VOLUME I

IMPROVING OUTCOMES FOR ADOLESCENTS AND ADULTS WITH TRAITS OF BORDERLINE PERSONALITY DISORDER (BPD)

BY

CLARE JOANNE O’GRADY

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for the degree of

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Department of Clinical Psychology
School of Psychology
University of Birmingham
Edgbaston
Birmingham
B15 2TT
United Kingdom
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Dedication

I would like to dedicate my thesis to my Mum, my sister Hana, Nana and Charlie; knowing you are always watching over me inspires me to be a better a person and persevere against adversity.

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I would like to thank the following people:

To the seven women who participated in this research; thank-you for your honesty and courage, in sharing your experiences. The mental health services who supported the recruitment of participants, putting the need for innovation and understanding above individual time constraints.

To the service users and teams, that I worked with throughout my placements, who taught me much, and kindly consented to be included in my clinical volume.

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THESIS OVERVIEW

This thesis is submitted in partial fulfilment of the requirements of the degree of Doctorate of Clinical Psychology at the University of Birmingham. It includes two volumes which incorporates both the research and clinical aspects of the course.

There are two papers contained within Volume I of the thesis. The first is a systematic review which aimed to assess the efficacy of psychological interventions with adolescents with traits of Borderline Personality Disorder (BPD). Specifically whether these interventions can be successful in reducing borderline symptomology, and what the potential mediating factors underlying any of these changes were. A systematic search of three databases resulted in 12 papers being found which met all of the inclusion and exclusion criteria. The papers were assessed against a quality framework, which revealed varying levels of quality across the papers. As there were limited papers which were of high quality and a paucity of evidence within each of the interventions assessed, it was difficult to draw conclusive results from the review. Methodological issues and future research is discussed.

The second paper in Volume I is a research study which sought to understand the experiences of females with BPD traits who had frequently been admitted to psychiatric inpatient services. Seven participants were interviewed using Interpretative Phenomenological Analysis. Four super-ordinate themes were identified: ‘BPD diagnosis is shorthand for untreatable and exclusion from services’, regarding the lack of help experienced as a result of perceived stigma; ‘battle for control’ explored the struggle with control, both internally and in their interactions with clinicians; 'Care-shaped gaps in services' was about the lack of care and support in the hospital and community services; 'Hospital as an illusion of escape, protection, safety, respite' was about the beliefs that participants had that hospital was a promise of protection, and disappointment felt around the reality of this. The importance of responsive and therapeutic relationships with clinicians was highlighted throughout the results as being fundamental to helping to develop better long term outcomes. A supportive transition from inpatient services to community, with a clear plan of support to empower the individual, was posited to be of utmost importance. Relevant literature is highlighted throughout the discussion and the limitations of the research are discussed.

Volume II incorporates the clinical component of the thesis and contains four Clinical Practice Reports (CPRs) which include examples of work completed throughout training[1]. CPR1 explored of the case of Elizabeth, an 82-year old woman who presented with depression and chronic pain at a Health Psychology outpatient clinic. The case is formulated from two perspectives: Cognitive Behavioural Therapy (CBT), using a Beckian formulation (Beck, Rush, Shaw, & Emery, 1979) and Psychodynamic Psychotherapy (PDP) using Malan's triangles (1979, 1995). CPR2 was an audit which incorporated both a questionnaire and semi-structured interview, to assess whether Health Care Professionals practice, at a Diabetes Centre for adults, was meeting the NICE (2011) quality standards for assessment and treatment of mental health problems. CPR3 presents the case of Sophia, a 9 year-old girl who was referred to Psychological Services due to obsessive traits. A formulation of Sophia's difficulties was understood using the Salkovskis, Shafran, Rachman and Freeston (1999) integrated schematic model. A CBT intervention was undertaken which included Exposure

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[1] All the names and any identifiable information in these CPRs have been altered or omitted in order to protect the service users' anonymity and confidentiality.

and Response Prevention (ERP) and an A-B single-case experimental design was used to assess the impact of the intervention. CPR4 is presented as an abstract about the case of Mrs Smith, a 67 year-old female who was referred to an Older Adult Psychology Service, for support with anxiety and low mood. The case is formulated using Fennell's (1999) cognitive model for low self-esteem and outlines the CBT intervention which was carried out.

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I THE EFFICACY OF 'EARLY PSYCHOLOGICAL INTERVENTIONS' WITH ADOLESCENTS WHO HAVE TRAITS OF BORDERLINE PERSONALITY DISORDER (BPD)

A systematic review of the literature

To be edited for submission to the Journal of Child Psychology and Psychiatry

ABSTRACT

Objective: The primary objective was to assess the efficacy of 'early psychological interventions' on borderline symptomology with adolescents with traits of Borderline Personality Disorder (BPD). The secondary outcomes were to assess mediating factors and attrition rates across the studies for the respective interventions.

Method: Three electronic databases were searched to find empirical studies which included adolescents and young people (<26), from 2000 and were written in English. Twelve papers were found for review. Papers assessed against a quality frame-work.

Results: Overall, the studies varied in their quality. All interventions were associated with changes in borderline traits pre to post treatment. There were very few studies which were able to find significantly better results than treatment-as-usual (TAU) on the outcome measures. A reduction in avoidance of difficult emotions and increased ability to mentalise were found to be potential mediating factors. Attrition was lowest on the Dialectical Behavioural Therapy for adolescents (DBT-A) studies overall.

Discussion: the results suggested that the evidence base was too sparse at present to draw strong conclusions about whether any intervention is favourable on any of the outcome measures or reliability of mediating factors. Theoretical explanations are given for the results found. Limitations of the review and recommendations for future research are discussed.

1. INTRODUCTION

1.1 What are the features of Borderline Personality Disorder (BPD) and how do we identify it?

When thinking about BPD in adolescence, it is helpful to consider definitions and diagnoses suggested in current literature and policies. There are two diagnostic manuals outlining the current criteria for defining BPD: the International Classification of Diseases (ICD 10; World Health Organisation, 1992) and The Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5; American Psychiatric Association, APA, 2013). The latter defines BPD when at least five of the following criteria are present for two or more years and they lead to significant impairment on daily life:

"Efforts to avoid abandonment, unstable relationships, identity disturbance, dangerous impulsivity, self-injury or suicidal behaviour, affective instability, feelings of emptiness, anger regulation problems, and cognitive disturbances" (APA, 2013, p. 663).

The DSM-5 posits that BPD can be diagnosed in adolescence when there is an enduring pattern of symptoms for at least one year, as opposed to the two years required for diagnosis in adults, and when that difficulty is not limited to a particular developmental period or to axis I disorder (APA, 2013). The National Institute of Health and Clinical Excellence (NICE, [2009] guidelines also provide support for a BPD diagnosis in adolescence. The ICD-10 is similar in definition to DSM5, but it terms BPD as 'Emotionally Unstable Personality Disorder' (EUPD), 'borderline type' (WHO, 1992). It is notable that the future ICD-11, 2017, is posited to have defined a new way of diagnosing BPD, which will recognise the heterogeneous nature of BPD (Sharp & Tackett, 2014). Subsequently, diagnoses are to be reclassified in the ICD-11 on a continuum-based approach: mild, medium, or severe.

The diagnosis for BPD is likely to be redefined as moderate or greater impairment in personality functioning and there will be no specified age required for diagnosis. BPD is also notable in its propensity to incorporate both internalising and externalising behaviours (Eaton, Krueger, Keyes, Skodol, Markon, Grant, & Hasin, 2011). Internalising behaviours make note of internal difficulties such as fluctuations in mood and externalising behaviours include aspects such as impulsivity.

1.2 Controversies in adolescent diagnosis

Adolescence is defined as being between the ages of 10 and 19 (World Health Organisation, 1986). However, there has been resistance to clinicians making a diagnosis of BPD before the age of 18 as personality is still considered to be developing (Miller, Muehlenkamp, & Jacobson, 2008). BPD and bipolar disorder have many features of similarity, that they have been collectively defined as the bipolar spectrum (Paris, Gunderson, Weinberg, 2007). Fundamentally, they are both posited to be underpinned by a difficulty with emotional regulation. However, this strong overlap puts the specificity of the diagnosis into doubt. There is a need for caution because there is doubt about the reliability and stability of the diagnosis over time (Laurenssen, Hustebaut, Feenstra, Van Busschbachl, & Luyten, 2013). This is complicated further by the view that adolescence is generally seen to be a time when young people may experience greater impulsivity and fluctuations in emotions as they transition into adulthood, making it hard to reliably assess their personality (Irwin, Burg, & Uhlercart, 2002). However, Bornovalova, Hicks, Iacono, and McGue, (2009) have found that BPD traits and diagnosis are relatively stable in young people and this is comparable to adults (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2006). Another concern is that the diagnosis of BPD is often associated with stigma and it is feared that this stigma could be internalised by the adolescent in the development of their self-concept (Aviram, Brodsky, &

Stanley, 2006). However, these concerns must be balanced against the positive aspects of diagnosis. A diagnosis can enable treatments to be specifically adapted to meet the particular needs of people experiencing those difficulties. Arguably, the problem is not with diagnosis per se, but with the judgements which clinicians attach to the diagnosis (Horn, Johnstone, & Brooke, 2007). BPD in adolescence has been found to be predictive of difficulties in relationships, education and employment (Crawford, et al., 2008; Winograd, Cohen, & Chen, 2008). Adolescents with a diagnosis of BPD are also more likely to have concurrent difficulties such as depression and anxiety (Chanen, Jovev, & Jackson, 2007), increased risk of suicide, and frequent hospitalisation (Cailhol, Jeannot, Rodgers, Guelfi, Perez-Diaz, Pham-Scottez., & Speranza, 2013). In consideration of those difficulties, the potential costs of not having evidence-based interventions which specifically target the difficulties of young people experiencing problems identified as BPD could be argued to outweigh the potential stigma.

1.3 Prevalence and possible causal factors of BPD

The prevalence of BPD in adolescents is estimated to be equivalent to adults: between 1- 3% of the population (Chanen, McCutcheon, Jovev, Jackson, McGorry, 2007) and adolescents with these traits have been found to represent approximately 53% of inpatient admissions in adolescent services (Becker, Grilo, Edell, & McGlashan, 2002). Early symptoms of BPD have been suggested to begin in late childhood and for symptoms to improve by middle age (Paris, 2008). There is some research which suggests that BPD has some underlying biological/genetic drivers (Torgersen, Czajkowski, Jacobson, Reichborn-Kjennerud, Røysamb, Neale, & Kendler, 2008). Other research posits that children’s early life, such a traumatic early experiences (for a review see Newnham & Janca, 2014) and poor attachments with caregivers (see Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004 for a review) may play a role in the development of BPD traits. Examples of potential mediating factors for these traits have been suggested to be owing to the role of invalidating environments, in which the caregiver does not support the child in the development of emotional regulation (Linehan, 1993), or the ability to mentalise, the process in being able to accurately understand the thoughts and feelings in oneself and others, as both of which are underpinning features of BPD (Bateman, & Fonagy, 2006).

It is important to note that the British Psychological Society views diagnosis as a social construction, which is dependent upon the current 'medical model' and interpretation of the clinician (see for example Kinderman, Sellwood, & Tai, 2008). As such diagnosis is not viewed as an objective fact with a reliable scientific basis (Boyle, 2002; Bentall, 2003).'Formulation', in which a person's difficulties are understood in context of their life experiences, is deemed by psychologists to be preferable (Johnstone, & Dallos, 2013). The premise of diagnosis as a social construction must be taken into account when discussing the concept of BPD, but has been necessary to use for the purposes of this review.

1.4 Interventions for adults with BPD

Knowing the potential costs of BPD on a person's life, it is important to consider what treatments may help in intervening with this. NICE guidelines (2009) recommend psychological interventions for adults with BPD. DBT is one of the recommended psychological interventions for adults (NICE, 2009). Other therapies shown to be effective in treating adults with BPD are Mentalisation-Based Treatments, System Training For Emotional Predictability and Problem Solving (STEPPS), Schema-Based Therapy (SBT), Cognitive Behaviour Therapy (CBT), Transference Focused Therapy (TFT), Acceptance and

Commitment Therapy (ACT) and Interpersonal Group Therapy (IGP; Paris, 2005). Although compared to other mental health difficulties, treatments for BPD are poorly understood, the evidence base for the efficacy of treatments for BPD has grown substantially in the past 20 years for adults and appears to be more extensively researched than other 'personality disorders' (Nathan, & Gorman, 2015).

1.5 Treatment for adolescents

Unlike treatments for adults, there is paucity of evidence for interventions for adolescents with BPD traits and the NICE guidelines (2009) concluded that there was an absence of high quality evidence to enable them to make specific recommendations for adolescents. Hence, guidelines developed for adults are being generalised to adolescents. The inability to provide evidence-based best-practice recommendations for what are potentially some of the most vulnerable children in society is disappointing. Treatments for adolescents have tended to focus on risk management, such as limiting suicide and self-harm attempts, without focusing on the longer term support for the underlying difficulties faced by the individual (NICE, 2009). Chanen and Thompson (2014) argue for 'early intervention' to 'emerging BPD' by intervening with targeted treatments to prevent the difficulties worsening. This is known as 'indicated prevention' (Chanen & Thompson, 2014). This highlights the need for more research into the efficacy of treatments for adolescents with BPD traits and the need for systematic reviews to consider the current evidence base.

1.6 Previous reviews

Systematic reviews have previously focused on the following areas: The effectiveness of interventions for suicidal adolescents (Corcoran, Dattalo, Crowley, Brown, & Grindle, 2011; Mujoomdar, Cimon, Nkansah, 2009; Robinson, Hetrick, & Martin, 2011) or for adolescents who self-harm (Brausch, & Girresch, 2012; Glenn, Franklin, & Nock, 2014).

There are two meta-analyses which have explored the effectiveness of interventions for self-harm and suicide (Corcoran, et al, 2011; Ougrin, Tranah, Stahl, Moran, & Asarnow, 2015). There were more general reviews which investigate a type of therapy for adolescents with a range of mental health difficulties, such as DBT (MacPherson, Cheavens, & Fristad, 2013) and psychodynamic psychotherapy (Palmer, Nascimento, & Fonagy, 2013) but the focus on interventions for BPD is limited. Two systematic reviews were aimed at specifically reviewing the effectiveness of interventions for BPD, but only focus upon DBT and do not include a quality review of the papers (Groves, Backer, van den Bosch & Miller, 2012; Hagen, Woods-Giscombe, Chung, & Beeber, 2014). In addition, there have been more studies investigating the efficacy of DBT since these reviews were published.

To the author's knowledge, and from the searches that have been undertaken (see method), there are no published systematic reviews which specifically consider all the available interventions for adolescents with BPD. Further, there are no reviews which focus specifically on the features often viewed as underpinning BPD, such as difficulties with emotional regulation, self-identity and relational difficulties (DSM-5; American Psychiatric Association, APA, 2013), as opposed to generalised outcomes, such as depression, quality of life, suicide attempts and self-harm. Although other outcomes are important, a specific understanding of how to intervene in BPD related difficulties is where there is the greatest gap in the evidence base. To the best of the author's knowledge, this is the first systematic review assessing the effectiveness of interventions in reducing BPD traits in adolescents.

2. METHOD

2.1 Search Strategy

Firstly, a scoping exercise was undertaken to assess the viability of undertaking a review on this topic. The scoping exercise was undertaken through the search engine ‘Google scholar’ and the databases listed below. The Cochrane database was also searched to ensure there were no new systematic reviews being undertaken with the same question. To retrieve papers for this review, the following three databases were searched: PsycINFO (1967 to March, Week 3, 2015), EMBASE (1974 to 2015 March 24), MEDLINE (1946 March, Week 3, 2015).

Given that interventions have only been adapted for adolescents with BPD traits within the last 16 years (see Miller, Wyman, Huppert, Glassman, & Rathus, 2000), databases were not searched to their maximum range. Combinations of the following key words/subject headings were used to search the databases, which are reported in table 1.

Table 1: Key words and subject headings used in search

1. Population	2. Intervention	3. BPD synonyms (outcome)
Adolescen*	Treatment*	"Borderline personality disorder*"
teen*	intervention*	“Emotionally unstable personality disorder*”
young*	therap*	BPD
youth*.	counsel*)	"Emotional dysregulation"
		"borderline trait*"
		Borderline state

Within each column the word “OR” was applied and between the columns (1, 2, 3) the word “AND”. This resulted in a total of **2905** articles. After removal of duplicates, the searches were limited further to include only articles with the following criteria:

1) written in English
2) studies including humans only
3) published between 2000- 2015
4) published in a peer reviewed journal

This resulted in a total of **1162** papers.

The remaining papers were examined through reading abstracts to ascertain suitability against the inclusion and exclusion criteria, which is presented in table 2.

Table 2: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
1) Psychological intervention	1) Population included is primarily focused on another psychiatric diagnosis
2) Population is between 12 and 25 years old	2) Non-research studies, e.g. reviews, opinion papers, conference abstract, books and protocols
3) Borderline Personality Disorder/ Emotionally unstable Personality Disorder or traits of either specified in method	3) Case studies
4) Empirical paper with outcomes	4) Dissertations
	5) Interventions for physical health problems
	6) Pharmacological interventions
	7) Qualitative studies

Within the papers included only outcome measures which were directly related to BPD symptomology, and related difficulties, such as self-harm were included. Other measures such as those that assessed depression were excluded because they were viewed to be a separate diagnosis despite the co-morbidity of these difficulties (Perugi, Fornaro, & Akiskal, 2011).

