

Clients' experiences of treatment and recovery in Borderline Personality Disorder (BPD): a  
meta-synthesis of qualitative studies

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## **Abstract**

**Objective:** This review synthesised findings from qualitative studies exploring clients' experiences of their treatment for borderline personality disorder (BPD) and their perceptions of recovery.

**Method:** Fourteen studies were identified through searches in three electronic databases. The Critical Appraisal Skills Programme was used to appraise the methodological quality of the studies. Thematic analysis was used to synthesise the findings.

**Results:** The meta-synthesis identified 10 themes, grouped into three domains. The first domain, "Areas of change", suggests that clients make changes in four main areas: developing self-acceptance and self-confidence; controlling difficult thoughts and emotions; practicing new ways of relating to others; and implementing practical changes and developing hope. The second domain, "Helpful and unhelpful treatment characteristics", highlights treatment elements that either supported or hindered recovery: safety and containment; being cared for and respected; not being an equal partner in treatment; and focusing on change. The third domain, "The nature of change", refers to clients' experience of change as an open-ended journey and a series of achievements and setbacks.

**Conclusions:** The meta-synthesis highlights areas of change experienced by individuals receiving treatment for BPD, and treatment characteristics that they value. However, further research is needed to better understand how these changes are achieved.

**Keywords:** Borderline personality disorder, Recovery, Qualitative research, Qualitative meta-synthesis, Psychotherapy

## **Introduction**

Individuals with a diagnosis of Borderline Personality Disorder (BPD), who comprise between 1% and 5.9% of the general population, often struggle with dramatic mood swings, emotional and relational difficulties, and self-harming (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006; Huang et al., 2009; NICE, 2009; Wittchen et al., 2011). They regularly use a wide range of services, including Accident and Emergency departments, community and specialist mental health care, and inpatient services (Zanarini, Frankenburg, Hennen, & Silk, 2003). Professionals caring for clients with such difficulties often find their treatment challenging (Markham & Trower, 2003).

Yet, epidemiological studies suggest that the symptoms of the disorder reduce substantially over time. Zanarini et al. (2003) found that 10 years after initial diagnosis only 26% of patients originally recruited upon admission in psychiatric hospitals met criteria for the diagnosis. Participants in that study received a range of generic community treatments following discharge from hospital, but less than 5% of them had ever received any type of specialist psychological therapy that has proven effective in treating BPD.

A substantial number of randomised controlled trials (RCTs) have found a range of specialist psychotherapies for BPD to be effective (Stoffers et al., 2012). These therapies include Dialectical Behavioural Therapy (DBT), Mentalization-Based Treatment (MBT), transference-focused psychotherapy and schema therapy. The trials have shown that patients who receive specialist therapies are more likely to reduce self-harming behaviour and service use and to improve on several mood and social functioning indicators. However, several of these trials have revealed that a large proportion of participants in the “control” arms, who received treatment as usual (eg., standard community treatment) or other forms of generic

psychological therapy, also made significant progress (Bateman & Fonagy, 1999; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Priebe et al., 2012).

Hence, evidence from epidemiological studies and RCTs indicates that people with a diagnosis of BPD can make substantial symptom improvements through the use of a wide range of interventions, including specialist psychotherapies, generic psychological therapy or standard community services. However, it remains unclear how clients across treatments think that they are supported in making positive changes in their lives; the common processes that facilitate positive changes are poorly understood.

Furthermore, we do not know whether clients see symptom improvement, commonly assessed in quantitative studies, as reflecting their own aspirations of personal recovery. It has been observed that clinical improvement and risk reduction, traditionally assessed in mental health research, do not always coincide with clients' personal evaluations of recovery and progress in their lives (Slade & Amering, 2008). Personal recovery is often seen as a way of building a meaningful and satisfying life, while accepting and integrating limitations caused by mental illness (Leamy, Bird, Le Boutillier, Williams & Slade, 2011).

Qualitative studies exploring clients' experiences of treatment and recovery in BPD might shed light into how they believe that they are supported in making positive changes in their lives and clarify what they perceive as meaningful change. Qualitative research can provide a detailed understanding of clients' lived experiences of treatment, clarify complex and often contradictory aspects of such experiences, and illuminate their perspectives on their goals and what works for them (Berry & Hayward, 2011; Timulak, 2009). Meta-synthesis is an established procedure of reviewing and bringing together findings from existing qualitative studies (Timulak, 2009). A meta-synthesis of qualitative studies in this field could therefore offer a comprehensive picture of clients' experiences and views of the treatments they receive and the complex ways in which these might contribute to their recovery.

The present meta-synthesis aimed to review findings from qualitative studies exploring clients' experiences of their treatment for BPD and their perceptions of recovery. We were particularly interested in gaining a better understanding of individuals' experiences of change and their views on treatment characteristics and other processes that might facilitate positive changes. Identifying such processes and how therapy might support them could contribute to the further development of specialist psychotherapies and generic treatment for BPD.

## **Method**

This section describes the data collection methods (inclusion and exclusion criteria for selecting studies, search strategy, study selection process, and extraction of study characteristics), the meta-synthesis researchers' background, the description of study characteristics and the methods of analysis (method of appraising study quality and the meta-synthesis method).

### **Data Collection**

**Inclusion and exclusion criteria.** The inclusion and exclusion criteria for selecting studies covered four areas:

1. **Participants:** Studies were included if participants were 18 years or older and had received treatment for BPD or other personality disorder (PD). Although our aim was to focus on the experiences of clients with a diagnosis of BPD, specialist community PD services often offer therapy to people with a wider range of personality disorders (e.g., narcissistic, avoidant PD, etc.); in an effort to improve access, these services sometimes do not require a formal, specific BPD diagnosis (Gillard, Turner, & Neffgen, 2015). Individuals treated in such services often mainly meet diagnostic criteria for BPD or present with similar difficulties (Lee et al., 2012). Therefore, it was decided not to exclude studies that were conducted in specialist PD services offering treatment to people with a range of PDs and that

described their participants as meeting criteria for PD rather than specifically BPD. However, studies focusing on individuals with a diagnosis of antisocial PD, or offenders, were excluded. Similarly, studies describing that they only included participants with one specific type of PD other than BPD (eg. dependent, avoidant, narcissistic, paranoid or schizotypal) were also excluded.

2. Type of intervention: Studies were included if the treatment consisted of any form of psychological therapy or generic mental health services, e.g., community mental health teams (CMHTs), etc. Treatment could be delivered in a one-to-one or a group setting or a combination of the two. Studies conducted in forensic, high security settings were excluded.
3. Study design/ method: Only qualitative studies that focused on clients' experience of treatment and/ or recovery were included. Studies exploring clients' experience of specific individual therapeutic events or techniques (e.g., ruptures in the therapeutic alliance, imagery) were excluded.
4. Publication type: Only peer-reviewed, English language journal articles were included.

**Databases and search terms.** Studies were identified through searches (conducted by the first author) in three electronic databases: PsycINFO, Medline and Embase. The following combination of search terms was used:

Borderline personality disorder/ Personality disorder

AND

Client\*/ service user\*/ patient\*/ participant\*/ people/ women/ consumer\*

AND

Recover\*/ change\*/ therapy/ treatment/ care/ service\*

AND

Experience\*/ perspective\*/ feedback/ view\*/ perception\*/ reaction\*/ narrative\*

AND

Qualitative\*/ mixed-method\*/ interview\*/ focus group\*

The asterisks at the end of some of the terms indicate that the search was broadened to include variations of those specific words. The word “women” was used alongside other relevant terms, as BPD is a diagnosis that is more commonly found among women and some of the studies might have described their participants as “women” rather than clients or other similar terms.

