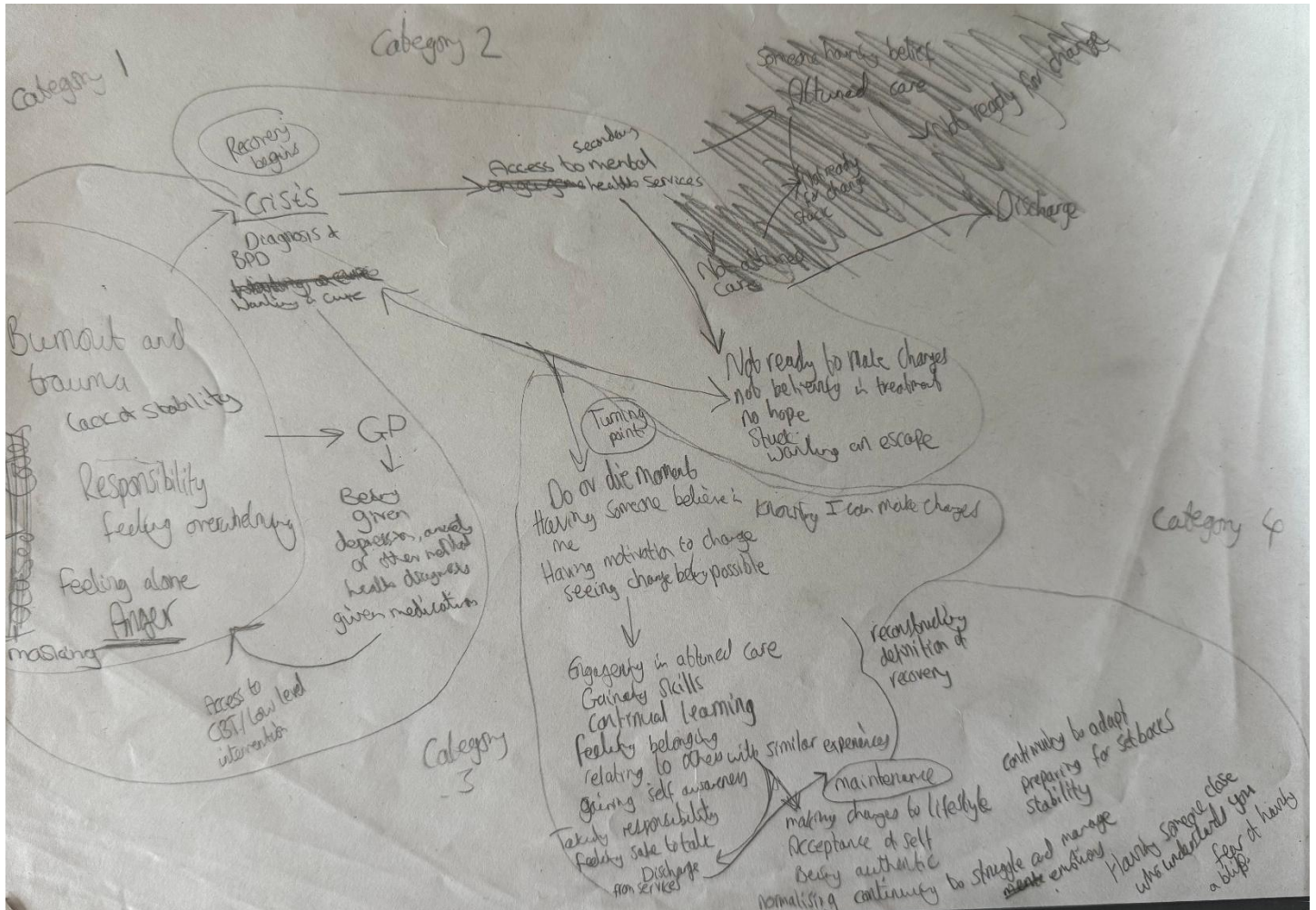