2.2 Article Selection

The title and abstract of each paper was examined based on the above criteria. When the content of the paper could not be deciphered from reading the abstract, the whole article was reviewed. Twenty-five papers were reviewed against the above inclusion and exclusion criteria (see figure 1). Following this process 12 papers were found to be eligible for inclusion in the review. The reference list of papers were explored and a further two papers were considered for inclusion. However, after full inspection one was not appropriate (James, Winmill, Anderson, & Alfoadari, 2011), as it did not focus on adolescents with BPD traits only and the other was included for review (James, Taylor, Winmill, & Alfoadari, 2008).

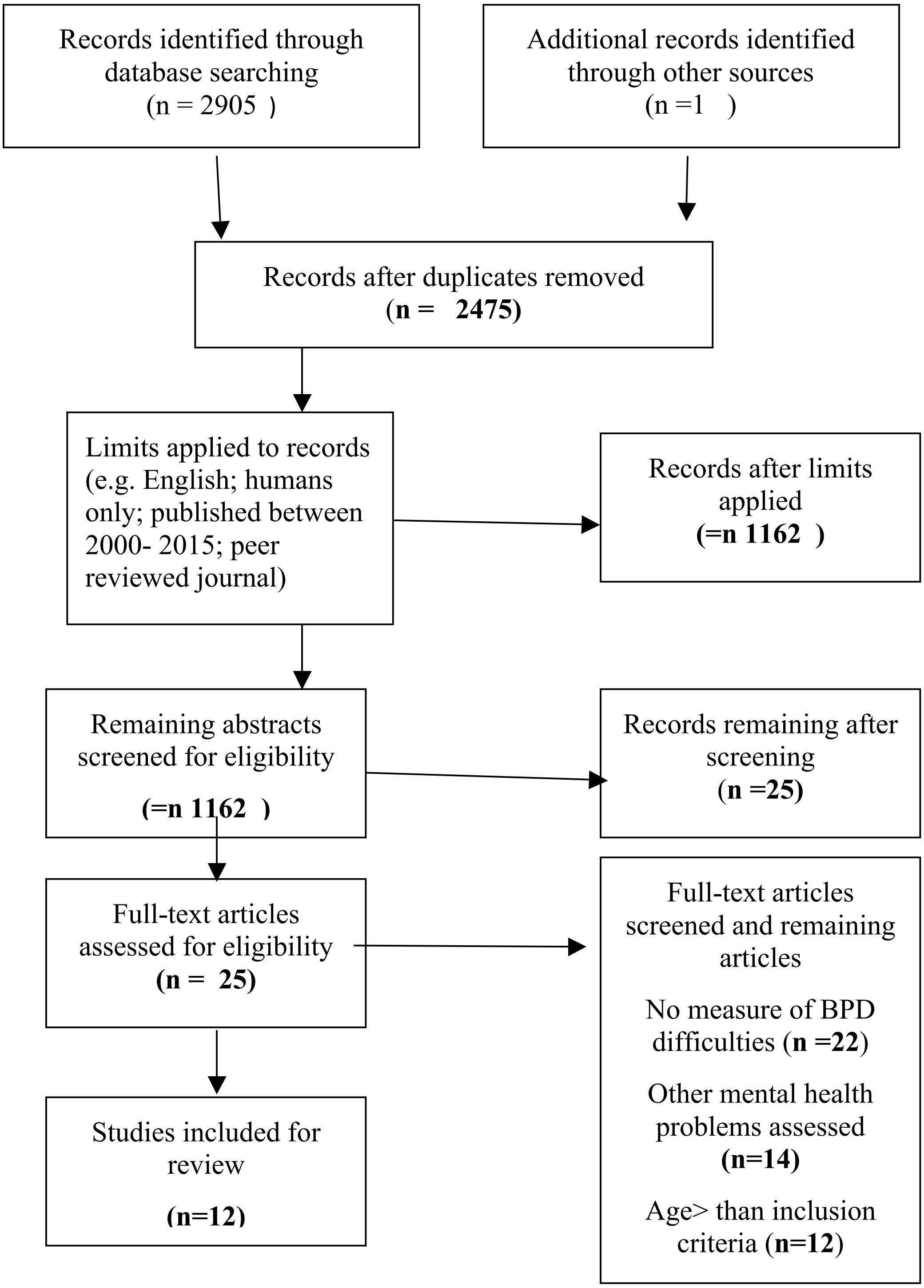

Figure 1: Summary of process of literature searching

2.3 Quality considerations

Of the final 12 papers assessed none were excluded on the basis of quality. The methodological quality of each of the papers was reviewed based on the framework by Kmet, Lee, and Cook (2004, see appendix 1 for further information). This framework was chosen because it provided criteria for assessing the quality of a diverse range of primary research study designs. It included clearly defined concepts to enable reliable comparisons between papers. Further, the criteria appeared to have captured the most salient aspects of what a quality of a paper needed without being excessively detailed. The Kmet et al., (2004) framework includes 14 subsections for markers of quality, which are scored numerically, with 2 given for 'yes', if all criteria for that subsection are met, 1 for it being partially met and 0 for when none of the criteria are met (see appendix 1 for an example of the full scoring process). It was decided post hoc that one quality indicator: *'If interventional and blinding of subjects was possible, was it reported?',* was not a realistic aspiration for the papers, as only one paper met this criterion (Rossauw & Fonagy, 2012) and therefore it was excluded from the quality framework. An additional sub-section was added to the framework, taken from Downs and Black's (1998) quality framework, to include number 4: '*Are the interventions of interest clearly described?'* (p382) and number 19: '*Was compliance with the intervention/s reliable?'* (p383). These two sections were added together as one category for intervention, and both needed to be met to get the full score, as the original paper was only awarding one point for inclusion of each. This was added because it was deemed to be important to be able to fully replicate the study and in order to fully assess the validity of the intervention. A summary of the quality assessment for the articles is presented in table 6.

In order to reduce bias and to increase inter-rater reliability, an independent trainee clinical psychologist reviewed the papers using the same checklist. Any differences in the assessment of papers were discussed and a final score was then agreed upon. All stages of the review were also checked by Michael Larkin (author on this paper and supervisor to the first author).

3. RESULTS

This review aimed to assess the effectiveness of ‘early interventions’ for adolescents with BPD traits and related symptomology. Secondary aims were to: consider whether the interventions impacted on any particular aspects of BPD symptomology; assess mediating factors; and consider how well participants engaged with the interventions.

The results section will outline the interventions studied and then provide an overview of the methodological quality of the papers to assess the results’ reliability, validity and the context in which the research was undertaken. The evidence for each of the different types of intervention will also be presented with a direct focus on the impact on BPD traits, clinical implications and mediating factors.

3.1 Summary of interventions included in this review

This section will provide a brief explanation of the therapies included in this review and the ways in which they have been adapted to be engaging for adolescents.

3.1.1 Dialectical Behaviour Therapy for adolescents (DBT-A)

DBT is an intervention which was developed specifically for adults with self-harming behaviours and BPD traits (Linehan, 1993). DBT is a third-wave cognitive-behavioural therapy (CBT) approach which combines emotional regulation techniques, a dialectical philosophy and behavioural techniques to enhance change and acceptance (Linehan, 1993). All of the DBT papers in the review had made some adaptations to the standard treatment for adults in order to be suitable for adolescents, known as DBT-A (Katz, Cox, Gunsaerkara, and Miller, 2004). For example in Rathus and Miller’s (2002) study DBT-A treatment programme was reduced from 1 year to 16 weeks, with shorter sessions, age appropriate examples and inclusion of the family/ carers in the treatment. Five of the six DBT-A interventions were undertaken through the medium of a group.

3.1.2 Mentalization-Based Treatment for adolescents (MBT-A)

MBT is based upon the premise that the underlying difficulty for people with BPD is related to their difficulties with attachment (Bateman & Fonagy, 2004). These attachment difficulties restrict one's ability to mentalise, which is the capacity to understand one's own and other's state of mind (Bateman & Fonagy, 2006). The ability to mentalise is thought to be one of the reasons for difficulties with relationships and with awareness of one's own emotions (Bateman & Fonagy, 2006). Rossouw and Fonagy (2012) have adapted MBT for adolescents in order to make it shorter, and to incorporate family work, in addition to individual therapy (MBT-A).

3.1.3 Cognitive analytic therapy (CAT)

CAT is a form of psychotherapy which integrates Psychoanalytic Object Relations Theory and Cognitive Psychology, in order to help make sense of difficulties with interpersonal and intrapersonal relationships (Ryle & Kerr, 2003). This is usually delivered as a one-to- one treatment modality. In the papers included in this review, CAT is delivered as part of the 'Helping Young People Early' programme (HYPE, see McGorry, Parker, Purcell, 2008), which is a specialised indicated prevention programme for young people (15-25). HYPE aims to help people with emerging BPD before the difficulties become more severe. The model includes providing families of the young people with psychoeducation, family intervention, assertive case management, activity groups, crisis team, inpatient care and pharmacotherapy (Chanen, Mccutcheon, Germano, Nistico, Jackson, & Mcgorry, 2009).

3.1.4 Emotion Regulation Training (ERT)

'Emotion Regulation Training' (ERT, Schuppert, Giesen-Bloo, van Gemert, Wiersema, Minderaa, Emmelkamp, & Nauta, 2009; Schuppert, Timmerman, Bloo, van Gemert, Wiersema, Minderaa, & Nauta, 2012) is an adapted version of 'Systems Training for Emotional Predictability' (STEPPS; Bartels, Crotty & Blum 1997). STEPPS is treatment for adults with BPD which is aimed to help in developing emotional regulation skills (Black, Blum, Pfol, & St. John, 2004). ERT is a 17 week group psychotherapy which includes a combination of individual psychoeducation, emotional skills training, and family psychoeducation (Schuppert et al., 2009, 2012). For both papers, participants who were undertaking an ERT intervention also had TAU.

3.1.5 Treatment-as-usual (TAU)

Under the umbrella of TAU there tended to be a combination of treatments: CBT, counselling and Family Therapy (FT) (Schuppert et al., 2009, 2012); psychodynamic psychotherapy (PDP), and FT (Rathus & Miller, 2002); PDP, counselling and CBT (Rossauw & Fonagy 2012). For some of the studies TAU was labelled as: 'enhanced usual care' (EUC, Mehlum, Tørmoen, Ramberg, Haga, Diep, Laberg, & Grøholt, 2014) or 'good clinical care' (GCC, Chanen, Jackson, McCutcheon, Jovev, Dudgeon, Yuen, & McGorry, 2008), in recognition of the quality of TAU as a treatment in its own right. EUC incorporated PDP and CBT (Mehlum et al., 2014) and GCC included problem solving and CBT. GCC was also combined with the HYPE model (Chanen et al., 2009). Historical- Treatment as Usual (H-TAU) was described as a general treatment package as part of an adolescent outpatient programme (Chanen et al, 2009).

3.2 Summary of papers

A summary of the papers included in this review can be found below in Table 3. There are 6 papers which include DBT-A as an intervention, (Fleischhaker, Böhme, Sixt,,Brück, Schneider, & Schulz, 2011; Geddes, Dziurawiec, & Lee, 2013; James, Taylor, Winmill, & Alfoadari, 2008; Mehlum et al., 2014; Miller, Wyman, Huppert, Glassman, & Rathus, 2000, Rathus & Miller 2002), making DBT-A the intervention with the largest evidence base. There are two studies that included CAT interventions (Chanen, et al. 2008; Chanen, et al, 2009), two studies which assessed ERT based therapies (Schuppert, et al., 2009; Schuppert, et al., 2012), and two studies which assessed MBT-A interventions (Laurenssen, Hutsebaut, Feenstra, Bales, Noom, Busschbach & Luyten, 2014; Rossow and Fonagy, 2012).

3.3 Design of studies

Five studies used pre-post designs (Fleischhaker, et al. 2011; Geddes et al. 2013; James et al., 2008; Laurenssen et al. 2014; Miller, et al., 2000). Seven studies compared the intervention to a form of TAU, five of which were randomised control trials (RCT) (Chanen et al., 2008; Mehlum et al. 2014; Rossouw & Fonagy, 2012; Schuppert et al., 2009; Schuppert et al, 2012). Quasi-experimental designs were used in two of the studies (Chanen, et al., 2009; Rathus & Miller, 2002).

3.4 Outcome measures

There was a wide variety of outcome measures used to assess borderline experiences, which all capture the fundamentals of the DSM-IV[2] criteria (see table 3). Three of the measures of BPD were specifically focused around the regulation of emotions only: Modified Affective Control Scale for Adolescents (MACS-A; Geddes, Dziurawiec, & Lee, 2007);

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[2] This was the version of the DSM being used when these outcome measures were used.

Multidimensional Emotion Regulation Locus of Control (Schuppert et al. 2009; Schuppert et al., 2012); LPI-ED (subscale: Emotional Dysregulation only; Schuppert et al., 2012). Most of the measures were based on validated adult measures, but were not validated for use with adolescents. This issue is considered more within the quality framework below.

In secondary measures of related symptomology there was also much variability in measuring the same concept across the studies. Many of the studies used were validated measures for adults but not adolescents, with the exception of one: Suicidal Ideation Questionnaire- Junior (SIQ-JR; Mehlum et al, 2014). Four studies did not use validated measures for adults or adolescents: semi-structured interview to measure parasuicidal behaviours (Chanen, et al, 2008, 2009) Self-Harm/Suicidal Thoughts Questionnaire (Geddes et al., 2013) and clinical interview (James et al., 2008). Five studies utilised the Youth Self-Report to assess internalising and externalising behaviours; (Chanen, et al, 2008, 2009; Fleischaker et al., 2011; Schuppert et al. 2009, 2012).

Table 3: Summary of papers

Author, year and country	**Inclusion criteria**	**Sample (Mean age, Female/male ratio)**	**Design, setting, Intervention**	**Outcome measures**	**Results of the primary outcome measures (BPD symptomology)**	**Secondary outcome measures**
1. Miller, et al. (2000) USA	a) Para-suicidal behaviour within the past 16 weeks or current suicidal ideation b) A minimum of 3 BPD symptoms (measured by SCID-II[3]) Needed to have completed DBT programme as data collected post hoc	Mean = 16.7 years F/M: 23/4.	Pre/post Outpatient DBT 12 x Weekly (Individual, multi-family skills group & Telephone sessions)	BPD measurement: Life Problems Inventory (LPI, Rathus & Miller, 1995)	Significant improvement in the total LPI score ($t = 5.65$, $p < 0.001$) Significant improvement in LPI on following areas: Confusion about yourself : $t = 4.78$, $p < 0.001$; Emotional instability: $t = 6.84$, $p < 0.001$, Interpersonal problems: $t = 3.84$, $p < 0.001$, Impulsivity: $t = 5.07$, $p < 0.001$	Attrition: NA.

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[3] Structured Clinical Interview DSM –IV Axis II personality disorders: BPD module (First, Spitzer, Gibbon, & Williams, 1997)

2. Rathus and Miller (2002), USA	DBT group: Same criteria as Miller, et al. (2000) For TAU group only needing to meet one criteria a or b, needed for DBT inclusion.	Mean age DBT = 16.1 years TAU= (mean=15 years) DBT= (27/2) TAU= (60/22)	Quasi- experimental Outpatient **DBT**: 12 weeks, 2 sessions/ week (Group/ Individual/ Telephone/ Family) **TAU:** 12 weeks 2 sessions/ week Psychodynamic (PDP) and Family therapy (FT)	Outcomes assessed at baseline and post-treatment: **BPD symptomology:** LPI **Measurement of suicidal thoughts, plans and behaviours:** Scale for suicidal ideation (SSI; Beck et al., 1979) **Measurement of ideation, plans and attempts:** (Harkavy-Asnis Suicide Survey -HASS; Harkavy-Friedman & Asnis, 1989). **Psychiatric hospitalizations and suicide attempts during treatment**: clinician records	***Within DBT group*** **(pre-post):** Significant decreases in total LPI scores ($t(12) = 3.44$, $p = 0.009$). Significant decreases in all four problem areas: Confusion about self: t (12)= 3.22, $p = 0.007$ Impulsivity: t (12) =3.43; p= 0.005 Emotion dysregulation: t (12) =3.37, p (12)=0.006 Interpersonal difficulties: $t(12) = 2.21$, $p = 0.047$ LPI not measured for TAU	**Attrition:** DBT=38%, TAU=60%, **Within groups** Significant reduction in suicidal ideation: t (9)=2.65, p =0.026 ***Between groups***[4]***:*** Significantly more treatment completion in DBT than TAU ($\chi2$ 1 = 4.32**,** p = 0.038). Significantly fewer participants had hospital admissions in DBT group than TAU: (0% versus 13%), $\chi2$ = 4.16, p = 0.041. No significant difference between the two groups for the number of suicide attempts[5] but there were 2.5 times as many in TAU group compared to

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[4] Not all of outcome measures collected for TAU