The electronic databases searches were complemented by citation searches and reviewing the reference lists of identified papers.

**Study selection process.** The study selection process, which was conducted by CK in consultation with NP, is summarised in Figure 1. The database searches yielded a total of 1475 articles. Only 51 papers were considered sufficiently relevant to have their full text read. From those, 36 were excluded and 15 met the inclusion criteria.

The 15 papers that met the inclusion criteria reported findings from 14 studies. Perseius et al. (2003) and Perseius et al. (2005) reported findings from the same study. These two papers were treated as one study in the synthesis of the findings.

The citation searches and the review of the reference lists of these 15 identified papers did not yield any additional studies.

(Insert Figure 1 here)

**Extraction of study characteristics.** A data extraction sheet was devised in order to consistently summarise the characteristics of the included studies. Information on study aims, participants’ characteristics, received intervention, setting and data collection and analysis methods was extracted by CK. The extraction process and areas of uncertainty regarding study characteristics were discussed with NP.

## **Meta-synthesis Researchers' Background and Preconceptions**

The research team consisted of two researchers with a clinical and academic background. The lead researcher (CK) is a clinical psychologist, with experience of working with clients with a diagnosis of BPD, using specialist psychological therapies (DBT and MBT). She tried to minimise her preconceptions about the strengths and weaknesses of such psychological therapies, by bracketing her beliefs and by regularly discussing the emerging themes with the second researcher (Chan, Fung & Chien, 2013). The second researcher (NP) is a clinical psychologist with clinical and research experience, particularly in qualitative methods.

Although the authors acknowledge that there has been much debate regarding the diagnosis of BPD and share some of the expressed concerns regarding the usefulness of this label (Gillard et al., 2015), the present analysis did not assume a critical stance towards this diagnosis, as our main aim was to use it as a descriptive category that would allow us to identify and review the existing literature in this area.

## **Description of Study Characteristics**

The characteristics of the 14 included studies are presented in Table 1 and summarised here.

(Insert Table 1 here)

**Study aims.** Although all included studies explored clients' experiences of treatment and/or recovery, some of the studies also examined additional topics that were not relevant to the present review. Nevertheless, in those studies, the findings that were relevant to the present meta-synthesis were clearly extractable.

**Participants.** The sample size in the included studies ranged from 5 to 60, with a total of 245 participants in all studies. The great majority of participants in most studies were female (207 across studies). Most studies recruited participants with a diagnosis of BPD, although



three studies (Castillo, Ramon, & Morant, 2013; Gillard et al. 2015; Haeyen, van Hooren, & Hutschemaekers, 2015) also included participants with other PD diagnoses.

**Setting and treatment.** The majority of studies were conducted in Europe: six in the UK, one in Ireland, one in the Netherlands, one in Sweden and one in Norway. Of the remaining studies, two were set in the United States, one in Canada and one in South Africa.

The treatments received by participants varied. Seven studies recruited participants from specialist services, including four DBT programmes and one art therapy programme within a specialist PD service. Five studies included participants from generic mental health services. One study recruited participants from both specialist (i.e. DBT and MBT) and generic services.

**Data collection and analysis.** Data from 11 studies was collected via individual interviews; three studies conducted both individual interviews and focus groups. Two of the interview studies included additional sources of data, such as collage, poetry, diaries etc., but it was unclear how this data contributed to the analysis (Larivière et al., 2015; Perseus et al., 2003; 2005). Studies used various methods of analysis (see Table 1), which all involved the generation of themes from the data.

## **Analysis**

**Method of appraising study quality.** The Critical Appraisal Skills Programme (CASP, 2002) for qualitative research was used to aid the process of appraising the methodological quality and limitations of the included studies. This tool, which is commonly used in qualitative meta-syntheses, assesses ten main areas: the clarity of research aims; the suitability of qualitative methodology; the appropriateness of the research design and more specific qualitative approaches; the recruitment strategy; the data collection methods; the description of the relationship between participants and researchers; the consideration of ethical

issues; the data analysis methods; the presentation of findings; and the overall value of the research (Dixon-Woods et al., 2007).

The CASP was not used with the purpose of providing an overall quality score for each study or of excluding individual studies: we believed it was important to synthesise all relevant evidence, even if some studies were appraised as methodologically poor (Atkins et al., 2008; Dixon-Woods et al., 2007). However, it became apparent that methodologically rigorous studies, which provided a deeper description of themes, contributed more substantially to the themes identified in the meta-synthesis than studies with thin, mainly descriptive analyses.

The appraisal of the studies was initially conducted by CK and was then discussed with NP; areas of uncertainty were resolved through discussion.

**Meta-synthesis method.** The synthesis of findings from the included studies was conducted using a thematic analysis approach, as described by Braun and Clarke (2006). The decision to use thematic analysis, rather than a more interpretative meta-synthesis approach, was based on guidance by the Cochrane group on qualitative meta-syntheses (Noyes & Lewin, 2011). The aim of the present synthesis was to summarise a range of views expressed by clients on the various treatments they received and their experiences of recovery, rather than to develop a more interpretative explanatory theory. Hence, a thematic analysis approach was deemed suitable.

All of the text in the results section of the published papers was treated as data for the current meta-synthesis. The topics and ideas presented in the studies were examined for their relevance to the aims of the present meta-synthesis. The thematic analysis cut across the descriptive labels (categories, themes or subthemes) given by the study authors; that is, all relevant material, regardless of how it was labelled in the studies, was synthesised in order to identify common ideas (themes) across studies. The original categories, themes and subthemes

from which the new themes were synthesised were documented in order to provide transparency.

The six phases of thematic analysis recommended by Braun and Clarke (2006) for primary qualitative research were followed. In phase 1, CK familiarised herself with the data by repeatedly reading the results sections of the existing papers, while searching for meanings and common topics. In phase 2, initial codes that summarised the main ideas and topics in each study were produced. In phase 3, these initial codes were compared, contrasted and combined across studies to form overarching themes and subthemes. In phase 4, the emerging themes and subthemes were reviewed and further refined and developed. In phase 5, the refined labelling of the themes and their inter-relationships was completed. The final phase involved writing up the meta-synthesis, which was a dynamic process that allowed further reflection on, and fine-tuning of, the themes. The analysis process and the emerging codes, themes and subthemes at each phase were discussed and refined in regular meetings between CK and NP.

In addition to the main thematic analysis, we attempted to explore how clients' experiences of treatment might be linked to their perceptions of recovery, i.e., treatment characteristics that might facilitate positive change. This was an interpretative type of analysis. We first searched for any explicit or implicit links between themes made in the original studies. Where these were implicit or absent, we drew on our knowledge of the wider literature and our clinical experience of working with people with a diagnosis of BPD, and we reflected on how specific treatment characteristics and areas of change identified in the reviewed studies might be inter-related.