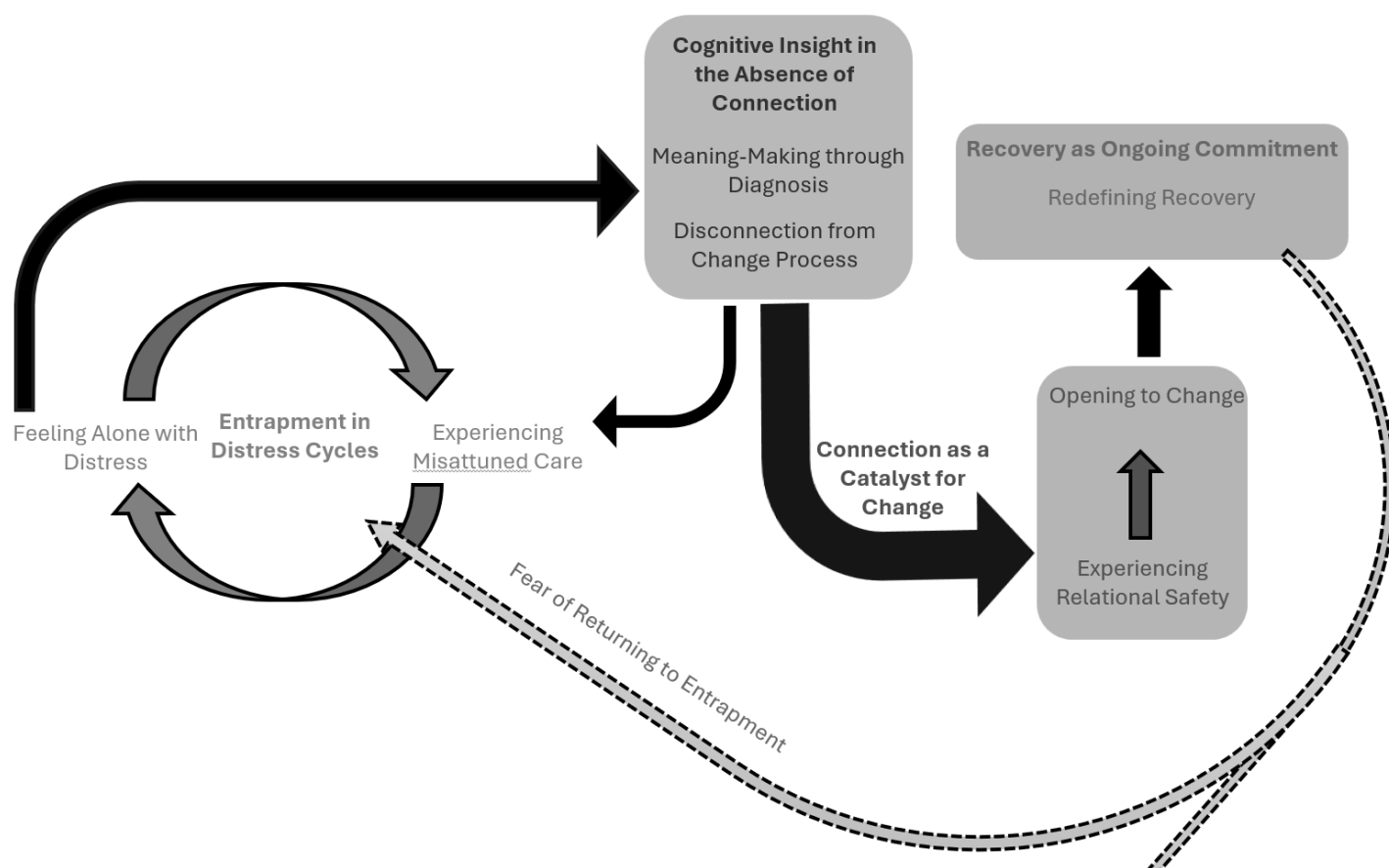