[5] Numbers in the group too low to report on clinical significance

						DBT (8.6% versus 3.4%).
3. James, et al. (2008), UK	At least 6 months of DSH	Mean= 16.4 years F/M:16/0 All met the criteria for diagnosis of BPD (SCID-II)	Pre-post and follow-up Outpatient Weekly DBT for one year (stage 1 only) Individual/ Group/ Telephone)	**BPD measurement**: Structured Clinical Interview DSM –IV Axis II personality disorders: (SCID-II) only collected for 7 participants post treatment, not follow-up). **DSH:** Clinical interview undertaken at start, end and follow-up (mean= 268 days)	BPD scores significantly reduced (F[6]=53.7, P<0.001).	Attrition: Mean=22% (Range: 36-100%) Significant reduction in DSH (F=23.95, p < 0.001).
4. Fleischhaker, et al. (2011), Germany	Female Aged between 13 -19 years DSH or suicidal behaviours in the past 16 weeks At least three BPD criteria	Mean age not reported F/M: 12/0	Pre-post and follow-up Outpatient DBT-A (two times per week): 16-24 weeks: (Individual, Family and Telephone)	Assessments were undertaken at beginning of therapy, four weeks after the end of therapy and one year after (follow-up). **BPD symptomology:** SKID-II[7] (Wittchen, Zaudig, Fydrich, 1997)	At the one year follow-up: A large and significant effect of DBT-A on reducing SCID-II (d = 0.78, p = 0.003).	Results: 25% attrition (n=3). Significant effect on internalizing behaviour (d =1.54; p = 0.007) and externalizing behaviour (d=0.57; p= 0.008). A significant effect on LPC (d=0.92,

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[6] DF's note reported

[7] German version of the SCID-II

	(DSM-IV)			**Internalizing and externalising behaviour**: Youth Self Report (YSR; Achenbach, 1991) **Suicidal and non-suicidal/self-injurious behaviour**: Lifetime parasuicide count (LPC, Comtois, & Linehan, 1999)		p = 0.015).
5. Geddes et al., (2013) Australia	Age range 13-18 years. A minimum of three BPD features DSH or suicidal ideation in past 12 months Average cognitive ability and reading level (year 5)	Mean age: 15.1 years. F/M: 6/0	Pre-post pilot with mediation analysis DBT-A: 8 weeks 'pre-treatment', followed by 18 weeks: Individual, family, group and telephone (weekly)	Collected pre, post and 3 months follow-up **Measure of control of emotions**: Modified Affective Control Scale for Adolescents. (MACS-A)[8] (Geddes, Dziurawiec, & Lee, 2007). **DSH/suicidal ideation:** Self-Harm/Suicidal Thoughts Questionnaire (SH/STQ)	**Pre to post** there was a large but statistically non-significant decrease in MACS-A ($r = -0.51$, $p > 0.05$). **At follow-up** there a moderate decrease in mean scores on MACS-A but this was non-significant ($r = -0.38$, $p > 0.05$).	Attrition=0% Reduction from all of the participants self-harming regularly to just one and a lower frequency of suicidal ideation reported[9]
6. Mehlum et al., (2014) Norway	Age 12–18 At least two BPD criteria and a history of self-harm	Mean age: 16 years DBT: (F/M: 34/5) 'Enhanced	RCT Outpatient DBT-A 19 weeks including (19 individual, 3 family sessions,	Assessed at 9, 15 and 19 weeks. **Borderline symptoms:** Borderline Symptoms List (BSL, Bohus, Limberger, Frank, Chapman, Kühler, & Stieglitz, 2007)	At the end of treatment: **Within groups** Within DBT-A group there was a large effect size and significant difference for BPD symptoms ($d= 0.89$, $p<0.001$).	Attrition: DBT-A= 25.6% EUC=28.9%. **Within groups** Statistically significant differences within DBT-A group for DSH

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[8] Reworded version of the adult measure of emotion regulation (Affective Control Scale)

[9] Numbers too low for assessment of statistical significance

		usual care' (EUC): (F/M: 34/4)	11 group sessions) for both conditions. EUC included: PDP[10], CBT and PH[11], 11 individual sessions, 6 family sessions, 1 group session	**DSH and suicidal ideation:** Suicide attempts and non-suicidal self-harm episodes (SIQ-JR, Reynolds, & Mazza, 1999).	Within EUC: No large effect sizes or significant differences for BPD symptoms ($d = 0.25$, $p = .061$). **Between groups:** No significant difference between groups for BPD ($\beta = -0.50$, $p < 0.50$).	frequency ($\beta = 1.28$, $p < .001$) and suicidal ideation, with large effect sizes ($d = 0.89$, $P < 0.001$). Within EUC there was no significant differences for DSH ($\beta = 0.36$, $p = .254$). ***Between groups*****:** DBT showed a statistically significant reduction in DSH over EUC ($\beta = 0.92$, $p = .021$) and suicidal ideation ($\beta = 0.62$, $p = .010$).
7. Rossouw & Fonagy, (2012) England	Aged between 12-17 years At least one episode of DSH within the past month History of DSH No psychotic Disorder	Mean age =14.7 years 73% met the full criteria for BPD MBT-A= 33/7 TAU= 35/5	RCT Outpatient (3 community Clinics) **MBT-A[12]:** (1 year, weekly manualised PDP & mentalization-based family therapy (MBFT)	Assessed at 3, 6, 9, and 12 months: **BPD symptomology:** Borderline Personality Features Scale for Children (BPFS-C, Crick, Murray-Close, Woods, 2005) **DSH:** Risk-Taking and Self-Harm	At the end of treatment: Significant reductions were found in both groups for BPD symptoms[13], overall change for both groups ($\beta = -0.21$, $P < 0.05$). BPFS-C, significant differential change between the two conditions, in favour of MBT-A	Attrition: MBT-A=50%, TAU= 58% MBT-A was shown to be significantly more effective than (TAU) in reducing self-harm, ($\beta = -0.049$, $p < 0.013$) No significant effect

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[10] Psychodynamic (PDP)

[11] Psychopharmaco- logical treatment

[12] Mentalisation based therapy for adolescents

13 The linear rate of change for both groups combined

			TAU: (1 year CBT, PDP, Counselling, supportive work)	Inventory (RTSHI, Vrouva, Fonagy, Fearon, & Roussow, 2010).	(β=0.072, p<0.042).	between two conditions for risk taking behaviours (β = -0.098, p=0.073).
8. Laurenssen et al. (2014) Holland	At least 2 BPD criteria met	14 - 18 years (mean= 16.5) (11/0) 8 met the full criteria for BPD (73%)	Pre-post, pilot study Inpatient (in one hospital) MBT Intervention weekly, over one year: Group, Individual, Art Therapy and MBT, FT (every 3 weeks)	Outcomes undertaken at the start of treatment and follow-up 12 months after. **BPD symptomology:** Personality functioning: Severity Indices of Personality Problems 118 (SIPP-118, Verheul, Andrea, Berghout, Dolan, Busschbach, van der Kroft, ... & Fonagy, 2008)	Large and significant effect sizes on the following SIPP-118 domains: Self-control (d = 1.29, p<.01), identity integration (d =1.42, p< .01) social concordance (d =.70, p<.05,), and responsibility (d =.58 p<0.05). The relational capacities domain, did not reach significance (p= 0.067).	Attrition not reported.
9. Schuppert et al. (2009). Holland	Aged between 14 – 19 years Mood instability and at least one other BPD symptom (BPDSI-IV)	Mean age: 16 Emotional regulation Training (ERT): 22/1 TAU: 16/4	Pilot (feasibility study) RCT Outpatient (In 5 mental health centres) ERT +TAU (Group x 17, weekly sessions plus 2 F/U) TAU	Outcomes assessed at baseline and end of treatment **Measurement of BPD symptoms:** Borderline Personality Severity Index, (BPDSI-IV, Arntz et al., 2003) **BPDSI-IV Subscales:** affect regulation **Internal locus of control:** Multidimensional Emotion	**Within groups** Significant decrease in BPDSI-IV, in both conditions pre to post (F [1,29]= 0.6.39, p=0.02) No significant difference over time for the conditions on BPDSI-IV subscale of affect regulation: (F [1,29] = 2.06; p=0.16) or internal locus of control (F [1,24]= 0.49; p=0.49).	Attrition was greater for ERT (39%) than TAU (15%). **Within groups** Over time there was a significant effect on the internalizing subscale (F [1,23]= 4.10; p = 0.06), but no significant effect on the externalizing subscale (F [1,24] = 2.61; p = 0.12).

			Individual: CBT, counselling, FT, medication	Regulation Locus of Control (MERLC, Nauta & Plat, 2005) **Externalising and internalising symptoms**: Youth Self Report (YSR)	**Between groups** No significant difference between groups on the total BPDSI-IV: (F[1,29]= 2.06; p = 0.16) or affect regulation (*F* [1,29]=0.24; *p*=0.63). ERT condition improved significantly more on locus of control (MERLC) than TAU: (F [1, 24] = 9.16; p = 0.006).	**Between groups** No significant effect between the groups for internalising (F[1, 23]= 0.32; p=0.58), or externalising: (F [1,24]= 0.06; p=0.82)
10. Schuppert et al, (2012), Holland.	A minimum of two BPD criteria (SCID-II) 14 to 19 years old	Mean age: 15.98 years 103/6 73% meeting the full criteria for BPD	RCT (In 5 mental health centres) Outpatient ERT + TAU (same as 2009)= : n=54 TAU= n=55	Undertaken at baseline, after treatment, 6 months follow-up (ERT+TAU only). **Borderline symptoms:** Borderline Personality Severity Index: BPDSI IV **Emotional regulation:** Affective Instability (AI): subscale BPDSI IV **Internal locus of control** (MERLC) LPI-ED (subscale**:** **Emotional Dysregulation** only)	**Within groups** Pre to follow-up: ERT+TAU was shown to have led to a significant decrease in: BPDSI-total scores (β = -8.27, p<0.001), AI (β =-1.78, (0.33), p<0.001), and LPI-ED (β -11.94, p<0.001). MERLC did not show a significant reduction (β =1.21; p=0.89[14]). **Between groups** Pre to post: There was no significant	19% attrition (Defined as attending less than half the training sessions.

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[14] Only reports statistics for significant results

					differences between ERT +TAU and TAU for any of the outcomes: BPDSI-total (d=-0.23), AI (d=-0.17), LPI-ED (-0.13) or MERLC (0.16)	
11. Chanen et al., 2008, Australia	15-18 A minimum of 2 BPD criteria (DSM-IV) + one or more of the following in childhood: Any PD symptom, any behaviour disorder symptom, low SES, depressive symptoms and a history of abuse or neglect No psychotic illness.	Mean age= 17 years, CAT+ HYPE[15]: F/M= 34/7 GCC[16]+ HYPE F/M= 25/12 32	RCT Outpatient Both conditions included HYPE model: (case management, Psychiatry, activity groups, crisis team) CAT 24 sessions GCC 24 sessions (incorporated CBT/ problem solving and in-patient and medication)	Assessment points and attrition: Baseline (n=78), F/U: 6 months (n=70), F/U: 12 months (n=70), F/U: 24 months (n=68) Outcomes: **BPD symptoms:** (SCID–II) **Para-suicidal behaviour:** (Semi-structured interview). **Internalising and externalising** (Youth Self-Report, YSR). **Frequency of service utilization:** Clinical records	**At 24 months follow-up CAT vs GCC showed that:** **BPD symptoms:** There was no substantial difference between any of the outcome measures, slightly better functioning for CAT on externalising scores (-0.32 s.d., CI–0.66 to 0.02); small differences in the favour of CAT for internalising: (–0.11 s.d., CI –0.51 to 0.28); and BPD total (OR=–0.10, CI –0.53 to 0.32).	There was no difference between the two study groups in the numbers of participants completing treatment, or withdrawing (x2=1.57, P=0.46)[17]. CAT was slightly less effective than GCC for frequency of para-suicidal behaviour (1.19, s.d.. CI 0.27 to 5.24).

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[15] Helping young people early

[16] Good clinical care

17 Individual attrition rates not reported

12. Chanen 2009, Australia	As above Chanen 2008	Mean= 16.3 H-TAU [18]= (n=32) CAT+ HYPE: n=34/7 GCC+ HYPE (n=25/12) 62% met full criteria for BPD	Quasi-experimental (H-TAU Non-randomized) As above for CAT and GCC H-TAU (information not given)	As above	All results reported are from final follow-up: For BPD symptomology, no significant difference overall for CAT vs GCC (-0.15 s.d, CI[19]: -0.56 to 0.27); CAT vs H-TAU (0.29 s.d, CI: -0.16 to 0.74), or GCC vs H-TAU (0.44 s.d, CI: -0.02 to 0.89) CAT showed greater change than GCC in externalising (0.19 s.d, CI: 0.58 to 0.20) and for H-TAU in both internalising (-0.79 s.d, CI: 1.21 to 0.37) and externalising (-0.69 sd, CI: 1.06 to 0.32). GCC was greater than H-TAU on internalising behaviours (-0.60 s.d; CI: 1.06 to 0.32).	Attrition as above and not reported for H-TAU There was no meaningful difference in rates of change for frequency of para-suicidal behaviour. The odds of undertaking parasuicidal behaviours were smaller[20] for GCC than H-TAU (0.23 OR, 0.06 -0.88) and slightly smaller for CAT vs H-TAU (0.32 OR; CI: 0.08-1.25); no meaningful difference for CAT vs GCC (1.42 OR; CI: 0.35-5.74).

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[18] Historical treatment as usual

19 95% CI

20 Better functioning shown by ORs <1 for parasuicide

Table 4: Mediating factors

Papers	**Outcome measures**	**Results**
Miller, et al. (2000)	Life Problems Index (LPI) DBT Skills Rating Scale for Adolescents (Rathus & Miller, 1995)	None of the helpfulness ratings corresponded to related module of the DBT training. Confusion about yourself significantly correlated with emotional regulation skills (r = .40, p =.04), master (r = .42, p = .03), and act opposite (r = .41, p = .03) Interpersonal problems positively correlated to radical acceptance (r = .38, p = .05). Emotional instability negatively correlated with participate skill (r = .46, p = .02). Emotional instability were negatively correlated to the participate skill (r = .46, p = .02).
Rossouw and Fonagy, England (2012)	To assess Mentalisation: 'How I Feel' (HIF) questionnaire (unpublished data, 2008) To assess Attachment status: 'Experience of Close Relationships' (Brennan, Clark, Shaver, 1998) .	Reductions in the outcome measures were mediated by a reduction in avoidant attachment, and an increased ability to mentalise. Self-harm and ECR avoidant scores were highly significant: (r(59)= -0.55, p<0.001) and HIF and self-harm (r(59)= -0.48, p<0.001) ECR and HIF were found to be highly significant in predicting the variance for self-harm (F(2,56) = 22.81, p<0.001, R2=0.43) Both ECR avoidance and HIF total scores independently contributed to the variance: (ECR avoidance (β =0.62, 95%, CI=0.30 To 0.94, t(58)=3.88, P<0.001; HIF (β = -0.17, 95%, CI= -0.23 to -0.10, t(58)= -4.73) Attachment anxiety was not a mediating factor (β=-0.33, P>0.05).

Table 5: Clinical validity

Papers	**Outcome measures**	**Results**
Laurenssen (2014) Holland	SIPP-118	Percentage of participants with clinically significant change: Identity integration (55%), Social concordance (36%), relational capacities (27%), self-concordance (18%) and responsibility (9%). Percentage of participants with reliable change on SIPP-118 ranged from 27% to 55%.
Rossouw & Fonagy, England (2012)	CI-BPD	By 12 months 58% of TAU group and only 33% of MBT-A group met CI-BPD criteria for BPD.
Fleischhaker, et al. (2011), Germany	SKID-II	The number of participants meeting the DSM-IV criteria pre to post: "unstable and intense interpersonal relationships" (9 to 1) "identity disturbance" (8 to 2) and "impulsivity" (8 to 2). At assessment 83% met the criteria for a BPD diagnosis, one year post therapy 17% of the patients had a diagnosis (Three had dropped out).
Schuppert, et al, (2012)	BPDSI	At the end of treatment: 19% of participants in ERT+TAU in remission (having an endpoint of 6 or lower on BPDSI total score) 12% of participants in TAU in remission

3.5 Overall quality of studies included in review

3.5.1 Summary of the quality framework

A summary of the quality framework for all the papers can be seen in table 6. Three papers were considered high quality (Chanen et al., 2008; Mehlum et al., 2014; Rossow and Fonagy, 2012). Five studies were considered medium quality (Chanen et al., 2009; Fleischhaker et al., 2011; Laurenssen et al., 2014; Schuppert et al., 2009, Schuppert et al.,

2012) and four studies which were considered to be weak in their quality (Geddes et al., 2013; James et al., 2008; Miller et al., 2000; Rathus & Miller 2002).

Weaknesses of studies

A common reason for papers not receiving the maximum rating was a result of confounding factors:

1) The paper failing to report *'fidelity of treatment to the model'* between therapists, (e.g. Geddes et al., 2013; Fleischhaker, et al. 2011; James et al., 2008; Mehlum et al., 2014; Miller et al., 2000; Rossouw & Fonagy, 2012).
2) Almost all of the studies had a variety of different modalities under the umbrella of one intervention or category of 'TAU', meaning that it could not be ascertained which treatment it was being compared to.
3) Inconsistency in the number of sessions within the treatment group, or between the conditions (Mehlum et al., 2014; Rossouw & Fonagy, 2012; Schuppert, et al., 2012).

Another common reason that papers did not receive the maximum rating was as a result of small sample sizes, (Fleischhaker, et al. 2011; Geddes, et al., 2013; James et al., 2008; Laurenssen et al. 2004; Miller, et al., 2000); and all papers except one (Rossauw & Fonagy, 2012) used outcome measures that were not validated for use with adolescents in measuring BPD symptomology/ diagnosis. A further difficulty was not consistently measuring BPD outcomes to post treatment and follow-up in all of the participants (James et al., 2008; Rathus & Miller, 2002) or the comparison groups not being equitable in their allocation of symptoms at baseline (Rathus & Miller, 2002).