## **Results**

### **Appraisal of Study Quality**

As described in the methods, the CASP consists of 10 questions, which evaluate a range of methodological issues. For the purposes of the critical appraisal in this meta-synthesis, these

questions were grouped under several headings, according to the wider areas that they covered, as described below. Particular emphasis was placed on evaluating the data analysis methods, the presentation of findings and the overall value of the research. These areas were the most relevant in assessing the overall contribution of each study to the understanding of clients' experiences of treatment and/ or recovery. The emphasis on these areas is also reflected in the presentation of the results of the present review, as studies that provided a "thick description" (Geertz, 1973) of the phenomenon they investigated contributed more substantially to the themes synthesised here. That is, when studies provided a detailed and substantial description of the emerging themes and the ways in which they were connected to each other, they provided richer data, which in turn informed the description of themes identified in the meta-synthesis. In contrast, studies offering only a brief presentation of the identified ideas and no description of how these ideas might be coherently linked to inform the phenomenon under study, contributed less to the themes emerging in the meta-synthesis.

**Research aims and design.** All included studies were considered to have sufficiently stated their aims and justified the use of qualitative methods. Nine studies described using more specific qualitative approaches and provided some justification for why they were chosen (Castillo et al., 2013; Fallon, 2003; Gillard et al., 2015; Haeyen et al., 2015; Holm & Severinsson, 2011; Katsakou et al., 2012; Langley & Klopper, 2005; Lariviere et al., 2015; Nehls, 2001).

**Sampling.** Only four studies (Castillo et al., 2013; Haeyen et al., 2015; Katsakou et al., 2012; Langley & Klopper, 2005) provided a clear description of the sampling process and the characteristics on the basis of which participants were included. The remaining studies reported that they recruited participants either with a BPD/ PD diagnosis or from a specialist service, but did not make any reference to further decisions regarding sampling. Similarly, only four studies clarified how many eligible participants chose not to take part and why (Katsakou et

al., 2012; Langley & Klopper, 2005; McSherry, O'Connor, Hevey, & Gibbons, 2012; Perseius et al., 2003; 2005).

Only four studies (Haeyen et al., 2015; Katsakou et al., 2012; Langley & Klopper, 2005; Morris, Smith, & Alwin, 2014) reported taking saturation of themes into account, which is a recommended procedure for informing the ongoing sampling of participants (Strauss & Corbin, 1998).

**Primary researchers' reflections on their background and preconceptions.** Only one study adequately described the researchers' background, role and potential preconceptions (Gillard et al., 2015). Three studies provided information on the researchers' backgrounds, but did not discuss how these might influence the analysis process (Castillo et al., 2013; Holm & Severinson, 2011; Katsakou et al., 2012). The remaining studies made no reference to these issues.

**Ethics.** Ten studies reported having approval from a research ethics committee. Three of the remaining studies made no reference to formal ethics approval procedures (Castillo et al., 2013; Cunningham, Wolbert, & Lillie, 2004; Nehs, 2001), but briefly described gaining informed consent from participants. One study made no reference to ethical considerations (Haeyen et al., 2015).

**Analysis and presentation of findings.** The description of analysis and the presentation of results in the majority of studies suggested that the analysis was a summary of ideas expressed by participants and did not provide a "thick description" (Geertz, 1973) of the phenomenon. The themes did not appear to follow a strong analytic narrative nor to identify patterns across the data. Furthermore, they were mostly presented as a list of poorly connected themes rather than as part of a conceptually meaningful synthesis of the ideas that were expressed (Fallon, 2003; Hodgetts, Wright, & Gough, 2007; Holm & Severinson, 2011;

Langley & Klopper, 2005; Lariviere et al., 2015; McSherry et al., 2012; Morriss et al., 2014; Nehls, 2001).

Three studies stood out as more methodologically rigorous, as they provided more than simple descriptions, i.e., themes with psychological meaning, and a more conceptual synthesis of participants' accounts (Castillo et al., 2013; Haeyen et al., 2015; Katsakou et al., 2012).

Credibility checks (Willig, 2013) were performed in most studies. The most common check was involving more than one researcher in the analysis. However, this appeared not to have taken place in four studies (Cunningham et al., 2004; Fallon, 2003; Langley & Klopper, 2005; McSherry et al., 2012).

### **Meta-synthesis Findings**

The findings from the 14 studies were synthesised into three domains of themes (Table 2). The first domain, "Areas of change", comprises four themes that describe experiences of progress in a range of areas (self-acceptance and self-confidence; new ways of relating to others; taking control of emotions and thoughts; and implementing changes and developing hope). The second domain, "Helpful and unhelpful treatment characteristics", consists of four themes that describe treatment elements that either supported or delayed people in making progress (safety and containment; being cared for and respected; not being an equal partner in treatment; and focusing on change). The last domain, "The nature of change", includes two themes describing individuals' perceptions of the process of moving forward (an open-ended journey, not a dichotomous outcome; and a series of achievements and setbacks).

Table 2 shows the themes in the included studies (using the theme labels given by the study authors) that provided material contributing to each of the themes in the meta-synthesis. The labels of some of the themes in those studies have an obvious connection to the new themes; for example "Accepting self and building self-confidence" in Katsakou et al. (2012) is clearly connected to the theme "Self-acceptance and self-confidence" in the domain "Areas of

change” in the meta-synthesis. In such cases, the studies elaborated in some depth on ideas that were directly relevant to the meta-synthesis.

In some instances, however, the theme labels in the original studies have a less obvious connection to the themes in the meta-synthesis. This reflects the fact that in our analysis we identified all the ideas described within each theme, whether or not the theme label given by the authors directly referred to these ideas. For example, the theme “My case manager has stuck with me for years” in Nehls (2001) provided some evidence for the theme “Self-acceptance and self-confidence” of the meta-synthesis, despite the very different theme labels; more specifically, it briefly described that participants often believed that their case manager enhanced their sense of self-sufficiency. In such cases, the theme labels in the studies tended to encompass a variety of ideas, only some of which were relevant to the corresponding meta-synthesis themes; the relevant ideas also tended to be described briefly with relatively little depth.

(Insert Table 2 here)

**Domain 1: Areas of change.** The majority of the studies described some areas of improvement for clients, which are presented below. However, with the exception of one study (Castillo et al., 2013), these areas were reported as a list of separate themes and not as interconnected parts of a recovery process.

***Theme 1.1: Self-acceptance and self-confidence.*** Thirteen of the 14 studies reported ideas about how treatment enhanced clients’ self-acceptance and self-confidence. These ideas were elaborated in six of these studies (Castillo et al., 2013; Haeyen et al., 2015; Katsakou et al., 2012; Lariviere et al., 2015; McSherry et al. 2012; Perseius et al., 2003; 2005), whereas they were only briefly mentioned in the remaining seven.

The six studies that expanded on this topic reported that, through therapy, clients gained a better understanding of themselves and their difficulties. Individuals were able to make sense

of their experiences and how these might have contributed to their struggles, which led them to become more accepting and compassionate towards themselves, less self-critical and able to reduce intense feelings of shame. They managed to integrate seemingly contradictory desires and aspects of themselves, which helped them develop a more coherent and stable sense of identity. This also allowed them to take responsibility for their lives and their efforts towards recovery and become more independent.