Figure I6

Example of an Early Construction of a Theoretical Model



Appendix J:

Audit Trail: Examples of Memos, Post-Interview Reflections and Category

Development Reflections

24/11/2025 – Post-interview reflection

I wonder if I could include a question towards the beginning of the interviews around what drew you to participate in the study, how do you identify as being eligible to participate in terms of either being recovered or in recovery from BPD (in light of responses implying that recovery is not possible).

15/02/2026 – Post-interview reflection

This feels similar to the last interview with Daniel, they have both said that they have had to be flexible in their thinking, specifically around the idea that just because something had helped them before it does not mean that the same thing will help again in future. They both spoke about being able to adapt. The notion of adapting and a commitment to change might be important here.

18/02/2026 – Reflection during initial coding of first few interview transcripts

Is there something around a shift in the meaning or expectations of what recovery means? Perhaps a shift from the idea of it being or wanting an instant cure to the notion of it involving setbacks. I recall the participant saying that possible alternative diagnoses may not be valid and may undermine the real struggles with mental health. Interesting how although the interview is specifically about recovery from BPD, recovery was also spoken about in terms of other diagnoses. It felt difficult at times to tell the difference between what was being attributed to BPD recovery and what wasn't, even when I explicitly prompted, perhaps this is an important sign though.

I'm noticing that people are finding it helpful to just hear that someone else has a similar experience to them and that they can relate. I wonder if that's why people feel strongly about sharing their stories, because this is a helpful tool in recovery. Something about belonging and not being the only one?

There's something there in being pivotal in creating change, I wonder what it is about that thing. For one participant, I remember it was the course he went on. Maybe it's about exploring what was fundamental about the course. The act of imparting knowledge of lived experience for him was also empowering, he said that feeling empowered is what keeps him carrying on.

16/03/2026 – Reflection on motivation and reciprocity

Noticing that lots of people with the diagnosis feel strongly about wanting to help others in a similar situation to themselves and to share their story. I thought initially that I understood this but right now the relevance of how this would help someone's own recovery wasn't ringing through for me.

22/03/2026 – Reflection on neurodivergence and diagnostic histories

I'm noticing that during interviews people are mentioning other mental health diagnoses and neurodivergence that they have received prior to the diagnosis of BPD. It might be interesting to explore this further.

29/03/2026 – Post-interview reflection (early emerging analysis)

There's a theme of making adjustments and working through things, and the idea that people think that other people with BPD might let the diagnosis weigh them down. Maybe

the difference in terms of recovery is the mindset of having hope being what is different in recovery.

30/03/2026 – Reflections after transcribing the first three interviews

After transcribing the first three interviews, I felt I got a new sense of understanding what was going on for the participants, relative to my experiences during the interviews themselves. It made me think a lot more about neurodiversity in relation to the BPD diagnosis. Also, after completing the initial three interviews I was filled with a sense of disappointment in myself, I thought that I had not done a good job at eliciting the information I needed to address the research question, and I felt very demotivated to carry on with the recruitment process. But it wasn't until after transcribing, writing in my journal and beginning to create initial codes, that I realised that the data was very rich, and that the meaning was not necessarily always in the specific words that were said only, and that lots could be inferred by what was being implied during the interviews. I felt very motivated after starting to analyse and after transcribing the first three interviews.

01.04.2026 – Reflecting on potential theoretical process

Recovery not started -> receiving diagnosis = recovery begins

- ➔ Accepting diagnosis
- ➔ Knowing what to do to get better
- ➔ Feeling there is no hope to get better
- ➔ Being consumed by survival
- ➔ Being shut-off from others
- ➔ Not wanting to engage with treatment
- ➔ Having a professional see past the behaviour and be seen

- ➔ Having someone else show belief and understanding
- ➔ Having somebody understand your behaviours beyond face value
- ➔ Hitting rock bottom and making a choice to get better
- ➔ Starting therapy and starting to take it seriously
- ➔ Having to want to get better yourself
- ➔ Realising that nobody is going to help you recover
- ➔ Learning about the self
- ➔ Helping others being part of recovery
- ➔ Full recovery not existing
- ➔ Always possibility of new unknown situations coming up and destabilising mental state
- ➔ Idea of being recovered reflecting a state of complete and stable mental stability that nobody can achieve
- ➔ Recovery being a place where your life includes other things and is not consumed by survival
- ➔ Maintaining recovery and getting to recovery involving relating to others

Cycle of FEELING WORTHLESS [WANTING CONNECTION/FEELING NOT BELONGED -> HARMING SELF -> OTHERS WITHDRAWING SUPPORT -> FEELING WORTHLESS ETC

Cycle of recovery: FEELING WORTHLESS [WANTING CONNECTION/FEELING NOT BELONGED] -> HARMING SELF -> OTHERS PROVIDING SUPPORT AND CONNECTION + ENCOURAGING ACCEPTANCE + RESPONSIBILITY = FEELING CONNECTION ETC

Needing to have support on an ongoing basis.