3.5.2 Higher quality ratings

The studies which included RCT or experimental designs tended to receive higher ratings owing to their thorough randomisation and the blinding of the investigators assessing outcome measures. Some of the ways in which studies limited confounding factors included using the same therapist in both conditions (Chanen et al., 2008) and both groups receiving TAU (Schuppert, et al.'s, 2009 & 2012). However, having the same therapist arguably may raise other issues, such as potentially leading to 'treatment bleed', which is where the condition is influenced by the therapist being trained in different modalities (Hulley, Cummings, Browner, Grady, & Newman, 2013). Reliability was increased in some studies by recruiting in different parts of the country (Schuppert, et al. 2012) or area, rather than just from one clinic. Although Chanen et al. (2009) used much of the same data as Chanen et al, (2008), the inclusion of data from H-TAU was not randomised. H-TAU data were gathered before the introduction of the HYPE clinic and had different therapists, which made it hard to ascertain whether other confounding factors were at play.

Table 6: Quality Assessment Checklist (Kmet et al., 2004)

	Question or objective sufficiently described	Design evident and appropriate to answer study	Method of subject selection or source of information	Subject characteristics or input variables/information sufficiently described?	Was compliance with the intervention/s reliable? Is the intervention clearly described?	If random allocation to treatment group was possible, is it described?	If interventional and blinding of investigators to intervention was possible, is it	Outcome and exposure measure(s) well defined and robust to bias?	Sample size appropriate?	Analysis described and appropriate?	Some estimate of variance is reported for the main results/outcomes	Controlled for confounding?	Results reported in sufficient detail?	Do the results support the conclusions?	**SUMMARY SCORE & RATING**
Rossow & Fonagy (2012)	🟩	🟩	🟩	🟩	🟨	🟩	🟩	🟩	🟩	🟩	🟩	🟨	🟩	🟩	0.93 High
Chanen et al. (2008)	🟩	🟩	🟨	🟩	🟩	🟩	🟩	🟨	🟩	🟩	🟩	🟩	🟩	🟨	0.89 High
Mehlum et al. (2014)	🟩	🟨	🟨	🟩	🟩	🟥	🟥	🟨	🟥	🟨	🟨	🟥	🟨	🟩	0.89 High
Schuppert et al. (2012)	🟩	🟩	🟩	🟩	🟨	🟩	🟨	🟨	🟩	🟩	🟨	🟨	🟨	🟩	0.79 Medium
Chanen et al. (2009)	🟩	🟨	🟨	🟩	🟩	🟨	🟩	🟨	🟩	🟨	🟩	🟩	🟩	🟨	0.78 Medium
Schuppert et al. (2009)	🟩	🟩	🟩	🟨	🟨	🟨	🟩	🟨	🟨	🟨	🟥	🟨	🟩	🟩	0.68 Medium
Fleischhaker et al. (2011)	🟩	🟨	🟩	🟨	🟨	⬛	⬛	🟩	🟥	🟩	🟨	🟨	🟩	🟨	0.67 Medium
Laurenssen et al. (2014)	🟩	🟩	🟨	🟩	🟨	⬛	⬛	🟩	🟥	🟩	🟨	🟥	🟩	🟨	0.67 Medium
Geddes et al. (2013)	🟩	🟨	🟨	🟨	🟨	⬛	⬛	🟨	🟥	🟨	🟨	🟨	🟩	🟨	0.54 Weak
James et al. (2008)	🟩	🟨	🟨	🟨	🟨	⬛	⬛	🟨	🟥	🟨	🟨	🟨	🟩	🟨	0.54 Weak
Miller et al. (2000)	🟩	🟨	🟨	🟨	🟨	⬛	⬛	🟨	🟥	🟨	🟨	🟨	🟩	🟨	0.54 Weak

Table Key: Green= Criteria met (score 2/2) Yellow= partially met(1/2) Red = weak (0/2) **Black**= N/A not possible to measure in that study

3.6 Overview of the papers

3.6.1 Participant characteristics:

i) BPD criteria

To receive a diagnosis of BPD a person needs to meet five to eight criteria on the DSM-5 (APA, 2013). However, for emerging BPD, which would be a target for indicated intervention and prevention, clinicians are only required to identify two to three traits in adolescents (Chanen et al., 2009). For six of the studies, the inclusion criteria were only two BPD traits (Chanen et al., 2008, Chanen et al., 2009; Laurenssen et al., 2014; Mehlum et al., 2014; Schuppert et al., 2009, Schuppert et al., 2012). Four of the studies only required three criteria (Geddes et al. 2013; Fleischhaker, et al., 2011; Miller et al., 2000; Rathus and Miller 2002). Two studies did not explicitly require any traits of BPD in their inclusion criteria, but 73% (Rossouw & Fonagy, 2012) and 100% met the full criteria for BPD (James, et al. 2008).

ii) Other demographics

The age range of participants in the studies was between 12 and 19 years old across the studies. There was a higher number of females in the studies than males (range 75% to 100%), with an average age of 15. The sample sizes included in the studies varied from six (Geddes et al., 2013) to 110 (Chanen et al., 2009)/111 (Rathus and Miller 2002).

3.6.2 Settings

There was diversity in the countries where the research had been undertaken (Australia, America, England, Germany Holland and Norway). The majority of the studies had been undertaken in outpatient settings, with the exception of Laurenssen et al.'s (2014) study, which was an inpatient treatment programme.

3.6.3 Delivery

For the delivery of the 'experimental treatment' interventions, eight of the papers incorporated both group and individual therapy (Geddes et al, 2013; James et al, 2008; Laurenssen, et al, 2014; Miller, et al, 2000; Mehlum et al, 2014, Schuppert et al, (2009 & 2012; Rathus and Miller, 2002). An element of Family Therapy was included within the 'experimental interventions' for all of the papers, apart from Schuppert et al., (2009 & 2012) and James et al, (2008). Laurenssen's study also included art therapy in addition to all of the other interventions, which was another variable which could have impacted upon the results.

3.64 Treatment lengths

Intervention time periods varied across the studies with the following lengths: 8 weeks, (Geddes et al. 2013), 12 weeks (Miller et al., 2000; Rathaus & Miller, 2002), 17 weeks (Schuppert et al., 2009, 2012), 19 weeks (Mehlum et al., 2014), 16-24 weeks (Fleischhaker, et al., 2011), 24 sessions (Chanen, 2008 & 2009), to one year (Lauressen et al., 2014; James et al., 2008; Rossouw & Fonagy, 2012).

3.7 Outcomes reported

3.7.1 Follow-ups

Follow-ups were undertaken in only six of the papers at the following time points: one month (Fleischhaker, et al., 2011), three months (Geddes et al. 2013), six months[21] (Schuppert et al., 2012), nine months (James et al., 2008), and twenty-four months[22] (Chanen et al, 2008 & 2009). Of those outcomes which were reassessed at follow-up, results were maintained for all but Geddes et al.'s (2013) study, which reported less pronounced reductions.

3.7.2 Attrition

Attrition has been included as a marker of how well the study was able to engage the participants. What constitutes attrition was not always described in the studies, but for those that did report upon this there appeared to be variability in how it was defined. For example, Schuppert et al. (2012) describes attrition as indicated by participants attending fewer than half of the training sessions, but for Rossauw & Fonagy, (2012) attrition was those who did not complete treatment at 12 months. In Rathus and Miller's (2002) study, significantly more participants completed treatment in DBT-A (60%) than TAU (38%). However, in Schuppert et al.'s (2009) study, attrition was substantially higher in ERT (39%) than TAU (15%). In Mehlum et al's (2014), study attrition was similar across both conditions. Attrition was shown to be the lowest for the DBT-A studies as compared to the other interventions.

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[21] For ERT group only in order for TAU group to undertake ERT as well.

[22] For final F/U

3.8 BPD symptomology

3.81 Pre-post results

Almost all of the studies found a significant reduction in BPD symptomology pre to post regardless of intervention type. The only exception was Geddes et al., (2013) which found a large but not significant decrease in the measure of emotional regulation. However, the lack of significant effect may be explained by small sample size.

3.8.2 Between group differences for BPD

Five of the seven studies which had experimental designs demonstrated no significant differences between any of the conditions for overall BPD symptomology (Chanen, et al., 2008 & 2009, Schuppert, 2009 & 2012**,** Mehlum et al., 2014). Rathus and Miller (2002) did not measure BPD symptoms in TAU, therefore no comparison could be made. The only experimental design to find significantly greater reductions on BPD symptomology was for MBT-A when compared to TAU (Rossouw & Fonagy, 2012). ERT was also shown to demonstrate significantly more improvement than TAU on the specific measurement of locus of control, but not for BPD measurement or affect regulation (Schuppert, et al, 2009).

3.8.3 Clinical validity

The majority of the studies reported statistical significance instead of clinical significance, with the exception of three papers. Fleischhaker, et al. (2011) reported that only 17% of adolescents in their study would still meet the criteria for a diagnosis of BPD following the intervention, compared with 73% in the beginning. However, three participants out of 12 did not complete the study which biases the results. Schuppert et al., (2012) moderate to large and effect sizes for Borderline symptomology, did not equate to impressive clinical validity with only 19% of the ERT plus TAU group and 12% of the TAU group in remission from their BPD symptoms at the end of treatment.

Laurenssen et al. (2014) reported that reliable change on Severity Indices of Personality Problems (SIPP-118) ranged from 27% to 55% clinically significant change, which was in the normative range for functioning. Rossauw and Fonagy (2012) reported the recovery rate for MBT-A was 44% compared to 17% in TAU on the outcome measures. However, more in-depth interviews with the participants demonstrated higher rates of recovery at 57% versus 32% (Rossauw & Fonagy, 2012).

3.9 Mediating factors to changes in BPD traits

Rossouw and Fonagy (2012) found that reductions in the outcome measures were mediated by an increased ability to mentalise and a reduction in avoidant attachment. Miller, et al.'s (2000) study provides an understanding of which skills adolescents perceived as being helpful for changing specific problem areas in relation to BPD traits. Miller et al. (2000) found that none of the helpfulness ratings for skills learnt correlated with the corresponding problem area. However, significant positive correlations were found in the following: 'confusion about yourself' with 'emotional regulation' skills; and 'interpersonal problems' with 'radical acceptance'. 'Emotional instability' negatively correlated with 'participate' skill. In Fleischhaker, et al.'s (2011) study, it was reported that DBT had the most notable reduction for the following BPD traits: "unstable and intense interpersonal relationships, identity disturbance and impulsivity" (p.8). Laurenssen et al. (2014) gave specific indications of which aspects of personality function changed, reporting large and highly significant effect sizes for self-control and identity integration, with significant results also being found for social concordance and responsibility, but not the relational capacities measure.

3.10 Secondary outcomes/related BPD symptomology

The results relating to the impact of the interventions on self-harm, para-suicidal behaviours, suicidal ideation and suicide attempts are presented in this next section. For the following outcomes there is a sparsity of results, as not all the studies measured the same outcomes.

3.10.1 Deliberate self-harm (DSH)

Within treatment

DSH was found to have significantly reduced by the end of treatment in all three of the papers which measured this outcome (Fleischhaker, et al. 2011; James et al., 2008; Mehlum et al. 2014). Geddes et al.'s, (2013) study also found large reductions in DSH, but no statistical analysis was undertaken. At follow-up there were large reductions found for the frequency of para-suicidal behaviours following both the CAT and GCC interventions (Chanen et al., 2008, 2009).

Between groups

Two papers found a significant reduction in DSH as compared to EUC/TAU (Mehlum et al., 2014; Rossauw & Fonagy (2012). In Chanen et al.'s (2008) study CAT showed no significant difference to GCC in reducing upon para-suicidal behaviour. In Chanen et al's (2009) study there was shown to be a better median improvement for the CAT intervention than achieved by GCC and H-TAU for parasuicidal behaviours. The odds ratios for the likelihood of para-suicidal behaviours occurring for CAT interventions were much lower than H-TAU, suggesting that CAT may be a more effective intervention than H-TAU for reducing these behaviours. However, this reduction was greater for GCC than CAT. There was no significant difference found for risk taking behaviours between the two conditions (Rossauw & Fonagy, 2012).

3.10.2 Suicidal ideation

Two papers, which utilised DBT interventions found a significant reduction of suicidal ideation pre-to-post (Rathus & Miller, 2002; Mehlum et al., 2014). Geddes et al., (2013) also found a reduction in mean scores for suicidal ideation following their DBT intervention. For the one experimental study which measured suicidal ideation, participants in the DBT-A condition were found to have demonstrated a significantly greater reduction in suicidal ideation than EUC (Mehlum et al., 2014).

3.10.3 Suicide attempts

Of the two studies which reported upon suicidal behaviour, within groups, both implemented DBT interventions and there was found to be a significant reduction of suicidal behaviour (Fleischhaker, et al. 2011) and a reduction in mean scores[23] (Geddes et al., 2013). For the one experimental study that measured suicidal behaviour there were no significant differences between DBT-A group and TAU for the number of attempted suicides (Rathus & Miller, 2002). However, Rathus and Miller (2002) reported that this is an important finding because there were significantly more suicide attempts at baseline than at the end of treatment in DBT-A condition. Rathus and Miller (2002) also found that there were significantly fewer hospital admissions for the DBT group than TAU.

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[23] The numbers were too low to report on statistical significance

3.10.4 Internalising and externalising

Of the four studies which measured 'internalising' and 'externalising' behaviour, three found a significant reduction in these symptoms: DBT treatment (Fleischhaker, et al., 2011); CAT (Chanen et al., 2008 & 2009). ERT plus TAU demonstrated a significant reduction on internalising and locus of control but not externalising behaviours (Schuppert, et al., 2009). There were shown to be significantly lower levels of externalising behaviours in the CAT condition, than for GCC and H-TAU. This was also found for internalising behaviours, but for H-TAU only. GCC also showed a significantly greater improvement overall than H-TAU for internalising behaviours (Chanen, 2009).

4. DISCUSSION

4.1 Overview of the evidence

This paper reviewed the evidence base for psychological interventions targeted at providing early intervention to adolescents with ‘emerging’ BPD traits. There was a secondary aim of understanding mediating factors to any changes identified and a consideration of how well the interventions engaged the participants. The evidence is currently limited for research in this area with only twelve papers, of which only five were RCTs. Overall, this systematic review provided evidence that psychological interventions (DBT-A, CAT plus HYPE, MBT-A and ERT plus TAU) were associated with significant changes pre to post in BPD symptomology and related difficulties. However, there was little evidence to help in ascertaining which interventions are most effective compared to TAU in the respective interventions. A review of the results with clinical and research implications follows.

4.2 Quality framework

All of the studies included in this review were assessed using a quality assessment tool which highlighted that the overall quality of the literature was varied. For those that were rated as weaker, the common reasons were as a result of difficulty with the design of study, such as lack of randomisation, small sample sizes, not using measures appropriate to the age group, and multiple confounding variables. There are some specific methodological considerations for future studies which will now be considered:

1) The papers often included a variety of modalities of treatment, often all within the same study. In addition, TAU often incorporated a number of different treatments,

making it difficult to know what was really being compared to the intervention being assessed. Future interventions would benefit from only including one modality of treatment in order to assess specifically which aspect is most effective. However, this may add difficulties with real world validity and all ethical considerations would need to be met.

2) As the majority of the outcome measures were not validated for assessments with adolescents, it may be that greater differences would be found with more sensitive measures. Further outcome measures such as SCID-II do not allow for much variation, with only three options (absent, subthreshold or present). The large variability of measures used to assess one concept (aside from internalising and externalising behaviours), also makes it difficult to compare results across studies. For those studies which discussed clinical validity, the level that is considered 'recovery' is also subjective.

4.3 Attrition

The studies have variability in how they define attrition, and whether they directly report it, which makes it difficult to compare which studies have the best engagement rates. This might form a misleading picture in suggesting that some studies have worse engagement rates, when it may be that the study was more flexible in what it defined as attrition. From the information that was presented by the authors of the studies, it was found that DBT-A had significantly lower attrition rates than TAU (Rathaus & Miller, 2002) and overall the DBT-A studies appeared to have lower attrition rates than the other studies. As engagement is a particular focus of DBT-A, this finding fits with literature

(Linehan, 1993). However, attrition was particularly high in TAU in Rathus and Miller's (2002) study, at 60%, which may suggest an unfair comparison to the other interventions. Further, the DBT-A studies appeared to be generally shorter in length, which may have helped with retention rates. Greater attrition in the ERT group than TAU could be accounted for by the group having greater engagement demands, as they undertook TAU in addition to the intervention (Schuppert, et al., 2009). Although attrition was shown to be high for MBT-A (Rossauw & Fonagy, 2012), this was based upon the number completing treatment at the end of 12 months. This was much more tightly defined and had a longer time frame than some of the other studies, such as Schuppert et al. (2012), who defined attrition as attending less than half of the sessions for just six months. The mean attrition rate across the studies was 27% of the participants, which is lower than the rate of attrition documented in another systematic review for adults with personality disorders, which reported an average attrition rate of 37% (McMurran, Huband & Overton, 2010). This may suggest that the adaptations for adolescents are helping to make a difference in engaging them. Although, arguably, it may be that adults have greater symptomology, which could affect their engagement (Schuppert et al., 2009). It is also important to consider that there may be a self-selection bias with the participants recruited. In order to assess this potential bias it would be useful to have a follow-up with individuals who did not opt in to a study, to assess the reasons behind this. It would also be beneficial for future studies to further assess young people's opinions about what would help them to engage with an intervention.

Intention-to-treat analysis was not used in most of the RCT studies due to the small sample sizes, but this may be misleading, as it may not fully capture the impact of the intervention across the different groups for those who did not follow all of the protocol (Feinman, 2009). Future studies with larger samples would benefit in using intention-to-treat analysis.