***Theme 1.2: New ways of relating to others.*** The idea of developing new ways of relating to others was mentioned in all 14 studies. However, only six provided a more elaborate description of this topic (Castillo et al., 2013; Cunningham et al., 2004; Katsakou et al., 2012; Langley et al., 2005; Lariviere et al., 2015; Perseius et al., 2003; 2005).

In these six studies, participants described that, through therapy, they were able to socialise more and feel less isolated. They built more supportive relationships and ended abusive ones. They were able to trust others more, talk more openly about their feelings, and allow themselves to feel vulnerable in close relationships. This led them to feel more connected and develop a sense of belonging and feeling cared for by others. This was often a process that started in group therapy, as participants developed relationships with peers.

Participants also described that they developed a better understanding of their behaviour in interpersonal contexts and its impact on other people. They were able to make sense of others' intentions, feelings and actions. This was subsequently linked to their finding better ways of communicating with people and being less aggressive; they became more assertive and able to tolerate and negotiate conflicts.

One of these six studies (Perseius et al., 2005) highlighted participants' ambivalence towards making changes in relationships. More specifically, it reported that interviewees felt torn between longing for love and fellowship and fearing close relationships.



***Theme 1.3: Taking control of emotions and thoughts.*** Seven studies made reference to the idea of gaining more control over emotions and negative thoughts. However, this was described in some detail in only five of these studies (Cunningham et al., 2004; Gillard et al., 2015; Haeyen et al., 2015; Katsakou et al., 2012; Lariviere et al., 2015).

These five studies described that clients became more aware of and able to experience emotions without disconnecting from them, but also to let go of negative emotions. This process often started in therapy, where individuals felt connected with their feelings and were able to make sense of conflicting emotions. They developed a more balanced emotional experience, including positive emotions and less dramatic mood swings. Clients also developed more helpful ways of thinking and were able to challenge negative thoughts. They could reflect on and analyse difficult situations before their emotions became too overwhelming and uncontrollable. This helped them to stop and think when in crisis, before impulsively reverting to harmful behaviours, such as self-harming.

Two of these five studies reported that, despite these improvements, emotional difficulties remained present in people's lives. Cunningham et al. (2004) reported that the majority of interviewees still experienced high levels of emotional suffering. Similarly, Gillard et al. (2015) described that some participants were unable to let go of a general sense of negativity and disconnection from their emotional experience.

***Theme 1.4: Implementing practical changes and developing hope:*** Twelve studies mentioned the idea of practical achievements and/ or the related concept of hope. However, an elaborate description of these concepts was given in only four of these studies (Castillo et al., 2013; Cunningham et al. 2004; Katsakou et al., 2012; Lariviere et al., 2015).

These four studies reported that service users described making changes in their lives, including confronting stressful situations, engaging more with community activities, managing their finances and household, and getting involved in voluntary or paid employment. They

described developing more skills and feeling more able to deal with problems and the world as a whole. Participants also became more involved in activities that were meaningful to them, which led them to develop a sense of purpose and hope for the future.

**Domain 2: Helpful and unhelpful treatment characteristics.** The majority of the studies described treatment characteristics that either supported or hindered clients in making progress. These characteristics were presented as a list of separate treatment elements and there was no explicit reference to how they might be connected or interact with each other.

*Theme 2.1: Safety and containment.* The idea of safety and containment was mentioned in seven studies. However, it was elaborated only in three studies (Castillo et al., 2013; Langley et al., 2005; Perseus et al., 2003; 2005).

One of these studies (Castillo et al., 2013) explored participants' perceptions of developing a sense of safety. When the therapeutic environment and relationships within therapy were experienced as a safe haven, people could internalise this feeling of safety and feel contained. When therapy helped them make sense of their experiences and difficulties, these felt less overwhelming and uncontrollable. Gaining a better understanding of their difficulties allowed clients to become more accepting and compassionate towards themselves. Feeling contained in the therapeutic relationship also led clients to develop a sense of trust in other people.

All three studies described setting boundaries and/ or having treatment contracts as necessary steps in developing a sense of stability and containment. Although such agreements were experienced as challenging and often frustrating, they were deemed helpful in tackling ambivalence and promoting commitment to therapy and change. Some participants also viewed such agreements as a commitment to others that they wanted to honour. They described gradually realising that their behaviour can cause distress to others, which they made a conscious effort to alleviate.

***Theme 2.2: Being cared for and respected.*** The importance of feeling respected and cared for was referred to in 12 studies. However, it was elaborated in only five studies (Castillo et al., 2013; Langley et al., 2005; Morriss et al., 2014; Nehls, 2001; Perseus et al., 2003; 2005).

In these five studies, participants reported that they appreciated being listened to and understood, not being judged and feeling supported in making sense of and trying to deal with their struggles. Hence, therapists who were perceived as available and approachable, honest, accepting, interested and genuinely concerned about clients' difficulties, were seen as assisting clients in better understanding and accepting themselves. More specifically, when clients felt listened to and taken seriously, they experienced being valued and viewed themselves as worthy individuals. They also worked towards building trusting, close relationships with their therapists.

On the other hand, when staff were perceived as distant, judgemental, unavailable or not understanding, clients felt isolated, criticised and undeserving of support. Similarly, when services only responded to risk issues, individuals felt that their underlying distress was ignored.

***Theme 2.3: Not being an equal partner in treatment.*** The idea of not feeling like an equal partner in treatment was mentioned in nine studies. However, it was examined in depth in only one study (Fallon, 2001).

In that study, interviewees described that they often did not feel included as equal partners in their treatment. When they thought that therapy goals were imposed on them, rather than negotiated and agreed, they did not feel motivated to take responsibility and make progress. Similarly, when they perceived the therapy to be too rigid and inflexible, they thought that their liberty was restricted and felt powerless and angry. In contrast, when interviewees felt included in treatment decisions and plans, they felt trusted, valued and empowered. Overall,

they reflected that therapies needed to strike a good balance between exerting some control when necessary (e.g., when clients are at risk) and promoting independence in the long-term.

**Theme 2.4: Focusing on change.** Six studies made reference to the idea of therapy promoting change. This was expanded upon in only two studies (Cunningham et al., 2004; Perseius et al., 2003; 2005).

In these two studies, participants described that therapies with a clear focus on facilitating change were helpful. They thought that therapy needed to focus on solving problems and teaching them skills that they could actively apply in their lives. Therapists who were perceived as “pushing” clients towards change and challenging them to try harder were seen as effective. When therapy was perceived as too open-ended, with no clear focus on offering solutions, it was experienced as confusing and unhelpful. Participants also appreciated being offered support during crises. They believed that talking to therapists while in crisis helped them tackle their overwhelming negative thoughts and focus on finding solutions. This also allowed them to develop better ways of managing difficult thoughts and emotions in the long-term.

**Domain 3: The nature of change.** Seven studies made reference to the nature of change in BPD, describing it as an open-ended, dynamic process.

**Theme 3.1: An open-ended journey, not a dichotomous outcome.** Five studies referred to clients’ experiences of change as an open ended journey rather than a dichotomous outcome. Only three of those studies analysed this idea in some detail (Castillo et al., 2013; Katsakou et al., 2012; Lariviere et al., 2015).