Traumatic incident that is serious enough, but that others are able to sit with and communicate with and to provide the appropriate support. Avoiding of self-harm and withdrawing keeping someone stuck. Maybe it's seeing others being at their lowest when people begin to realise and to provide that care?

06/04/2026 – Reflection on recovery conceptualisation

Rejecting the idea that recovery is a cure and something you need to work towards in an upward path, maybe it's a sideways path of just understanding the self better and continually improving? Because it makes me curious about what does full recovery look like for anyone, what is the goal, and is this vague and is this different for everyone. Is it everyone's goal to score highly on the standardised functional outcome scales e.g to be working full-time etc, or is recovery for them something different and is it evolving as they are evolving as people. I don't think there is an end goal of recovery.

19/04/2026 – Reflection on service experience and CBT

Its common for participants to not like CBT. But when explored, it doesn't seem to be the specific techniques. I wonder if it reflects more systemic service issues around the way CBT is offered. It comes across as very inconsistent and therapists being described as cancelling sessions and ending sessions without explanations.

26/04/2026 – Reflection during initial coding stage of analysis

As I'm going through looking at all the initial codes, I'm thinking about building a theory based on these alone. And whilst going through one interview transcript in particular, I'm

noticing that if I were to look at an initial code at face value, I could easily come up with my own assumptions about it, however during the interview whereby I was able to listen to the full context and story behind specific points of view, it made me realise that different perspectives and points of view, whilst at face value may seem unfavourable by some, are completely understandable and appropriate given the individual's history and experiences. It is making me realise more than ever to be mindful of each person's history and circumstances before making judgements about their perspectives and behaviours.

29/04/2026 – Reflection on meaning of recovery

Thinking about the idea of full recovery or being fully recovered a lot of the time being rejected as an idea due to the belief that BPD is somewhat permanent and unchanging.

There is also the idea that you are in a constant state of recovery which includes managing thoughts and behaviours around what may be triggering. Just reflecting on things in particular, so the idea that certain personality traits or vulnerabilities remain. From memory these were some kind of biological difference that makes feeling emotions more intense than others may do and other personality traits such as being open or trusting that may be perceived by others as vulnerable.

05/05/2026 – Reflections during focused coding

- The idea of having blips or setbacks meaning you cannot recover is interesting. Also the idea of recovery being unrealistic – it seems that the medicalised “cure” meaning is attributed to recovery within the BPD and mental health context, which may explain why people go through a process of redefining what recovery means. This is presumably after wanting a “cure” but realising that perfection in terms of mental health does not exist. There are also narratives around the brain being wired

differently, or that BPD should be considered a form of neurodiversity in and of itself.

- I'm noticing that only male participants have stated that they use humour as a protective mechanism.
- Feeling alone with BPD seems to be one of the most difficult experiences.
- I'm thinking about the role of inpatient stays and how the restrictions can prevent someone living their typical life. I do wonder if this serves a protective function or whether it shows that their current lifestyle or something within their life needs processing/ slowing down or there is burnout.
- I'm noticing I'm not adding very many focused codes by the time I got to interview number eight of twelve. By interview twelve I was adding no more focused codes.
- I notice that although many participants described DBT as lifesaving, most participants did not emphasise using specific skills which was surprising due to it being a skills-driven in approach. However, a commonality was the ability to be mindful, and to be able to pause and reflect before acting. It reminds me of the STOP skill in DBT. It's also about relating to others who are similar in their experiences that was powerful. For some, medication was impactful as it helped them to be able to get to a place where they could pause before acting.

Appendix K:**Ethical Approval****University of Essex ERAMS**

02/09/2024

Miss Lauren Gibbs

Health and Social Care

University of Essex

Dear Lauren,

Ethics Committee Decision

Application: ETH2324-1098

I am pleased to inform you that the research proposal entitled "Exploring processes of recovery in borderline personality disorder: lived experience perspectives" has been reviewed on behalf of the Ethics Sub Committee 1, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

REO Research Governance Team

Ethics ETH2324-1098: Miss Lauren Gibbs

This email was sent by the University of Essex Ethics Review Application and Management System (ERAMS).