4.4 Interventions

Overall the evidence base is sparse at present. DBT-A was shown to be the intervention with the largest number of studies, which is in-line with the adult literature (Stoffers, Völlm, Rücker, Timmer, Huband, & Lieb, 2012), but the majority of those papers were rated as weak methodologically. The other interventions are limited by having only two papers each. This is limited further by the CAT and ERT being undertaken by the same research team, with Chanen et al., (2009) using some of the same data as the 2008 paper.

4.4.1 Within group differences (pre-post)

All of the interventions demonstrated a significant effect pre-to-post, on all of the outcomes measures in the review, with exception of one, (Geddes et al, 2013), but this may have been explained by the very small sample size (n=6). These results may suggest there is a therapeutic effect of so called 'common factors', such as the clinician's warmth and positive regard, which could account for changes (see, for example, Lambert, 2005; Duncan Miller, Wampold, 2009), rather than the specific effects of any one intervention. Arguably the pre-to-post changes across the papers could suggest that adolescents naturally make improvements in symptomology over time. Again, better quality and a higher volume of RCTs are needed to assess this sufficiently. Most of the papers did not account for whether this significant change was actually clinically significant, which makes it hard to ascertain how meaningful the changes were overall to the young people's quality of life.

4.4.2 Between group differences BPD

Between the conditions only one study was found to be more effective than TAU in reducing BPD traits (Rossauw & Fonagy, 2012), and it was promising given its high methodological quality. However, more studies will be needed to replicate this before any conclusions about MBT-A can be made. The lack of significant differences found between TAU and the intervention may be partly explained by the adaptations to the interventions, such as making them shorter, which may suggest they were not long enough to have a significant impact. Further, it may be that in many of the treatment programmes such GCC/TAU, in the HYPE model, were of such high quality it led to no significant differences being found (Chanen, et al, 2009). It is hard to ascertain how representative these programmes of TAU were of standard treatment in CAMHS services. However, in Schuppert et al.'s (2009, 2012) studies TAU was added to the intervention, but they still did not find significant differences between the groups. These papers were deemed to be medium quality, meaning some caution must be noted when considering these results. In the adult literature, although there is still a sparsity of data, there is more evidence of psychological interventions being favourable to TAU (Stoffers, et al., 2012).

4.4.3 Secondary outcome measures

For the secondary outcome measures/ related BPD symptomology (e.g. suicidal ideation, suicidal attempts, DSH, internalising and externalising behaviours) the amount of evidence is very limited, as not all papers measured the same aspects. All of the papers which assessed these related symptomology did find an improvement pre-to-post, suggesting again that having any intervention is helpful, in reducing BPD related experiences. This review did find evidence for DBT-A being favourable to EUC/TAU, in reducing DSH and suicidal ideation (Mehlum et al., 2014). MBT-A was also found to be significantly better than TAU at reducing DSH (Rossauw & Fonagy, 2012). Both of these studies were deemed higher quality. For MBT-A the theoretical assumptions were that self-harm may be reduced due to an increased ability to understand thoughts and feelings of others, which in turn may enhance a sense of control and greater self-efficacy of impulses (Fonagy, 1998). This may be particularly helpful when experiencing inter-relational difficulties (Bateman, & Fonagy, 2004i). The mediating factors behind changes were assessed in this paper and are discussed further below. As DBT-A specifically focuses upon DSH and risk-taking behaviours it is unsurprising that this intervention was found to be effective. However, for the one study, which measured suicide attempts, there were no significant differences found between DBT-A and TAU (Rathus & Miller, 2002). The authors do note that the groups were not equal pre intervention, which may have skewed the results (Rathus & Miller, 2002). This was also deemed to be a weak quality paper, which may limit the reliability of these results.

For the one study which measured para-suicidal behaviours, the odds ratios (OR's) for para-suicidal behaviours occurring for the CAT intervention were much lower than H-TAU, suggesting CAT was a more helpful intervention, but 'Good Quality Care' (GCC) had lower OR's than CAT (Chanen, et al., 2009). It is hard to ascertain what it was about GCC intervention which made it appear to be more effective than CAT. It would be useful to know how GCC compared to other interventions such as DBT and

MBT in reducing these behaviours, to help assess its effectiveness. The greater reduction in externalising and internalising behaviours demonstrated in the CAT intervention, as compared to H-TAU, and in externalising versus GCC, provides some evidence that this is an effective intervention for these behaviours. As internalising and externalising behaviours are a broad concept and there was no mediation analysis, it is hard to ascertain why this is. It may be that having a new way to make sense of their relationships is helpful in the way feelings are communicated externally. Conversely ERT plus TAU's significantly better impact on internalising behaviours, and locus of control over TAU, may be understood through the intervention specifically targeting control over emotions and thoughts (Schuppert et al, 2009). ERT also aims for greater control over behaviour, but this was not the case in this study as there was no significant difference between TAU and ERT on the externalising subscale. From these results it may suggest a combination of CAT and ERT may be useful for improvement on both internalising and externalising behaviours, but the research is still very limited at present.

4.5 Clinical significance

For the studies which made note of the clinical applicability of the significant results, only participants in one study, a DBT intervention, were deemed to no longer meet the criteria for BPD (Fleischhaker, et al. 2011). However, it is hard to ascertain whether they would have still met the criteria for emerging BPD and the sustainability of these results. For two of the papers, the results were inconsistent or had limited clinical change (Laurenssen et al, 2014; Schuppert et al., 2012). Due to the short time frame of the interventions within these papers, it may be that they did not have long enough to make changes of clinical significance. However, this highlights the importance of not considering statistical significance alone.

In Rossauw and Fonagy's (2012) study having TAU to compare the recovery rate to MBT-A helped in showing greater effectiveness, regardless of how recovery was defined. The 43% recovery reported on for MBT-A is comparable to recovery rates found in adult primary care mental health services (40.7%) (Barkham, Stiles, Connell, & Mellor-Clark, 2012), which suggests these results are promising in applicability to meaningful change. Further assessment of clinical significance is needed across all papers to ascertain the clinical validity of statistical results. However, as Barkham et al. (2012) note, the results change depending on how recovery is defined and which participants are included, hence must be interpreted in relation to the context.

4.6 Mediating factors

A consideration of mediating factors and specific personality changes found in the papers may help to make further sense of the results. Miller, et al.'s (2000) correlations of helpfulness ratings suggested that skills may be utilised in different ways than expected. Mindfulness skills, which required participants to tolerate feelings rather than avoid them, was deemed as the most helpful set of skills within the DBT-A intervention. This is in-line with Rossouw and Fonagy's (2012) findings that a reduction in avoidant attachment style, is one of the mediating factors in change of symptoms in MBT-A, alongside increased ability to mentalise. In the studies that made particular note of changes in personality traits (Laurenssen et al., 2014; Miller at al., 2000; & Schuppert, et al., 2009), those with the greatest change were self-control (in ERT, DBT, and MBT-A); and identity integration (for MBT and DBT). However differences were only found in interpersonal relationships within DBT-A and not MBT-A, which may be explained by DBT's focus on interpersonal relationships. Taken together, increased efficacy to experience feelings and situations may enable these young people to feel more in control of their feelings and have a greater awareness of them. This may prevent the adolescents from using unhelpful methods such as DSH to manage their feelings. These results are in-line with the wider literature for adults (Stoffers, et al., 2012). Miller et al.'s (2000) study would also suggest that it may be harder in the short-term to do this, owing to the negative correlation between 'Emotional Instability' and 'Participate' skill, as it may be particularly overwhelming for adolescents with BPD traits to experience their emotions, but the authors argue that greater exposure to these feelings will be likely to be beneficial in the longer term. It may be that some of the skills need to be applied in a more graded manner when the individual has built the resilience to experience some of their difficult feelings. All of these findings need further assessment, which may be done qualitatively as well as through large quantitative studies.

The majority of those studies that include follow-up appear to show sustainable results, which is promising in terms of longevity. However, the longest follow-up is 24 months, with the majority only being one year. It may also be important for future research to continue to follow-up results with participants into adulthood (post 25) to truly ascertain if the intervention has been effective at preventing a full BPD diagnosis longer term.

4.6 Limitations of the literature and aims for future research

4.6.1 Demographics

The number of BPD traits that the participants had varied across the papers, which may have affected the reliability of the results. It is also hard to compare these results to those of an adult sample, because most of the participants only met two or three criteria for BPD, which is all that was needed to meet criteria for 'emerging BPD' (Chanen, et al., (2008). The majority of the participants included in the studies were female, which allows for real world validity, as females are more regularly diagnosed with BPD (Skodol, & Bender, 2003). Further, the way that BPD traits are measured is varied both in the use of measures and the aspect of the symptoms which is being considered. This makes it difficult to generalise results from the papers to wider populations.

The maximum age found across the studies was 19 (of those which met other inclusion criteria). However, 'early intervention' in Psychosis in the UK includes people up to the age of 35 (Department of Health, 2001). Neuropsychological studies have indicated that the adolescent brain is still developing up to the age of 25 (Giedd, Blumenthal, Jeffries, Castellanos, Liu, Zijdenbos & Rapoport, 1999) and is hence considered a critical period for intervention (Skodol, Pagano, et al., 2005). It is also a time when BPD traits have been found to be most malleable to change (Lenzenweger & Castro, 2005). Not including participants up to the age of 25 is arguably a criticism of all of the studies, who may be missing a significant proportion of young people who should be targeted for 'early intervention'. The reason behind this may be because most of the healthcare systems are separated for children/ adolescents and adults. However, this separation does not seem to have a strong developmental rationale. It would be useful to assess whether any differences in results were found if the older age group was included. Across the studies, the inclusion criteria were generally broad which may be useful for assessing real world validity.

All of the studies were undertaken in ‘Western’ settings which limits generalisability to other parts of the world and cultures. However, it is positive that studies have been undertaken in a variety of countries. Differences in health care systems, such as payment for healthcare may limit the applicability to different countries. In order to better understand the effectiveness of these interventions for males, future studies are needed for males alone. Further, there were no studies which focused on adolescents with a learning disability. The evidence base for engaging and treating adolescents who have diverse needs should also be a consideration for future research.

4.7 Limitations of the review and future considerations

The design of this review has several limitations which will now be considered further. This review only includes research papers which are written in English and therefore may be missing important studies which have not been translated. There may be other research which has not been peer-reviewed, which is of relevance. However, without the peer-review the papers may not be appropriate for a good quality systematic review. The review is selective in only including interventions which directly aim to target BPD symptoms, which has produced only a very limited evidence base. However, arguably inclusion of measures of other related difficulties, such as depression or quality of life, may have been helpful in building a wider picture of the effectiveness of the interventions and possible mediating factors.

It may be helpful for interventions to be applied earlier than adolescence given that there is literature which theoretically points to early indicators and precursors of BPD in childhood, (Brezo, Paris, & Turecki, 2006). Systemic ways of working, such as family therapy as a stand-alone treatment, and attachment focused interventions such as Dynamic-Developmental Psychotherapy (Hughes, 2010), would be useful to be further assessed with this population and their families. Further assessment of interventions which have been found to have an evidence base with adults, such as Schema Therapy (Giesen-Bloo, Van Dyck, Spinhoven, Van Tilburg, Dirksen, Van Asselt & Arntz, 2006) also need further investigation. Arguably, when studies such as DBT have been adapted to short treatment lengths, it may be that they cannot state that they are truly using a 'DBT' intervention (James, et al., 2008). There is a difficult balance to be found between engaging adolescents, which may mean shorter treatments, versus having true fidelity to the model. Overall, what is of great importance for all of the interventions in this review would be greater replication with high quality RCTs. It would also be beneficial for a meta-analysis to be undertaken, as this is the gold standard of systematic reviews (Simmonds, Higginsa, Stewartb, Tierney, Clarke & Thompson, 2005).

4.8 Conclusion

Overall, this review did not identify enough high quality papers to provide support for one particular intervention, and as such, reliable or valid conclusions cannot be drawn in relation to the aims of this review. From the evidence that has been gathered, it can be posited that psychological interventions are associated with reducing BPD symptomology for adolescents with BPD traits, but the evidence is too limited to suggest that one intervention is better than another or TAU. Many of the studies fared well on engaging participants, compared to research carried out with adult participants. There was no indication that the treatments in this review could cause harm, or lead to worse results, and considering the potential risks of not intervening, this review would provide support for ‘early intervention’. From the mediating factors considered it can be argued that helping adolescents to become more mindful and aware of their feelings, rather than using experiential avoidance (through unhelpful coping strategies), could be a useful part of any treatment intervention. Further RCTs of higher quality with longer follow-ups are required to provide much needed evidence to help this vulnerable population.

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II **EMPIRICAL PAPER**

EXPLORING THE EXPERIENCES OF PEOPLE WITH BORDERLINE PERSONALITY DISORDER (BPD) TRAITS WHO ARE ‘FREQUENT ATTENDERS’ AT PSYCHIATRIC INPATIENT SERVICES

Paper to be edited for submission to the Journal of Personality Disorders

1. INTRODUCTION

This section will present a rationale of why this service user group was chosen for exploration of their experiences and an overview of some of the selected relevant existing literature, which helps to make sense of this particular group's reported difficulties.

The DSM-5 (American Psychiatric Association, APA, 2013) definition will be employed for recognising Borderline Personality Disorder (BPD) traits in this study. Being diagnosed with a personality disorder is reported to be a significant predictor of having a more than one episode of hospital admission (Saarento., Øiesvold, Sytema., Göstas, Kastrup, Lönnerberg & Hansson, 1998). There is not one agreed definition in the literature of what constitutes a person who would be identified as a 'frequent attender' of inpatient services, as it ranges from three or more admissions within a lifetime (Langdon, Yaguez Brown & Hope, 2001), to readmission within 30 days of discharge (Swett, 1995).

Service users with a diagnosis of BPD make up a disproportionate number of the inpatient population; only 1-2% of the population in general have a diagnosis of BPD (NICE, 2009) but 15- 20% people with BPD are represented in inpatient services (Gunderson, 2009). As people with BPD often have comorbid diagnoses such as low mood, anxiety, or addiction problems, it is often the Axis I disorder, such as depression, which may be the focus of treatment (Zimmerman, Rothschild, & Chelminski, 2005). As a result, it is likely that the true number of people with BPD utilising services is actually much higher (Grant, Chou, Goldstein, Huang, Stinson, Saha, & Ruan, 2008).

Hospital staff are reported to have more negative attitudes towards those with frequent attendance at inpatient psychiatric services (Byrne, Murphy, Plunkett, McGee, Murray, & Bury, 2003) and particularly those who display suicidal behaviours (Suominen, Suokas, & Lönnqvist, 2007). Frequent attendance at inpatient services has both a large financial impact on inpatient services and can be a negative experience for service users (NICE, 2009). As such, it is very important to better understand the experience of people with BPD who may frequently attend inpatient services in order to consider ways to improve services and promote recovery for this group, from both a person-centred and financial point of view.

It is important to have an understanding of some of the underpinning features of the difficulties, with which this group of people may present with. One of the ways that the behaviour of those people who may attract a diagnosis of BPD can be understood is through an attachment theory perspective. An attachment is a connection that one person forms with another which leads a person to sustain proximity to an 'attachment figure', such as a caregiver, who provides a 'secure base' in healthy attachment relationships (Bowlby, 1969). The premise of attachment theory is that essentially humans need relationships for survival and that this need for an attachment figure is particularly heightened when a person is unwell and needs comfort (Bowlby, 1969). In a review by Agrawal, Gunderson, Holmes, and Lyons-Ruth (2004), the attachment style of people with BPD was explored across 13 papers. They found that insecure attachment styles were the most common, particularly unresolved and anxious subtypes, which was often found to be coupled with preoccupied attachment traits. People with insecure attachment styles are posited to show a pattern of wanting close relationships with others but have difficulties with trusting them. The development of this attachment style has been linked to the finding that people with BPD often have high rates of childhood trauma (Kingdon, Ashcroft, Bhandari, Gleeson, Warikoo, Symons, & Mason, 2010) and particularly experiences of neglect in childhood (Weinstein, Meehan, Cain, Ripoll, Boussi, Papouchis, & New, 2016).

Attachment theory has been also used to help make sense of ‘illness behaviour’. Hunter and Maunder (2001) identified that those with an insecure-anxious attachment style, (which, as described above, is common for people with BPD), may engage in ‘compulsive care seeking’ behaviour. Dozier (1990) argued that people with a preoccupied attachment style may find it harder to be separated from the caregiver and those with unresolved styles may find it very painful to deal with the emotions any treatment may evoke within them. Hunter and Maunder (2001) argue that they may experience their caregiver as not sufficiently meeting all of the person’s physical and emotional needs and subsequently they do not feel reassured by this person, which may lead to even more care-seeking behaviour.

Psychiatric systems and professional caregivers may play a large role in a person’s experience of help seeking, from helping them to feel contained within a ‘safe base’, to increasing their difficulties with trust (Adshead, 1998**;** Dozier & Tyrrell, 1997).