In these three studies, making progress was described as an open-ended journey, consisting of small steps. This was summarised as a gradual, ongoing process of personal development. Two studies reported that a “full” recovery, which would imply the absence of problems, was seen as an inappropriate way of conceptualising improvement in BPD, as it

could reflect a sense of denial of enduring difficulties (Katsakou et al., 2012; Lariviere et al., 2015).

**Theme 3.2: A series of achievements and setbacks.** The idea that change involved a series of achievements and setbacks was mentioned in six studies. Two of those studies elaborated on this idea (Katsakou et al., 2012; Perseius et al., 2005).

In these two studies, progress was perceived as constant movement between achievements and setbacks. In Katsakou et al. (2012), participants described times when they felt better and in control, followed by periods when they felt defeated. However, they maintained a sense of moving forward and becoming more able to deal with difficulties.

Perseius et al. (2005) described that the process of making progress was experienced as particularly challenging. This was often reflected in a profound sense of ambivalence about whether to continue making an effort. Clients were described as feeling torn between longing for life and longing for death; between feeling hopeless and struggling to make changes; and between remaining isolated and reaching out to others.

**Links between treatment characteristics and specific areas of change.** The included studies did not draw any explicit links between the treatment characteristics described in Domain 2 and specific areas of change described in Domain 1, although some connections were implied. Using an interpretive type of analysis (see Method), we made tentative links, as presented in Figure 2. The third domain, describing the nature of change, was not meaningfully connected to the specific areas of change or to the helpful/unhelpful treatment characteristics identified; therefore it was not integrated into the interpretive analysis.

(Insert Figure 2 here)

Building on the description of treatment characteristics in Domain 2, we understood that safety and containment and being cared for and respected might lead to changes in self-acceptance and self-confidence and in developing new ways of relating to others. That is,

clients' developing a better understanding of their experiences and difficulties through feeling contained in therapy might lead to their becoming more accepting and compassionate towards themselves and more confident in dealing with their lives. Furthermore, feeling safe and understood in therapeutic relationships and honouring agreements with therapists might offer the opportunity to experience and practice new ways of relating to others. Similarly, being cared for and respected in therapy might offer individuals the opportunity to develop more secure attachments and feel more valued, and therefore experience increased levels of self-acceptance and confidence.

In contrast, not being an equal partner in treatment is likely to hinder the development of self-acceptance and self-confidence. When individuals are not included in treatment decisions and planning, they might feel inadequate and less able to deal with their difficulties, which might lead to becoming more critical and harsh towards themselves, and to a more negative sense of self.

Lastly, treatment focusing on change might facilitate positive changes in taking control of emotions and thoughts, as well as implementing practical changes and developing hope. That is, when therapy emphasises problem-solving and taking action, individuals are likely to become more skilful in managing their distressing thoughts and emotions and actively implementing changes in their lives.

## **Discussion**

The present review aimed to synthesise clients' experiences of treatment and recovery in BPD, as described in 14 qualitative studies. The meta-synthesis identified 10 themes, grouped into three domains. Themes in the first domain, "Areas of change", suggest that clients make positive changes in four main areas: developing self-acceptance and self-confidence; practicing new ways of relating to others; controlling difficult thoughts and emotions; and implementing practical changes and developing hope. Themes in the second domain, "Helpful

and unhelpful treatment characteristics”, highlight treatment elements that clients believed either supported them or hindered them in making progress: treatment providing a sense of safety and containment; being cared for and respected; not being an equal partner in treatment; and treatment focusing on change. The third domain of themes, “The nature of change”, refers to clients’ experience of change as an open-ended journey rather than a dichotomous outcome, and a series of achievements and setbacks.

The meta-synthesis highlighted areas of change that appear important for clients receiving treatment for BPD. Although some of the identified areas, such as developing hope and implementing practical changes, reflect concepts of recovery described in the wider recovery literature and might be applicable to people with a wider range of difficulties (Leamy et al., 2011), the description of specific changes in some of the areas appears particularly relevant to BPD.

More specifically, the development of self-acceptance and self-confidence, as described in this review, goes beyond re-claiming a sense of identity after experiencing severe mental health problems, an idea commonly referred to in the wider recovery literature (Leamy et al., 2011). Indeed, it highlights how therapy might support people with a diagnosis of BPD in understanding the origins of enduring feelings of shame and in developing different ways of making sense of and accepting themselves. Such feelings often emerge from poor early attachment relationships, which also contribute to profound difficulties in relating to others (Gilbert, 2010). In this context, the description of new ways of relating to others in this meta-synthesis offers a better understanding of specific challenges and improvements in this area, such as opening up and trusting others, tolerating a sense of vulnerability in close relationships, understanding others, and developing better ways of communicating. Finding new ways of managing negative thoughts and emotions is also closely linked to ongoing difficulties in BPD, which has been described as mainly a disorder of emotional dysregulation (Linehan, 2015).

However, it is worth noting that, with one exception, the studies included in the meta-synthesis did not explore processes of change. In our analysis, we attempted to link treatment characteristics to specific areas of change, in an effort to better understand such processes. Our findings suggest that therapy might facilitate change and recovery by focusing on two central aspects: first, creating a safe, caring environment, where clients feel valued and actively participate in developing a better understanding of their difficulties; and, second, promoting practical change. These findings echo the understanding of mechanisms of change in specialist psychological therapies for BPD. For example, DBT proposes that one of the central therapy processes promoting recovery is striking a balance between validating clients' experience and encouraging them to change unhelpful behaviours (Linehan, 2015). Other therapies have identified at least one of these central mechanisms as important. For example, MBT sees developments in mentalizing, i.e., gaining a better understanding of one's own and others' thoughts, emotions, motivations and goals, as the main process driving change. Similarly, CBT for BPD emphasises actively implementing changes and solving problems, as this is understood to be one of the main drivers of progress (Davidson, 2008; Linehan, 2015).

Some of the treatment characteristics identified as helpful in this meta-synthesis might shed some light into more specific therapeutic approaches that could facilitate recovery in BPD. For instance, setting clear boundaries and having treatment contracts were described as an effective way of providing containment. This is consistent with the current rationale in specialist therapies for BPD, including DBT and MBT, where emphasis is placed on enhancing clients' motivation to commit to their treatment by honouring agreements with therapists (Bateman & Fonagy, 2006; Linehan, 2015).

Yet, some of the treatment characteristics identified here appear generic and do not offer a detailed picture of recovery processes in BPD. More specifically, feeling safe, contained, cared for and respected have been identified as positive treatment experiences for



clients with a wide range of problems (e.g., Lemma, Target & Fonagy, 2011). Similarly, not participating in treatment decisions has been reported as contributing to dissatisfaction with and disengagement from various services (Katsakou et al., 2011; 2012). However, it is hard to imagine how such generic characteristics, in the absence of other processes, can play a substantial role in the treatment of a condition as complex as BPD. Thus, the more specific mechanisms through which such characteristics promote change and additional processes that might facilitate recovery remain poorly understood.

The description in this review of clients' experience of change as an ongoing process involving a series of achievements and setbacks mirrors understandings of recovery in a wide range of conditions, mainly in Axis 1 disorders, where recovery is also described as a continuing journey (Leamy et al., 2011). However, some aspects of this journey identified in this review might indeed be more relevant to individuals with BPD. For example, clients' accounts of fluctuations between yearning for change and feeling defeated is particularly pertinent to individuals diagnosed with BPD, who struggle with mood swings and ambivalence regarding change (Corradi, 2013). Similarly, the view that "full recovery" might be an inappropriate way of conceptualising improvements in BPD, which was expressed in some of the included studies, might reflect the presence of enduring difficulties in BPD that define people's sense of self throughout their lives and do not just manifest as symptoms of distinct episodes of mental illness (Shepherd, Sanders, Doyle & Shaw, 2015).

### **Limitations**

The findings of the present meta-synthesis were limited by the quality of the included studies, the majority of which provided a thin description of clients' experiences. In the process of synthesising findings, it became obvious that the three studies that were more methodologically rigorous and offered a thicker description of service users' expressed views

(Castillo et al., 2013; Haeyen et al., 2015; Katsakou et al., 2012) contributed more substantially to the generation and the description of themes.

Although the majority of studies reported thinly described and poorly connected themes, they were not excluded from the meta-synthesis. Instead, it was decided to include all studies in order to provide a more accurate presentation of the current knowledge base in this area, and to use the CASP to provide a comprehensive description of methodological shortcomings in the existing studies.

The review was also limited by the fact that the literature searches, the identification of relevant papers, the synthesis of themes from the included studies and the critical appraisal were conducted mainly by the first author, although decisions at all stages were thoroughly discussed with the second author.

### **Implications for Clinical Practice and Future Research**

The present review points to areas of improvement in psychological functioning that people struggling with BPD issues have identified as both important and achievable. It also highlights treatment characteristics that might facilitate change in these areas. Treatments emphasising these characteristics, namely striking a balance between creating a safe, caring space and actively promoting change, may increase clients' motivation and engagement with services and facilitate recovery.

Given that these clients experience change as a dynamic process involving a series of achievements and setbacks, therapies need to incorporate specific strategies to support them to remain hopeful, fight ambivalence and deal with setbacks. Some specialist therapies have developed mechanisms to address this challenge. For example, DBT provides a set of "commitment strategies" to increase clients' sense of responsibility for personal change (Linehan, 2015).

Although the studies in this review identify areas of change that are important for people with a diagnosis of BPD, they provide limited information about how improvements in these areas are reached. We attempted to highlight links between therapy processes and changes in specific areas, but this analysis was based on our own interpretations and therefore remains tentative; however, the suggested links could inform future research on how specific therapy characteristics might bring about specific therapeutic outcomes. Future qualitative research in this area should be guided by the methodological literature on psychotherapy process research (e.g., Elliott, 2010; McLeod, 2011). Careful attention needs to be paid to eliciting detailed accounts of change processes and to conducting rigorous qualitative analyses, in order to provide rich and nuanced descriptions of how therapeutic change occurs. Qualitative studies obtaining the perspectives of therapists and family caregivers might also expand our understanding of recovery processes. The findings of such research could inform the future development of existing therapies for BPD.

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Table 1. *Study characteristics*

Study	Aims	Sample	Setting	Intervention	Data collection method	Data analysis method
Castillo et al., 2013	To explore how service users define recovery, what factors are important in the recovery process, and if/ how the service contributes to this process	60 participants with PD (13 male)	A specialist PD service in Colchester, UK	A service drawing on crisis house and therapeutic community models. The treatment included individual and group therapy, crisis coaching, and respite for those in crisis	Interviews and focus groups	Thematic analysis
Cunningham, 2004	To explore clients' perspectives on what is effective in DBT and why	14 women with BPD	A community DBT programme within an assertive outreach team in Michigan, United States	DBT	Interviews	No specified type of analysis
Fallon et al., 2003	To analyse participants' experiences of contact with mental health services and its impact	7 participants with BPD (3 male)	A variety of settings within a mental health trust in Salford, UK	A variety of unspecified interventions	Interviews	Grounded theory
Gillard et al., 2015	To explore participants' understandings of recovery	6 people with PD (3 male)	A specialist service in London, UK	Peer support groups	Interviews	Thematic and framework analysis techniques

Haeyen et al., 2015	To provide a systematic investigation of patients' experience of the benefits of art therapy	29 art therapy patients with a cluster B or C PD (2 male) who had received at least 15 sessions	A specialist PD mental health centre in the Netherlands	Art therapy, though all participants were simultaneously receiving some form of verbal therapy	Interviews (12 participants) and focus groups (17 participants)	Grounded theory
Hodgetts et al., 2007	To explore clients' experiences of DBT and the impact this treatment has on their lives	5 participants with BPD and experience of DBT (1 male)	DBT service in Plymouth, UK	DBT	Interviews	Interpretative Phenomenological Analysis
Holm & Severinsson, 2011	To explore how a recovery process facilitated changes in suicidal behaviour	13 women with BPD	Various mental health settings in Stavanger, Norway	Not specified (we assume generic services)	Interviews	Thematic analysis
Katsakou et al., 2012	To explore what service users view as recovery	48 service users with BPD (9 male)	Specialist and generic mental health services in East London, UK	DBT, MBT, generic mental health services	Interviews	Drawing on Grounded theory and thematic analysis
Langley et al., 2005	To explore what factors patients consider helpful in facilitating their mental health	6 participants with BPD (1 male)	The outpatients and psychotherapy unit of a specialist referral hospital in Johannesburg, South Africa	Inpatient and outpatient services, as well as individual and group therapy in private practice	Interviews	Interpretive descriptive approach
Lariviere et al., 2015	To explore participants' experiences of recovery	12 women with BPD	Two specialist programmes in two cities in Quebec, Canada.	Both programs had a multidisciplinary team and integrated various therapeutic approaches	Interviews and a collage	Thematic analysis

McSherry et al., 2012	To examine service users' perspectives on the effectiveness of an adapted DBT programme and its impact on their daily lives	8 participants with BPD (2 male) currently using an adapted DBT service	A community mental health centre in Dublin, Ireland	Adapted DBT	Interviews and focus groups	Thematic analysis
Morriss et al., 2014	To examine service users' lived experiences of accessing mental health services	9 participants with BPD (2 male) with significant contact with mental health services in the last 3 years	Voluntary sector organisations in the North West of England	General adult mental health services	Interviews	Thematic analysis
Nehls, 2001	To explore clients' experiences of having a case manager	18 clients (1 male) with BPD who had a case manager for at least 6 months	A community mental health centre in Wisconsin, United States	Case management	Interviews	Multistage data analysis
Perseus et al., 2003; 2005	To describe patients' perceptions of receiving DBT and their experiences of encounters with psychiatric care.	10 women with BPD, who had received DBT for at least 1 year	Outpatient DBT service in Stockholm, Sweden	DBT	Interviews and biographical material (diary excerpts and poems)	Qualitative content analysis and a hermeneutic approach