A better understanding of the models underpinning psychiatric systems and how they respond to service users may also help with better understanding of these difficulties. The predominant model in health care settings in the UK and other western countries is biomedical. This model views symptoms such as hallucinations as having an underlying physical cause, meaning the experiences are deemed to be due to genetic or biological factors which impact upon the brain (Deacon, 2013). This premise of psychiatric disorders having an underlying biological cause, shapes much of the way that psychiatric systems have been designed. As there is no medication which is licensed for use in BPD (NICE, 2009), an underlying message to clinicians may be that the service user cannot be treated, when viewed from a biomedical perspective. This way of understanding difficulties may create a dichotomy about the way that people are viewed, in terms of patients who can be treated because they are ‘ill’, or those that cannot. The latter is often the way people with BPD are viewed (Ross, & Goldner, 2009) and consequently, the implicit message is that people with BPD do not require a hospital admission (Bodner, Cohen-Fridel, & Iancu, 2011). Markham (2003) discussed the idea of an ‘ideal patient’, as perceived by clinicians, and how this shapes their view of whether the patient is deserving of care. Koekkoek, van Meijel and Hutschemaekers, (2006), in their literature review, noted that psychiatric service staff often found their interactions with people with BPD as amongst the most ‘difficult’ of all patients. Furthermore, clinicians are more likely to have negative feelings and less empathy for such people with BPD compared with people who have a different diagnostic label such as schizophrenia (Westwood & Baker 2010). In parallel to this, people with BPD have been found to be most likely to feel unsupported by the mental health system (Hayward, Slade, & Moran, 2006).

Historically, there have been difficulties accessing services for people with a diagnosis of BPD, which was challenged by the National Institute of Mental Health policy (NIMH; 2003) that BPD was ‘No longer a diagnosis of exclusion’. How effective this policy has been at informing the development of appropriate services over the past 13 years is hard to ascertain, but taking into account the above research, there is still evidence of at least implicit exclusion.

“To provide treatment when a person’s illness cannot be managed in the community, and where the situation is so severe that specialist care is required in a safe and therapeutic space. Admissions should be purposeful, integrated with other services, as open and transparent as possible and as local and as short as possible. (p7)”.

This quote defines the purpose in terms such as “illness” and also highlights the need for it to be “short”. The commission also found that 92% of wards that participated in the audit reported that they had patients who could have been treated by other services, such as crisis teams, personality disorder services and other community services, if they had been available.

The evidence base for understanding of the phenomenon of frequent attendance appears to be limited. There are many studies which report the demographics of people who are likely to be a 'frequent attender' (see for example, Bernardo & Forchuk, 2001) and the symptoms with which they may present (see for example, Webb, Yaguez, & Langdon, 2007). However, this way of conceptualising 'frequent attenders' provides a very limited understanding of their lived experience. An experiential perspective is very important since service users are the experts on their own care (Muir, 2012).

Three databases were searched (PsycINFO, EMBASE, and MEDLINE), and the search engine Google Scholar, to review the literature and from this it was ascertained that there were no qualitative studies which have directly asked the question being posed by this study. However, a better understanding of this area is hugely important for service users and for services to provide the best quality care. This study aims to better understand the experience of service users who may attract the diagnosis of BPD through a qualitative frame-work which allows an understanding of their lived experience of attending psychiatric hospital.

2. METHOD

This section will provide an outline of the method which was undertaken with consideration of design, recruitment, participant information and analysis of data.

2.1 Design

The aim of using Interpretative Phenomenological Analysis (IPA) is to gain an understanding of particular phenomena through the way that individuals make sense and give meaning to their personal experiences (Smith, Flowers, & Larkin, 2009). IPA focuses on an idiographic level of analysis. IPA recognises that all of the understanding that we gather about people's meaning making is developed through an interpretative lens, which is in-line with the theory of hermeneutics (Smith & Osborn, 2003). A double hermeneutic process is undertaken in IPA as the researcher is using their interpretation to understand the participants own subjective view of the world (Smith et al., 2009). An understanding of where the researchers' interpretations have developed from is therefore important in understanding any particular biases they may have in their interpretations (Larkin & Thompson, 2012). In order to recognise these biases, the researcher must demonstrate reflexivity about how their own experiences have influenced their interpretations of the topic (Shaw, 2010).

2.2 The researcher's reflections

I had limited experience of working with people with a diagnosis of BPD, other than during a placement between May 2014 and September 2014, as part of my clinical psychology training. I had my own personal experience of being a service-user on an inpatient ward from December 2004 to January 2005 and this is likely to have had an influence on some of the ways that I interpreted the experience of service users I interviewed, such as reflections on my own memories of the admission and inpatient stay. However, I have become aware of many differences in my experiences possibly as a result of having a different diagnosis (first episode psychosis). The participants were all aware that I was a trainee clinical psychologist which may have shaped their responses to a certain extent. However, they were not aware of my previous experience of being a service user.

2.3 Ethics

Ethical approval was gained from the University of Birmingham's Ethics Committee and the NHS National Research Ethics Service (NRES) Committee West Midlands - South Birmingham (see appendix 3). Any potential risk was managed through a plan to follow the lone working policies laid out by the NHS Trust in which I was recruiting. Liaison with the Care Coordinator (CC) was important to ascertain each potential participant's current mental state, using the risk assessment they had already undertaken. As part of the consent procedure, the participants were made aware that the interview could be paused at any time and that they were under no obligation to continue. They were also made aware they had the option of excluding certain parts of the interview that they felt uncomfortable with and could withdraw consent for up to two weeks after the interview had taken place. Furthermore, participants were given contact details of the research team so that we could provide answers to any questions that may have arisen before or after the interview. At the end of the interview there was a de-briefing process, with the interviewer, which allowed the participant to reflect on the experience of undertaking the interview and to establish whether the interview had evoked any difficult issues for them. I could then ensure that if any support was required for the participant, this could be arranged through liaison with their CC.

2.4 Sampling strategy

Sample sizes for IPA studies are comparatively smaller than some other qualitative research methods, such as framework analysis, due to the depth of analysis that the method demands (Smith, 1996). The research team (Michael Larkin, Eleni Theodosi & Clare O'Grady), aimed to recruit between 5 to 10 participants for the study, as this is a recommended number for an IPA study (Smith et al., 2009). Participants were recruited through purposive sampling to ensure that they would be able to answer the research questions relevant to the inclusion criteria (Smith & Osborn, 2003).

It was important that the group of participants who were recruited were as homogenous as possible, in order for the development of shared themes in the data as required by the IPA method (Smith et al., 2009). As the definition of 'frequent attenders' was so varied in the literature a definition was developed for this study, by myself and the research team. This was decided through consideration of the literature and information gathered from an audit, which found that over one calendar year (2013-2014) there were 56 readmissions in 180 days (n=44) in one psychiatric hospital. Participants were recruited in terms of symptomology rather than diagnosis, as the diagnostic classification system is known to be unreliable (Claridge & Davis, 2013). Further it was also deemed that not using diagnosis may enable a wider pool in which to recruit service users, who may display the same characteristics and experiences of the service users of interest. Table 1, summarises the inclusion and exclusion criteria decided upon.

Table 1: *Inclusion and exclusion criteria*

Inclusion Criteria	**Exclusion criteria**
Difficulties with emotional regulation and relationships.	Having a learning disability, as they may be less likely to be seen in a generic adult inpatient ward.
A risk of using self- harm, and/or suicide to manage feelings.	People who cannot speak English because funds for interpreting and translating services are not available for this exploratory project.
They will have been out of hospital for at least two weeks.	People with a primary diagnosis of an addiction for homogeneity of the sample.
A readmission at least every 6 months within one year, at some point within the last three years, to ensure the experience was relatively recent.	People who have organic brain disorders, for homogeneity of the sample.
They will be female, as females present with these difficulties more regularly than males and for this type of analysis (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004) and in order to make it homogenous.	Those who have active plans of suicide and hence may need a readmission to hospital.
Participants will be currently living in the community, and not an inpatient.	People who are currently experiencing psychosis or have a primary diagnosis of schizophrenia,.
Adults of working age (over 16 but under 65).	Those perceived to be too vulnerable to manage the sensitive nature of the interview questions, in order to avoid a negative impact on the emotional wellbeing of the participants.

2.5 Participant recruitment

At the start of the recruitment process, it was planned that all of the recruitment would take place across Community Mental Health Team's (CMHT's) in the Black Country Partnership Foundation Trust (BCPFT). I liaised with the teams in that trust and the individual CC's regarding the suitability of their service-users for the study. At the time of initial recruitment (May-August 2014), there was only 1 participant identified by the CCs as fitting all of the inclusion criteria. This small number seemed to be partly due to a concern that talking about their experience may cause a relapse or that they would be likely to disengage in the research process if recruited. Subsequently, the research team slightly amended the recruitment criteria, (with the approval of NHS ethics and the research and development teams in four more NHS Trusts, see appendix 2 for further information), in order to widen the recruitment pool.

Mental health teams were contacted (n=35) and I liaised individually with the CCs within those teams. Four teams across three Trusts identified participants, all of whom were recruited in the study. The participants were recruited by their CC who had the relevant inclusion and exclusion criteria. The CC then liaised with me before deciding about the suitability of the service user. If deemed appropriate for the study, the CC provided the service user with an invitation letter (see appendix 5) and information sheet (see appendix 6). If there was an expression of interest, the CC asked the service user to sign a permission sheet to share contact details with myself (see appendix 7) and I then contacted the service users by telephone to talk through any questions about the study and provide further information.

Information regarding the demographics and other relevant information is displayed below in Table 2.

Table 2: *Participant demographics*

Pseudonym	Age*	Ethnicity	Reason for recent admissions (diagnosis)	Number of admissions in the past year
Jane	39	WB	EUPD	2
Sally	44	WB	EUPD (and Cyclothymia)	2
Alice	39	WB	EUPD	3
Lucy	46	WB	EUPD	2
Sandra	62	WB	Prolonged depressive reaction	3
Lindsay	41	WB	EUPD and paranoid schizophrenia	2
Sarah	22	WB	EUPD	2

Key: **at time of interview; WB= White British*

EUPD= Emotionally unstable personality disorder (this diagnostic category was used by v cxthe services which were recruited from). However, the participants spoke about their diagnosis as BPD.

The table shows that the mean amount of admissions was 2.28 over the past year and all participants had at least two admissions over the past year. The mean age of participants was 42. One participant was included who had a previous diagnosis of schizophrenia, but as she thought her admissions in the past 3 years had all been due to her difficulties associated with emotionally unstable personality disorder (EUPD) and it was those experiences that she was reflecting upon for the interview, she was deemed appropriate for the study. One participant did not have a diagnosis of EUPD but her CC identified that she met the criteria for the study

2.6 Interview procedure

Written, informed consent was gained prior to each interview (see appendix 8). All interviews were conducted by myself between August 2014 and June 2015. Participants were interviewed face-to-face, in the most convenient location for them, which was either at their home address (3 participants) or the outpatient clinic where they saw their CC (4 participants The duration of interviews ranged between 50 and 130 minutes. All interviews were audio recorded with prior consent. The interviews were transcribed verbatim and all potentially identifying information was removed or edited for participant anonymity.

To help to ensure that the questions would be accessible to the participants, the interview schedule was taken to a service user group prior to ethical approval. The service users commented on the questions, and then changes were made accordingly (see appendix 9 for relevant minutes of the meeting). The structure of the first part of the interview was focused around a timeline of participants' admissions in order to help them to focus their responses to the questions about particular events. The interview structure included general topics such as the participants' experiences of diagnosis, their journey to admission and discharge from hospital, the experience of being an inpatient, the support they received after discharge, and where they thought they were in regards to recovery (see appendix 10 for a copy of interview schedule). Although an interview schedule was used, I ensured that I was flexible in what was discussed, in order that information that was salient to the participants' priorities was captured and that the interview was not led by my own agenda, as is appropriate for IPA (Smith, et al., 2009). After the interview the participants' CCs were informed that they had participated in the interview and they were updated if there was any information relevant to current risk. Participants were given a £10 voucher as a thank-you for the time taken to be part of the interview.

2.7 Data analysis

The data were analysed using the method of IPA (see Smith et al., 2009) as reported above. I read each transcript individually and initial ideas were noted in the margins, known as 'free coding' in order to be aware of my initial preconceptions (Larkin & Thompson, 2012). I then re-read the transcript a few times in order to become more familiar with data and made note of the objects of meaning for the participant and the phenomenon that the participant was describing. I did this for each line of the transcript and also made a note of any parts of the transcript which stood out, such as interesting use of language, metaphors and repetition. I re-read the transcripts again from an interpretative perspective, which meant that I tried to make sense of the descriptions that the participants gave from what I viewed to be their perspective. This was obviously undertaken through the lens of my own perspective and therefore awareness of this was important. From this I was able to code initial themes within the transcript, in relation to the research question. This process was undertaken for each of the transcripts and all of the comments were transferred to a Word document. From here the codes were edited to develop emerging themes. Once emerging themes were found across all of the transcripts, they were clustered to develop superordinate and subordinate themes (see appendix 11 for examples of all the stages).

2.8 Validity and Quality Checks

Smith (2010) developed suggestions on how to undertake good IPA research, which included use of credibility checking, to assess the trustworthiness of the results. One way of undertaking a credibility check is through ‘sample validation’, which enables service users who were eligible for the research but did not partake to assess the validity of the analysis (Larkin & Thompson, 2012). It was not possible to undertake this method as there were no participants who had expressed an interest in the research who did not participate. The analysis was checked through peer validation with another researcher who was also currently undertaking research in IPA. Parts of transcripts were reviewed at random and coded by the external researcher then similarities and differences were discussed, which informed the final themes. Peer validation was undertaken again at a later stage of analysis around the clustering and interpretation of themes. My research supervisor, who is very experienced in using IPA, was involved with checking all stages of analysis. I also tried to stay reflective throughout the process through the use of a journal, in order to recognise my own biases and try to separate them as much as possible from the stages of interviewing and analysis.

3 ANALYSIS

3.1 Summary of the superordinate themes

Four super-ordinate themes emerged from the analysis:

‘**BPD diagnosis is shorthand for untreatable and exclusion from services’:** This theme is about the lack of help that the participants perceived, due the stigma that they thought was associated with the BPD diagnosis. The participants thought that they did not get appropriate support and, subsequently, also felt invalidated. The perceived stigma was offered as an explanation for the lack of support. The **Battle for control** theme explored the continual battle with control that the participants fought, both internally (struggling to manage their impulses) and in their interactions with clinans. There were contradictions in this sense of control of actions. The **‘Care-shaped gaps in services’** theme explored the lack of care and support that the participants identified in both the hospital and community services. The ‘**Hospital as an illusion of escape, protection, safety, respite**’ theme explored the belief that participants had that an admission to hospital was a promise of protection and safety. However, this safety was experienced as being short-lived and participants thought that clinicians were not protecting them when they were most vulnerable. A summary of the superordinate themes and subthemes are summarised in table 3.

Table 3: Superordinate themes and sub-themes of participants' experiences of their frequent attendance to inpatient services

Superordinate Theme	Sub-Theme
3.2 'BPD diagnosis is shorthand for being untreatable and exclusion from services'	*3.2.1* "Nobody knows what's wrong with me" *3.2.2* Diagnosis is a double-edged sword *3.2.3* Not getting help when you need it *3.2.4* All that you need is to be supported and listened to when in crisis
3.3 Battle for control	3.3.1 Battle with internal control of feelings and actions 3.3.2 Variant: Dying to be heard 3.3.3 Push and pull of help seeking 3.3.4 Angry adult to naughty child 3.3.5 R-E-S-P-E-C-T: find out what it means to me
3.4 Care-shaped gaps in services	3.4.1 Container without care 3.4.2 The hospital or nothing 3.4.3 Scaffolding when you feel wobbly
3.5. Hospital as an illusion of escape, protection, safety, respite	3.5.1 The hope of protection and safety from oneself in hospital 3.5.2 Hospital as a place of respite 3.5..3 Variant: You can't escape your own feelings 3.5.4 I'm fine now, even though I tried to kill myself yesterday. 3.5.5 *Another experience of care: empowerment and respect*

3.2 BPD diagnosis is shorthand for being untreatable and exclusion from services

This overarching theme considers participants' experiences of how they thought their diagnosis shaped the way they were understood by services and how the diagnosis helped them in making sense of their symptoms. It also explores how responsive help had made a postive difference for participants. This will be examined further in the following subthemes:

3.2.1. "No-body knows what's wrong with me"

This theme was identified by four of the participants who had the sense that having a BPD diagnosis meant there was no hope or treatment for people with BPD, because 'what works for BPD' is so poorly understood. Jane explained this further:

> *"Basically I've read up on it and it's just like, erm, the doctors diagnose you with that (personality disorder) when they don't know what's wrong with you (I: umm) .. I feel like nobody really understands me (I: umm), nobody knows what's wrong with me".* (Jane)

Sarah explained how having a BPD diagnosis was just a way to describe (but not necessarily understand) a person's difficulties. There was a sense of hopelessness about her chances of receiving meaningful treatment ("they don't know what's wrong .. nobody understands .. nobody knows ..").

3.2.2 Diagnosis is a double-edged sword

In this theme, five of the participants explained how receiving a diagnosis was experienced in both helpful and unhelpful ways. The participants explained that diagnosis can be validating, giving people a sense of why they have the feelings and difficulties they do. In some ways this was experienced as helpful. This is illustrated in Sally's example:

> *"I have been disbelieved all my life (I: yeh, yeh), so that's why I need diagnosis .. So me having this diagnosis, I can turn around and say, see I am not lying (I: yeh). I can actually say that to myself [..] and get that self-belief myself, and proving to other people .. you know what I mean?"* (Sally)

Sally's narrative was about how having a diagnosis not only helped others to understand her, but particularly how it was important for her to be able to trust in her own feelings. However, for four of the participants there was a theme of feeling unworthy of care or support due to their diagnosis of BPD. In this context, the diagnosis was identified as being a barrier to being helped, which was perceived not to be therapeutic. This is articulated in the following example:

> *"That I was like not worthy of a hospital bed, not worthy of being looked after and not worthy of any support, because it was my behaviour that led to it and not because it was an illness".* (Lindsay)

Lindsay explained the experience of feeling unworthy of care here. She perceived that having a diagnosis of BPD meant that clinicians viewed her 'behaviour' as the problem, and therefore within her ‘control.’ This is construed as different from a real ‘illness’, which would be more worthy of support.