Table 2. *Domains and themes in the meta-synthesis and the included studies*

Meta-synthesis domains and themes	Themes contributing relevant material
<b>Domain 1: Areas of change</b>	
Theme 1.1: Self-acceptance and self-confidence Evidence from 13 studies	<p><i>Castillo et al. (2013)</i>: A sense of safety and building trust; Feeling cared for and creating a culture of warmth; Containing experiences and developing skills; Achievements, identity and roles</p> <p><i>Cunningham et al. (2004)</i>: Clients' assessment of DBT; Skills group; Relationships, Control of emotions, Level of hope</p> <p><i>Fallon (2003)</i>: Relationships</p> <p><i>Gillard et al. (2015)</i>: Reconciling the internal and external worlds; Feeling and thinking differently</p> <p><i>Haeyen et al. (2015)</i>: Perception and self-perception; personal integration; insight and comprehension</p> <p><i>Hodgetts et al. (2007)</i>: Internal processes; Non-specific factors</p> <p><i>Holm &amp; Severinsson (2011)</i>: The desire to recover by searching for strength; Recovering by being able to feel safe and trusted</p> <p><i>Katsakou et al. (2012)</i>: Accepting self and building self-confidence</p> <p><i>Lariviere et al. (2015)</i>: Person; Occupation</p> <p><i>McSherry et al. (2012)</i>: Therapy-specific factors; Renewed sense of identity; Impact of treatment on daily life</p> <p><i>Morriss et al. (2014)</i>: Non-caring care; It's all about the relationship</p> <p><i>Nehls (2001)</i>: My case manager has stuck with me for years</p> <p><i>Perseius et al. (2003; 2005)</i>: The therapy helps in accepting your feelings and not condemning (yourself or others); Your own responsibility and the stubborn struggle with yourself</p>
Theme 1.2: New ways of relating to others Evidence from 14 studies	<p><i>Castillo et al. (2013)</i>: A sense of safety and building trust; Feeling cared for and creating a culture of warmth; A sense of belonging and community; Containing experiences and developing skills</p> <p><i>Cunningham et al. (2004)</i>: Skills group; Relationships; Control of emotions</p> <p><i>Fallon (2003)</i>: Relationships</p> <p><i>Gillard et al. (2015)</i>: Reconciling the internal and external worlds; Doing things differently</p> <p><i>Haeyen et al. (2015)</i>: Behaviour change</p> <p><i>Hodgetts et al. (2007)</i>: Non-specific factors</p> <p><i>Holm &amp; Severinsson (2011)</i>: The desire to recover by searching for strength; The struggle to be understood as the person you are; Recovering by refusing to be violated; Recovering by being able to feel safe and trusted</p> <p><i>Katsakou et al. (2012)</i>: Improving relationships; Accepting self and building self-confidence</p> <p><i>Langley et al. (2005)</i>: Trust takes time</p> <p><i>Lariviere et al. (2015)</i>: Person; Environment; Obstacles to recovery</p> <p><i>McSherry et al. (2012)</i>: Renewed sense of identity; Impact of treatment on daily life</p>

	<p><i>Morriss et al. (2014)</i>: It's all about the relationship  <i>Nehls (2001)</i>: My case manager has stuck with me for years  <i>Perseius et al. (2003; 2005)</i>: The therapy helps in accepting your feelings and not condemning (yourself or others); Solitude, fearing relations- longing for love and fellowship; The group therapy- hard but necessary</p>
<p>Theme 1.3: Taking control of emotions and thoughts  Evidence from 8 studies</p>	<p><i>Castillo et al. (2013)</i>: Containing experiences and developing skills; Hopes, dreams and goals and their relationship to recovery  <i>Cunningham et al. (2004)</i>: General reflections; Clients' assessment of DBT; Control of emotions; Level of suffering  <i>Gillard et al. (2015)</i>: Reconciling the internal and external worlds; Doing things differently; Feeling and thinking differently  <i>Haeyen et al. (2015)</i>: Emotion and impulse regulation; perception and self-perception; personal integration  <i>Katsakou et al. (2012)</i>: Taking control of emotions, mood and negative thinking  <i>Lariviere et al. (2015)</i>: Person  <i>McSherry et al. (2012)</i>: Therapy-specific factors; Impact of treatment on daily life  <i>Perseius et al. (2003; 2005)</i>: The therapy provides skills to help conquer suicidal and self-harm impulses; Hopelessness and helplessness- will to struggle for a change</p>
<p>Theme 1.4: Implementing practical changes and developing hope  Evidence from 12 studies</p>	<p><i>Castillo et al. (2013)</i>: Achievements, identity and roles; Hopes, dreams and goals and their relationship to recovery; Containing experiences and developing skills  <i>Cunningham et al. (2004)</i>: General reflections; Control of emotions; Level of hope; Clients' assessment of DBT  <i>Gillard et al. (2015)</i>: Reconciling the internal and external worlds; Doing things differently  <i>Haeyen et al. (2015)</i>: Behaviour change  <i>Hodgetts et al. (2007)</i>: Evaluation of DBT  <i>Holm &amp; Severinsson (2011)</i>: Recovering by being able to feel safe and trusted  <i>Katsakou et al. (2012)</i>: Practical achievements and employment  <i>Langley et al. (2005)</i>: Hope  <i>Lariviere et al. (2015)</i>: Person; Occupation  <i>McSherry et al. (2012)</i>: Impact of treatment on daily life  <i>Morriss et al. (2014)</i>: non-caring care; It's all about the relationship  <i>Perseius et al. (2003; 2005)</i>: The therapy is life-saving</p>
<p><b>Domain 2: Helpful and unhelpful treatment characteristics</b></p>	

<p>Theme 2.1: Safety and containment Evidence from 7 studies</p>	<p><i>Castillo et al. (2013)</i>: A sense of safety and building trust; Containing experiences and developing skills; Learning the boundaries- love is not enough  <i>Fallon (2003)</i>: Service responses  <i>Haeyen et al. (2015)</i>: Art therapy versus verbal therapy  <i>Nehls (2001)</i>: My case manager is more than a case manager; My case manager has stuck with me for years  <i>Holm &amp; Severinsson (2011)</i>: Recovering by being able to feel safe and trusted  <i>Langley et al. (2005)</i>: Trust; Caring  <i>Perseius et al. (2003; 2005)</i>: The therapy contract brings support and challenge</p>
<p>Theme 2.2: Being cared for and respected Evidence from 12 studies</p>	<p><i>Castillo et al. (2013)</i>: Feeling cared for and creating a culture of warmth  <i>Cunningham et al. (2004)</i>: Individual therapy  <i>Fallon (2003)</i>: How accessible were the services?  <i>Haeyen et al., (2015)</i>: Behaviour change  <i>Hodgetts et al. (2007)</i>: Non-specific factors  <i>Holm &amp; Severinsson (2011)</i>: Recovering by being able to feel safe and trusted  <i>Langley et al. (2005)</i>: Trust; Caring; Trying to understand; Professional  <i>Lariviere et al. (2015)</i>: Environment  <i>McSherry et al. (2012)</i>: Personal factors  <i>Morriss et al. (2014)</i>: Non-caring care; It's all about the relationship  <i>Nehls (2001)</i>: My case manager treats me like a person; My case manager is more than a case manager  <i>Perseius et al. (2003; 2005)</i>: Respect and confirmation is the foundation; Not being understood and disrespectful attitudes</p>
<p>Theme 2.3: Not being an equal partner in treatment Evidence from 9 studies</p>	<p><i>Cunningham et al. (2004)</i>: Individual therapy; Skills trainers  <i>Fallon (2003)</i>: How accessible were the services?; Negotiation  <i>Hodgetts et al. (2007)</i>: Non-specific factors; External factors  <i>Holm &amp; Severinsson (2011)</i>: Recovering by being able to feel safe and trusted; The desire to recover by searching for strength  <i>Katsakou et al. (2012)</i>: Balancing personal goals of recovery versus service goals  <i>Langley et al. (2005)</i>: Trust; Caring; Professional  <i>McSherry et al. (2012)</i>: Personal factors; Therapy-specific factors  <i>Nehls (2001)</i>: My case manager treats me like a person; My case manager is more than a case manager  <i>Perseius et al. (2003; 2005)</i>: Not being understood and disrespectful attitudes</p>
<p>Theme 2.4: Focusing on change Evidence from 6 studies</p>	<p><i>Nehls (2001)</i>: My case manager is more than a case manager; My case manager has stuck with me for years  <i>Perseius et al. (2003; 2005)</i>: The method of therapy- brings understanding and focus on problems; The group therapy- hard but necessary; The poorly adapted tools of psychiatric care  <i>Cunningham et al. (2004)</i>: Individual therapy; skills coaching  <i>Hodgetts et al. (2007)</i>: Specific factors; Evaluation of DBT</p>