Overall, the experience of the participants seems to be that having a diagnosis could be helpful when used in a way to make sense of their difficulties. However, some of the participants also described how receiving a BPD diagnosis led to stigma, and rejection from services. The next theme considers the consequences of clinicians’ perceived lack of responses to the participants’ needs when in crisis.

3.2.3. Not getting help when you need it

Five participants highlighted the feeling of urgency to obtain the support they thought was required when in crisis. Coupled with this was a general feeling of frustration at not having those needs met in a responsive and timely manner. This is illustrated in the following example:

> *“Cause I thought, did she not realise, I needed help NOW. I was there then, that moment of time I was desperate (I: yeh, yeh). I hadn't washed my hair for days, I hadn't bothered with myself (I: ummmm). I was crying. I needed help, there and then and (I: yeh) ‘Oh I will meet you tomorrow (sniffs) (pause), try not to stress,’ or something. I was like ‘Ok’ (I: laughs) [.....] You feel like sometimes you are screaming, but no-one listens”.* (Alice)

Alice highlighted the sense of desperation and the vulnerability she experienced when in crisis. Alice’s description of feeling as though she was “screaming” with no one listening, exemplifies the feeling of being ignored and invalidated at the times when she felt help was most needed. This experience of being ignored when help was needed most was highlighted by five other participants.

Another theme which was discussed by five of the participants was that if they had been listened to and supported at the time they had asked for help, then it would have prevented multiple admissions, as is explained further by Jane:

> *"It just.. I just feel let down by the services (I: umm, yeh) coz I've been sectioned quite a number of times (I: umm) and I think that if I would have been listened to before (I: yeh), and that wouldn't of happened .. but they've just left me .. so I've got further distressed with my mental illness".* (Jane)

The participants shared an experience of being ignored and of problems then worsening. The next theme considers how supportive listening at the right time can make a difference.

3.2.4. All that you need is to be supported and listened to when in crisis

Five of the participants explained that during all parts of their journey through the psychiatric system the most important thing was to be 'heard' and validated by clinicians when in distress. For the participants this was largely about being respected as another human being. Lindsay explained another example of a better experience which meant that no admission was required:

> *"You know. So I dunno just feel like the psychiatric liaison- I mean they sat and talked to me for an hour which is unheard of (I: Yeah yeah) but that was all that I needed to get me over the bad patch".* (Lindsay)

From Lindsay's narrative it seems that being heard at the right time helped her to not need an admission. For Alice her care coordinator's approach helped her to prevent admissions:

"She doesn't judge me, she doesn't blink an eyelid, she doesn't…(I: yeh) look at me like it's harsh or anything erm…she just looks at me like it's normal you know and stuff (I: yeh)….so then I think… "oh it's not so bad…I'm not so bad" (I: umm). So obviously that must make me feel a bit better then". (Alice)

Alice explained how her care coordinator's non-jugemental approach helped to contain her and offer another view of herself, as not bad or unusual, which she found supportive when she felt low.

Overall, the importance of being listened to and understood by clinicians and not dismissed was prominent throughout the data (there are further examples to support this from Jane, Sandra, and Sally). Particularly pertinent is the way that clinicians respond to the participants and the ideal was to have a clinician who knew them well, with an understanding about the background to their problems and the time to do this. The next theme considers the nature of the control that participants feel in their interactions with clincians, as well as how control - or lack of it - is experienced internally.

3.3. Battle for control

This overarching theme is about the lack of control that participants experienced over their feelings, actions and interactions with clinicians. This battle for control is further echoed in the participants' relationship with clinicians. The relationship that the participants have with control is varied and complex. This will be explained further in the following subthemes.

3.3.1 Battle with internal control of feelings and actions

This subtheme is about the experience all participants identified with: feeling powerless in their ability to control their feelings or actions when in crisis. The participants described feeling separate from themselves and "out of control" when in crisis and linked to that was an implicit vulnerability. This is explained further in Alice and Sarah's examples:

> *"It's (I: umm) out of my control, they say you know, that you can control it and it's up to you when you want to die but if I could control it (pause)…I wouldn't do it."* (Alice)

For Alice, her experience was that she had a lack of control over her actions, which implied a sense of helplessness and anger at this not being understood by others around her. The feeling of hopelessness about recovery, was also clearly identified by Sarah as she explained that her determination to recover was often overtaken by an impulse: "*I'm never going in there again (I: umm), but, I can't control…(I: yeh) myself at the time, it's impulse".* Her explanation suggested that the impulse was almost separate from her and controlling her. This feeling of hopelessness around recovery was further explained by Sarah through the metaphor of: *"being trapped in a steel box".* This metaphor emphasised a real sense of powerlessness in this pursuit for maintaining recovery. In this theme, the participants described this sense of helplessness they have over being in control of their feelings and actions, but in the next theme there is a variation on the participants' view of their control over their suicidal actions.

3.3.2 Dying to be heard

A narrative offered by four participants described how the only way to have emotional distress 'heard' and validated by clinicians was through purposeful drastic actions such as suicide attempts:

> "'*What are you going to do if you go out, are [you] gonna do something to yourself?' (I: mmhh). I said 'If you send me out here, then yeh I will'".* (Sally)

In Sally's account there is a sense of it being a struggle to gain admission to inpatient services, and that service-users have to 'play the game' (i.e. threaten to harm themselves), in order to be admitted. Lindsay's account echoes the experience that the only way to be heard is through suicide attempts:

> *"Yeah, but people weren't listening to me. So in the past like you know when I've taken overdoses I've been listened to, so it sort of reinforces your behaviour really, even if they say you shouldn't behave in that way".* (Lindsay)

In Lindsay's narrative, she highlighted the contradiction of how clinicians may say "you should not behave that way", whilst their reactions reinforce that this is the only way to be listened to. This subtheme highlighted the ways in which participants thought that they needed to act in order to gain some control over whether they received admission. The next subtheme considers the powerlessness participants may feel once admitted to hospital.

3.3.3 Push and pull of help seeking

This theme considers the different experiences that the participants have in relation to control in hospital, particularly in their interactions with clinicians. It also explores how those interactions may influence service-users' perceptions of being supported by clinicians.

The experience of lack of control continued to be felt once in hospital, which is explained through some of the participants' narratives surrounding their expectations for treatment. For all of the participants, there is some expectation of taking a passive role regarding their responsibilities once admitted to hospital. However, there was a stark difference for one of the participants, regarding their feelings about what was a helpful level of control to have when in hospital. This will be considered further in the following examples. In Lucy's account of admission to hospital it seems as if she fully expected to relinquish control: "*Yeah, going to hospital, it's er… it's passing yourself over".*

Lucy's language here conveys a sense of passivity; her expectations are that others will take charge of her. For six of the participants, their willingness to allow the clinicians to be 'in charge' of them was generally experienced as unhelpful and they did not feel comfortable with this lack of control over their treatment and day-to-day functioning, as Jane explains: *"just…like I'm a puppet (I: umm) I mean they're just pulling your strings (I: yeh, yeh) I just found it annoying".* It is clear from this analogy that Jane thinks that someone else is controlling her, which was not experienced as therapeutic.

There is also a theme which emerged from three of the participants that feeling controlled leads to wanting to be discharged earlier than they may be ready for, as Sandra described in the following example:

"Very good at covering it up. So as that I could get out. Because, to get away, to get out…(Mm-hm). It was 'Oh, have another week.', 'Do this.', 'Do that.' And I'm thinking 'Another week of sitting doing nothing?' (I: Yeah. Yeah). Another week of boredom, you don't want to be doing that, you want to be doing something". (Sandra)

In Sandra's account, we hear that she experienced the clinicians in the hospital as taking a dictatorial stance, which led her to "cover up" her true feelings and to fight to "get out". This made it sound as though it is like leaving prison, in that it is something that needs to be escaped from, as it may feel punitive. Lucy also experienced a lack of autonomy in her decision-making process around being discharged, but in a different way to Sandra:

> *"Well, n- no. Not that I was ready- that I think that the hospital said 'Right,' y'know, 'it's time to move on.', really". (*Lucy)

From this narrative there is a sense of being 'done to' and passivity in her care. Arguably this lack of collaboration surrounding discharge may explain partly why people think that they are discharged before they are ready and possibly why they may have another readmission close to discharge.

3.3.4 Angry adult to naughty child

There is a subtheme of a 'battle for control' between clinicians and participants, in which the clinician plays the role of angry parent and the participant in the role of a ‘naughty child’. This is expressed by five participants and is illustrated by Sarah’s example:

> *“One day I was, like, self-harming. And he just- just came in and like, (pause) go- like, proper snatched it. (I: umm). Snatched whatever I was self-harming with out of me hand. And just was like, and then didn’t say nothing to me then after, like. (I: umm). I don’t know. Maybe it’d been nicer if he’d asked what was not…(I: yeh, umm). Whether you was okay and stuff”. (Sarah)*

The wording of ‘snatched’ conjures an image of an angry parent taking away something that a child is not allowed. This uncaring image was compounded by the lack of communication or soothing for Sarah in her experience and communication of distress.

3.3.5 R-E-S-P-E-C-T: find out what it means to me

For five participants, alternatives to the interactional style of previous theme were couched in terms of good communication from clinicians, which involved a clear idea of what to expect about their treatment and care-plans whilst in hospital. This was identified particularly as clinicians being respectful as another human being: *“that to get respect you’ve got to earn it…and they’ve got to earn my respect as well… and they’re not listening”* (Alice). Alice highlights the reciprocal nature of respect and how for her, this again comes back to good communication.

3.4 **Care-shaped gaps in services**

One of the barriers to admission and treatment in hospital was deemed by the participants to be due to be financial cuts which have left gaps where there have previously been services. Where there are services, participants reported that the staff members did not have enough time for the participants, which was experienced as uncaring. This overarching theme is explored more in the following subthemes:

3.4.1 *'Container without care'*

There was a theme common to all participants that hospital was 'somewhere to be held' when in crisis, but not a place to experience care and treatment. For many of the participants, they wanted a sense of being cared for and understood. Care meant the following for Jane:

"I don't know…just sometimes, just having somebody to talk to (I: yeh) but, they're always too busy, or (I: umm) some of them will say…oh I'm not…". (Jane)

Jane's sense of being cared for by the staff was about them having the time to spend and talk to her and be held in mind, but from her account she feels dismissed. For Sandra, there is a strong experience of being abandoned by the staff in hospital:

"What could I say? You're put in a room, you're took to a ward you've never been in before. (I: Mm-hm). And you're sat down. ((pause)) And you're just left. You're just left. Um, takes a couple of days before you'll settle down. ((pause)) And in that couple of days you don't see a doctor, you don't see anybody". (Sandra)

The language such as "put in a room" gave an indication of being done to and language such as "being left", without any communications. This also communicates that she thought everyone had forgotten her, which again leads to a sense of being uncared for, which is not experienced as therapeutic.

Overall, this theme highlighted that some of the participants thought there was not any care or treatment in hospital. Also, there was a sense of being done to without collaboration on treatment plans. The next subtheme considers how participants think that gaps in care are even greater in the community than in the hospital.

3.4.2. *The hospital or nothing*

This theme explores the gap which is described by some of the participants between the hospital and community, which is understood as two extremes of responsibility. Five of the participants reported that the gaps in services when they left hospital were part of the reason why they had repeated admissions. Sandra's experience highlights how this gap in care may be the reason for repeated admissions:

"But it took three more ((pause)) attempts. Because I was in, I was out. I was in. I was out. (yeh) Because there was nothing put in place for me……… so at least you haven't gone from everything, to nothing". (Sandra)

Sandra's narrative explained the theme of 'hospital or nothing'. Exactly what is meant by having "everything" in hospital is unclear, but from the other themes, it may be partly understood in the contrast from being without any freedom to having complete freedom. The lack of anything "being in place" appears to make this transition very stark. Part of what is difficult about this transition was described by Sally: "*I was told nothing, absolutely nothing. That's the only thing, John (husband) goes mad about it (I: yeh), there's nothing, absolutely nothing".*

From Sally's example it may be understood that services are not communicating or offering any support out of hospital, which led Sally to think that she is left with nothing. This theme is confusing in some respects as the participants state that they have had a lack of care in hospital, but there is perhaps something about the containment that the hospital offers with physically having people there and restrictions, which is experienced as more helpful than the lack of support experienced in the community. Overall, however untherapeutic and controlled participants may find hospital, it may be that the contrast to community is very difficult and there is a general sense of having no input at all from services in the community. The next theme will consider what a more helpful alternative to this would be.

3.4.3 *Scaffolding when you feel wobbly*

There is a theme that four participants contributed to, about their need to be supported enough to empower themselves to increase independence and recovery, when they are out of hospital:

"I don't know, sometimes ((slight pause)) it could be nice to have someone come, ..like, help you out in the community like. (I: umm). To do things by yourself. If you know what I mean?" (Sarah)

Sarah's suggestion may almost sound a contradiction, but we can understand that in order to do things independently there is a process of support that is needed from others to perhaps learn necessary skills in the first instance.

Four of the participants were able to begin to think about what recovery might look like and much of this was around the possibility of being empowered to manage their own feelings. However, there were subtle differences in what recovery might mean for the participants:

"Recovery for me would be and hopefully will be with the DBT (Hmmm).. um is being able to just feel distressed and not react in an extreme way. (Yeah) so.. and it would be not to have to rely on other people for the way I feel". (Lindsay)

For Lindsay recovery is about being empowered to not rely on others, whereas for Sarah it was about how she can learn to be more open with others about her feelings: "*Because I can use me DBT skills. Erm, so when I'm distressed now, which I do get, I can try and- and if they are home, go to me family a bit more now. And say 'Listen, I'm not okay.'"(Sarah)*

Overall, participants wanted someone to support them, through using supportive listening and empowerment, to be able to help themselves in a way which suited their needs. Given the struggles that the participants have to be admitted, it may feel very disheartening that they often felt let down when being admitted to hospital. This is explored more in the next theme.

3.5 Hospital as an illusion of escape, protection, safety, and respite

This theme explored the participants' experiences of the times when they seek a hospital admission; usually when they feel very unsafe and vulnerable. However, the experience that the participants reported is that hospital does not serve the function that they hoped for, which will be explained further in the following subthemes.

3.5.1. *The hope of safety and protection from oneself in hospital*

There is a theme relevant to six of the participants about hospital as a way to seek protection from themselves which is explained further by Sandra:

"You want to get- you want- you don't want to be sat there for hours. When you're feeling vulnerable, and that's what it is, because you am vulnerable, um, you want somebody to protect you and look after you. And you sit up in that waiting room, and they put you in a little room to yourself". (Sandra)

Sandra explains her feelings of anger at her treatment and also the experience of vulnerability and need for protection. However, her experience is that clinicians are not responsive to this vulnerability. There are others reasons that participants require a hospital admission as explained by the next theme.

3.5.2 *Hospital as a place of respite*

There was a theme relevant to five of the participants that a hospital admission may serve as a way to gain a break from life**,** as described by Lucy: "*I think I went into respite, y'know. Just away from the situation".* From Lucy's account it seemed that this respite may be partly about avoiding a difficult situation and feelings. The reality of hospital being able to provide an escape from feelings is considered more within the next theme.

3.5.3. *Variant: You can't escape your own feelings*

There is a variant in the internal support that hospitals may nurture, which is described by two participants and is explained again further by Lucy's account: *"Yeah, even though you feel dead lonely in hospital, because you do. Because you're trapped in* *your own head".* Lucy explained how some of the difficult feelings she has, such as loneliness, are still felt in hospital, as it is not possible to escape her feelings, because they are internal to her. This may help to explain why some of the participants think hospital does not meet their expectations. In other ways, participants explained expectations of safety not being met, as described in the next theme.

3.5.4 'I'm fine now, even though I tried to kill myself yesterday'.

There is a theme contributed to by five of the participants that the safety in hospital is uncertain and quickly compromised, as participants thought that they were often discharged too easily, as Alice explained:

"Erm, at first it was good, and then on my third visit, cause I knew exactly what to say and that, it kind of (pause), I know when I am getting put in there I feel safe, but on that first, second day, I know how to get out, so, you know (I: umm), so I've just got to start saying the right stuff, and then, you just go up to em, (voice speeds up and gets louder) and they have seen you, you know like nearly kill yourself and everything and you say I feel fine and honestly "I wanna go home and I feel great" (I: umm), "what's changed", give em a big spiel and then they let you go (I: yeh) and I am thinking (breathes in) they are psychiatrists and they know very well that you haven't just recovered like that (I: umm, umm), but they let you go (I: umm). You know?" (Alice)

From Alice's experience it seems that she feels let down at a time when she feels vulnerable and it sounds as though she thinks that clinicians need to be like responsible parents and set boundaries for the service users when they are vulnerable. This may mean 'reading between the lines' of what they are saying and using their clinical judgement. There are suggestions made by participants about how expectations have been better met in alternatives to inpatient stays, as described in the next theme.