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*Katsakou et al. (2012)*: Balancing personal goals of recovery versus service goals  
*Haeyen et al. (2015)*: Behaviour change

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**Domain 3: The nature of change**

Theme 3.1: An open-ended journey  
Evidence from 5 studies

*Castillo et al. (2013)*: Transitional recovery and how to maintain healthy attachment  
*Cuningham et al. (2004)*: Control of emotions  
*Gillard et al. (2015)*: Reconciling the internal and external worlds  
*Katsakou et al. (2012)*: Problems with the word recovery; Able to deal with things in a better way but not (fully) recovered  
*Lariviere et al. (2015)*: The concept of recovery for women with BPD: not consensually the best term to name their experience

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Theme 3.2: A series of achievements and setbacks  
Evidence from 6 studies

*Fallon (2003)*: Movement; Negotiation  
*Perseius et al. (2003; 2005)*: Fear of life, longing for death- fear of death, longing for life; Hopelessness and helplessness- will to struggle for a change; Solitude, fearing relations- longing for love and fellowship  
*Cuningham et al. (2004)*: Level of suffering  
*Katsakou et al. (2012)*: Recovery fluctuating; Able to deal with things in a better way but not (fully) recovered  
*Lariviere et al. (2015)*: The concept of recovery for women with BPD: not consensually the best term to name their experience  
*Gillard et al. (2015)*: Feeling and thinking differently

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Figure 1. *The process of study selection*

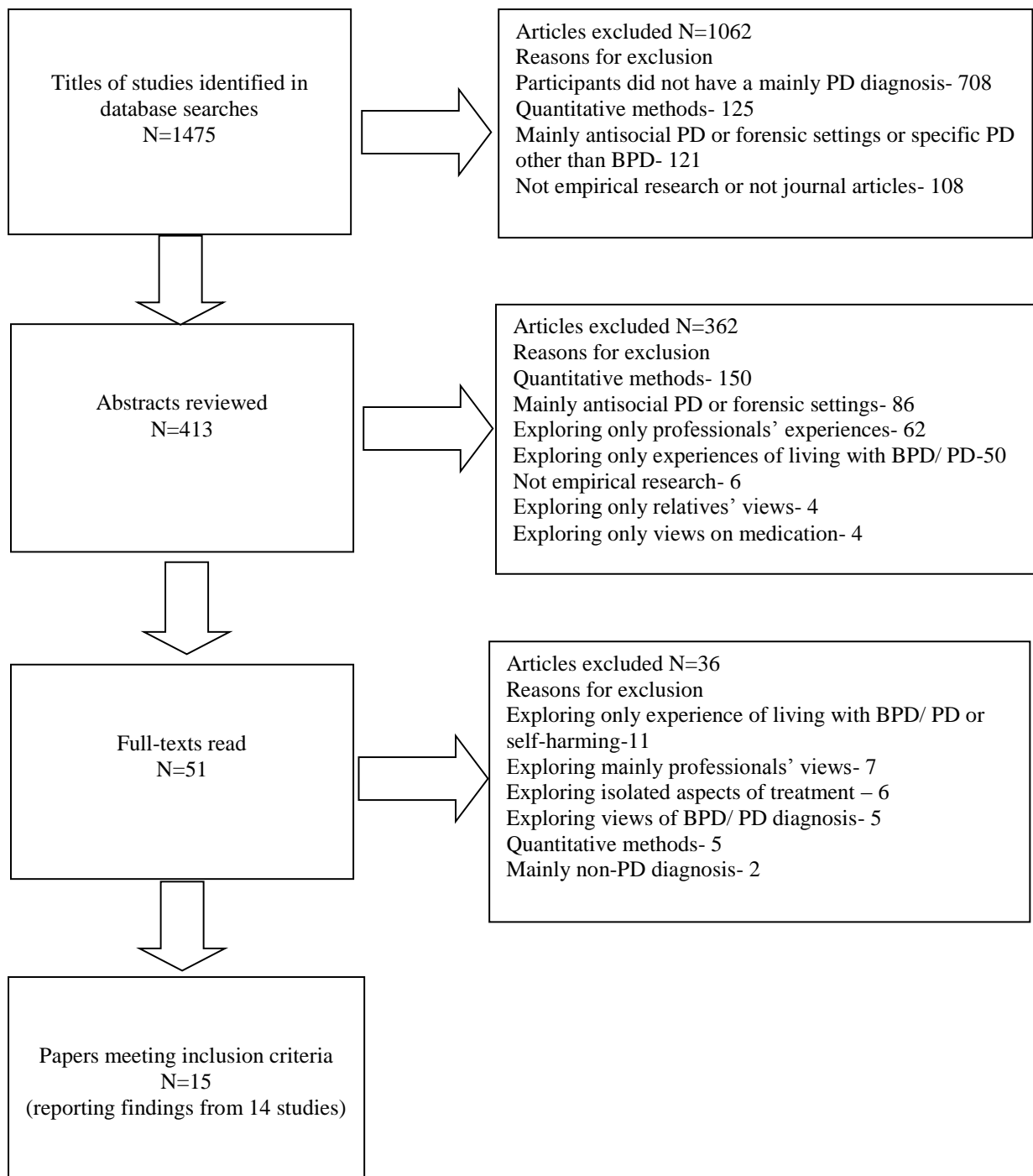


Figure 2. *Links between Domains 1 and 2*

**Helpful and unhelpful  
treatment characteristics**

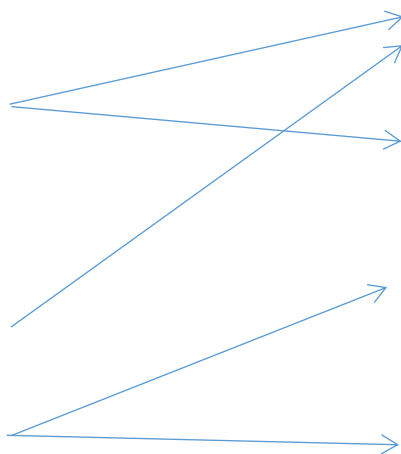
Safety and containment

AND

Being cared for and  
respected

Not being an equal partner  
in treatment  
(negative link)

Focusing on change



**Areas of change**

Self-acceptance and self-  
confidence

New ways of relating to  
others

Taking control of  
emotions and thoughts

Implementing practical  
changes and developing  
hope