3.5.5. Another experience of care: empowerment and respect

Two participants (Lindsay and Lucy) had an experience of an alternative provision to the standard acute inpatient setting. Lindsay explained how getting the right help made a difference to her:

Lindsay: "I was admitted to 'Summer house'[24]*(residential respite facility) there before it got to the point where I would have taken an overdose. So like I went in there. It was only about 3 or 4 days but it was just time out of life. Um.. and so that meant that.. I was treated really well there and people were like you know ...sort of nice with me and sympathetic and stuff and basically it just led to ....usually I would have taken an overdose or self-harmed .. .but it just led to you know a better outcome for me. [.....]Um...they gave me like you know, your own ability to make decisions for yourself, whereas when you're on a hospital ward all your decisions you feel are taken away from you[....] It was like being at home but with a lot more support".* (Lindsay)

In Lindsay's example she explains about the middle ground between hospital and being alone with impulses in the community. Much of her narrative is about the sense of being cared for at a time when she needed it rather than her perception of being dismissed and how much more supportive that felt. Also, Lindsay highlights the importance of having the autonomy to be able to make your own decisions, which is akin to being

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[24] Pseudonym

home, but with support; this may be the factor that led towards a better outcome for her. This theme seemed to be a negative case as only two of the participants discussed having this experience. Both participants who added to this theme were recruited from the same trust, in which there was an alternative provision to the inpatient service, and this did not seem to have been an available option for the other participants.

Overall in this theme there is a shared understanding of the need for protection from oneself at times of crisis, which is often difficult to find due to the participants ambivalent relationship with the hospital. This was linked with clinicians taking what they say on face value. Hospital may also be a way to escape feelings which are argued by some not to be possible, which may be why participants may think that hospital does not meet their expectations. Arguably, the positive experience of an alternative support to psychiatric hospital illustrates that what the participants seek isn't actually an illusion, but it is about having the right support for the person, and being creative in how vulnerable people are kept safe and empowered to help themselves, in a setting that can balance safety with appropriate levels of validation, mastery, and autonomy. Possibly, these are the key ingredients needed to reduce repeated admissions

4. DISCUSSION

4.1 Summary of the superordinate themes

This research aimed to gain a greater insight into the experiences of service users who have frequent attendance in inpatient settings with BPD symptomology. This discussion will firstly provide a summary of the main themes and then consider their relevance in the wider literature. Finally, clinical and research implications will be discussed. Table 4 provides a summary of the results.

Table 4*: Summary of themes*

Four superordinate themes emerged from the analysis. The *'BPD diagnosis is shorthand for untreatable and exclusion from services'* theme considered the lack of help that the participants experienced, due the stigma that they perceived to be associated with the BPD diagnosis. The *'battle with control'* theme explored the battle with control that the participants fought, both internally (struggling to manage their impulses) and in their interactions with clinicians. There were contradictions about their sense of control over their actions. The *'Care-shaped gaps in services'* theme explored the lack of care and support that the participants identified in both the hospital and community services. The *'Hospital as an illusion of safety and escape'* theme was about the belief that hospital promised protection and safety. However, this safety was experienced as being short-lived and participants felt that clinicians were not protecting them when they were most vulnerable.

4.2 ‘BPD diagnosis is shorthand for untreatable and exclusion from services’

In this theme, the experience of the participants was that many of the clinicians who worked with them did not have a good understanding of their diagnosis or what treatments were effective. This left the participants feeling somewhat hopeless about their chances of recovery. Part of clinicians’ negativity in treating people with BPD can be understood as a misconception that there is a lack of effective treatments for people with BPD (Horn, Johnstone, and Brooke, 2007), which may leave clinicians feeling frustrated and deskilled (Filer, 2005). Having a message of hope about a person’s diagnosis is noted as being very important in helping people with BPD in their recovery (NICE guidelines, 2009).

The participants also thought there was much stigma attached to their diagnosis which they believed affected clinicians receptiveness to their communication for support. This problem has been widely cited in the literature (Mind, 2011; Stalker, Ferguson, Barclay, 2005). Having a BPD diagnosis was viewed as a *‘double-edged sword’,* in that the service users also experienced some positive aspects of having a diagnosis. For example, validation of their difficulties, which enabled them to have another way to make sense of their difficulties and communicate this to others. This finding had been reported in a previous study about experiences of having a diagnosis of BPD (Horn, Johnstone, and Brooke, 2007). The participants in this study emphasise that what they really need when in crisis is responsive listening, understanding and validation, within a timely manner. For some participants they felt that this support had been enough to prevent re-admission. The needs of people with BPD to feel validated is a fundamental part of DBT and this need may have partly arisen as a result of invalidating environments in childhood

(Linehan, Tutek, Heard and Armstrong 1994). Another part of DBT which many viewed to be helpful, in-line with the participants' experiences, is having a clinician who can be contacted when the person is in crisis, as this helps with consistency of care and containment (Linehan et al. 1994).

4.3 Battle with control

This frustration many participants felt at not being taken seriously led some of the participants to respond with more extreme actions, in order to be heard by the clinicians. This was felt by the participants to be reinforced by clinicians. Some of the participants did identify that they may have problems communicating their needs in effective ways at times. People with BPD often have difficulties with interpersonal relationships, assertive communication and with problem solving (see Lazarus, Cheavens, Festa, & Rosenthal, 2014 for a review). However, the participants describe how often this isn't a choice, as they feel so out of control of their actions and feelings when in crisis. This can be understood in terms of the difficulties with impulse control, which is often noted in the literature for people with BPD (see for example Barker, Romaniuk, Cardinal, Pope, Nicol, & Hall, 2015; Chapman, Leung, & Lynch, 2008). Some of the participants also described a theme of separation from the person they had been when in crisis, which is inline with the suggestion that people with BPD have a fragmented sense of self (Wildgoose, Waller, Clarke, & Reid, 2000). It may be helpful for clinicians to understand that people with BPD may feel very out of control of their actions and are not 'choosing' to act in harmful ways. This may be important as the interpretation of self-harmful behaviours has led to some clinicians to see them as less vulnerable and in need of care (Forsyth 2007; Markham and Trower 2003; Starr, 2004), which was also how the participants thought clinicians viewed them.

The experience of feeling out of control appears to be exacerbated by a reported power struggle with staff, throughout their journey with mental health services but particularly once admitted to inpatient services. The participants generally felt controlled, and not communicated with as an equal by clinicians. This led them to feel disempowered in being able to increase independence and honesty about their feelings, as well as wanting to be discharged from hospital sooner than they may be ready for. Over-restrictive rules within inpatient settings has been a problem cited by previous research (Goodwin, 1999) and such environments have been found to have a negative effect on mental health (Baker 2000). The Mental Health Act Commission (2005) notes of the importance of *"inpatient mental health services providing their patients with acceptable levels of security, care, or a sense of being treated as someone who matters"* (p19).

This need for strict rules within the acute hospital setting may be necessary to some extent, as a way to keep patients safe, but the role that staff can still play within responding therapeutically to service users is important to consider. Langley & Klopper (2005) make note of the reciprocal nature of relationships and the important part clinicians can play with engendering trust in people with BPD. From an attachment perspective, clinicians may be experienced by service users as attachment figures (Adeshead, 1998). Hence, an awareness of how to manage possible projection from the service users may be very important in responding in the most appropriate way and also in being aware of what feelings the service user may evoke in the clinician (Gabbard & Wilkinson 2000). People with BPD may seem to present with conflicting help seeking behaviours, as many have insecure attachment styles that may lead them to seek care, but then show ambivalence or much sensitivity to the threat of rejection (Bradley & Conklin, 2007). This may be confusing or frustrating for some clinicians. Compassion-focused approaches may help clinicians to better understand responses to shame and the difficulties service users may have with accepting care giving (Gilbert & Plata 2013).

Clinicians' own 'burn- out' may lead them to have difficulty in responding in therapeutic and respectful ways. This may be understood through such things as feeling helpless in their sense of their ability to support people with BPD, which they may internalise in a negative way towards themselves (Rayner, Allen, & Johnson, 2005; Woollaston, & Hixenbaugh, 2008). The importance of using the principles of a good therapeutic relationship, such as consistency, empathy, and respect are key for containment and also providing an alternative way of experiencing relationships (Paul, & Charura, 2014). Staff may need to be supported in providing this care through having their own space, support and supervision. This may be fundamental in preventing premature discharge and, potentially, rapid readmission.

4.4. Care-shaped gaps in services/treatment

One of the experiences the participants identified was problems with reduced and insufficient resources in the acute care systems and in the community. This was particularly felt in regard to nurses in hospital not having enough time to spend with them, which was partly viewed to be due to a lack of staff. Further, those interactions with staff were not experienced as being caring, as was noted above. The experience of lack of care in the hospital left the participants feeling that there was very little therapeutic intervention and that the hospital was only somewhere to be held. In Shattell, Andes and Thomas's (2008) study this lack of therapeutic intervention in the hospital was argued to be the main reason for the 'revolving door' of some of the service users.

This lack of support was also reported by the participants during the discharge process and then in transitioning back to life in the community. NICE guidelines (2009) note the importance of developing collaborative structured plans to help service users manage endings and transitions, which may be likely to evoke strong feelings for people with BPD. However, the participants' experiences were that discharges were often not orientated to their needs, but the needs of the services and they felt there was very little communication about their discharge plan. The participants explained the difficult contrast in going from an environment where they may have little control over anything, to being completely without any support and an overwhelming amount of freedom. One way of understanding this transition from being an inpatient to the community is through ideas from the 'Social Capital' literature. Social Capital is based on the premise that building trusting relationships and social networks are vital for being part of a community (Whitley & McKenzie, 2005) and this is also important for good mental health (Tew, 2013). It may be that, whilst in hospital, service users start to build bonds with services and a social identity as 'service user'. With little support in building bridges, through social connections in the community, they may seek reconnection with the hospital whenever this identity is made salient (Hayward et al 2006). What many of the participants wanted was support to be able to help themselves, such as through engaging in activities or with developing skills to feel more in control of their feelings. Concepts such as empowerment, support in developing a new positive personal/social identity and feeling more in control over one's life are found to be fundamental for people's recovery (Leamy, Bird, Le Boultier, Williams, and Slade 2011). For those who have started to break this cycle, this support in the community to help oneself has been attributed to what is beginning to make the difference for them. Other participants noted the importance of continuity of staff who know them and they feel understand them as being a very important part of their recovery. One study emphasised the importance of continuity into the community (Chiesa, Fonagy, Holmes, & Drahorad, 2004) found that a medium term residential stay, with a "therapeutic milieu" (p, 469) and longer term outpatient support, was more effective in reducing readmissions longer term than a longer-term therapeutic treatment programme, with no community follow-up or than general acute wards.

4.5 Hospital as an illusion of escape, protection, safety, respite

One of the main aspects of what participants wanted, when they sought an admission to hospital, was having a place of safety for protection, whilst they were feeling vulnerable. This need for safety and security may be heightened in people with BPD, who may have been less likely to have had a secure and safe base in their early life (Holmes, 1999). For some of the participants, hospital was a way to escape their feelings and as a source of respite for them and their family. Given that for people with BPD some of the common features such as self-harm may serve a function of trying to avoid aversive feelings (Gratz and Roemer, 2008; Hulbert & Thomas, 2010) it is understandable that this may also be goal of hospital. Some of the participants noted that they could not escape their feelings in hospital, which may be part of the reason they wanted to leave after a short time. Conversely, participants' experience of being able to be discharged very soon after a suicide attempt, left them feeling unsafe and let down by clinicians. This was because they felt clinicians should be protecting them by using their clinical judgement rather than simply taking what they say at face value, perhaps alike to protective parents. It may be partly that this relates to those interpersonal problems noted above around effective communication and realistic expectations of clinicians' ability to understand their needs without their expression. However, these nuances may also not be recognised, because there can be such a drive to get people with BPD out of hospital quickly (Krawitz, Jackson, Allen, Connell, Argyle, Bensemann & Mileshkin 2004) as it is argued that shorter admissions are more appropriate for people with BPD, due to fears about increased dependence (Linehan et al 1994) and due to the financial implications (Burgess, & Hockenberry, 2014). Two of the participants had an experience of residential alternatives with different models of care, which enabled greater collaboration and empowerment for the service user and was experienced as more therapeutic than an acute setting. This is in-line with other research which suggests residential alternatives are preferable because of the greater amount of time staff could spend with them service users (Lloyd-Evans, Johnson, Morant, Gilburt, Osborn, Jagielska, & Slade, 2010) and that service users felt they had more autonomy over their care (Osborn, Lloyd-Evans, Johnson, Gilburt, Byford, Leese, & Slade, 2010).

4.6 Evaluation

The research has a number of strengths and limitations which will now be discussed.

It is an important piece of research as it captures the experiences of an often stigmatised and misunderstood group of individuals. I was very impressed by the honesty of many of the participants who gave very insightful and open responses to the questions. This provided many themes which could have been used to write different papers, such as around diagnosis, and recovery. It may be beneficial for future IPA studies to focus on those topics to provide greater depth, as they were of importance for the participants.

4.6.1 Limitations of method

As an idiographic approach was utilised these results are not directly generalizable However, this was balanced against the richness of the data achieved from the depth of analysis that an IPA study allows.

4.6.2 Recruitment

The recruitment sampling frame was diverse, as care coordinators were approached across different trusts, in different areas of the country. As purposive sampling was utilised there may have been a selection bias in those participants who were approached by CC's and those who wanted to take part in the research. There were difficulties with recruitment which led to such a wide sampling pool being approached. It is difficult to ascertain why the recruitment process was so challenging. It may have been due to a number of reasons such as not spending enough time developing relationships with the CC's. However, three of the participants were recruited from the lead of a specialist team which supported people with personality disorders. This could possibly suggest that the success of recruitment in that team was owing to the way people with BPD are understood. An understanding of clinicians' positivity or hesitancy towards putting service users forward for research may be of interest, as other research has found it difficult to gain access to people with BPD (Breeze, & Repper, 1998).

4.6.3 Participants

A homogenous sample of participants is important within an IPA study (Smith et al., 2009), which will be given consideration here. One of the participants (Sandra) did not have the BPD diagnosis. This could have led to some diversity in how she thought about her problems, particularly in answering the questions about diagnosis. Two of the participants (Lindsay and Sally) had comorbid diagnoses of other more enduring mental health problems (Schizophrenia and Cyclothymia), which may have made them more diverse in how they made sense of their experiences. However, Lindsay's previous diagnosis of schizophrenia allowed her to reflect on how having different diagnoses affected her treatment, which added an extra layer of richness to her interview. There was diversity in the amount of admissions the participants had in a lifetime, with around half of the participants (n=4) having had frequent admissions over the past 10 to 15 years, but the other half (n=3) had only begun to have admissions in the past couple of years. This may have an impacted upon the homogeneity of the group. However, they all had a similar number of admissions within the last year. There was some diversity in age range, although the majority were homogenous, in being in the 35-45 age range. It is a limitation that there was not precise information gathered about the type of admission (voluntary or section) and the exact number of admissions that the participants had throughout their lifetime. The reason why this is a limitation is because these potential differences may have accounted for any variants in the data and may have been useful in interpreting some of the responses.

4.6.4 Reflections on my interviewing style/reflection

On reflection of my own experience of undertaking this research, it was difficult in some respects to go from trainee clinical psychologist to the role of research interviewer as I needed to ensure that I was interviewing from a researcher's perspective and not that of a psychologist. This meant not interpreting and reflecting within the interview itself. Undertaking a practice interview and undertaking brief training in IPA helped with transitioning to this different role. I also found it helpful to use a reflexive journal to track preconceptions and be aware of my initial reflections. I think limited experience in working with this service users group enabled me to try to keep an open mind and understand their experiences, from their perspective. From the experiences I did have in working in mental health services and hearing the narrative some professionals gave about people with BPD, the participants experiences of being stigmatised did not surprise me. Listening to their stories of repeated rejection was very difficult to hear at times and it was important to seek my own supervision around this. I had expected there to be a much greater focus about the role of services acting as attachment figures for the service users and the interplay of their relational patterns in understanding this research. However, the limitations of services in their ability to respond to the needs of these service users seemed to be experienced as a stronger, more distinct theme, than I would have predicted before undertaking this research. The lack of sample validation may affect validity of the interpretations of the results. However, the use of peer and supervisor review did help with this somewhat.

4.7 Clinical recommendations

The following recommendations, (table 5), have arisen directly from the results and the aim is to inform clinicians and service providers about ways that the quality of life, and treatment plans can be enhanced to better meet the needs of service users with BPD. It is important to note that clinicians are limited somewhat in the changes they may be able to make, due to constraints and pressures on services/resources. However, it is aimed that this research and recommendations will help to provide a dialogue of hope and positivity which may help support the way people with BPD are approached by services. Further, it is hoped that any resources invested into developing the recommendations below will also be more than repaid financially, through a reduced need for repeated inpatient admissions.

Table 5: *Clinical recommendations*

The research found:	**1) Clinical recommendations for clinicians in their practice**
1a) Diagnosis of BPD is not deemed to be a problem per se, but it is how this is communicated which is noted to be important.	1a) BPD diagnosis should be communicated with a message of hope about the possibility of positive change and with information about effective treatments.
1b) Participants often felt their needs were not being taken seriously, which sometimes led them to communicate in more extreme ways in order to have their needs recognised.	1b) In any interactions with people with BPD any needs expressed should be validated in a responsive and timely manner.
1c) Overall participants felt that this experience of rejection and being dismissed carried on throughout their inpatient admission which was not experienced as therapeutic.	1c) During an inpatient admission, the team should aim to take into account a person's formulation as a way of understanding them and not just their diagnosis. This may enhance the teams' ability to make sense of the person's problems and functions of their behaviour, to increase team empathy and reduce staff burn out. It may be that reflective practice groups and supervision will help in supporting this.
The research found:	**Recommendations for clinicians and service providers:**
2a) Participants often felt out of control of all aspects of their care and that they were not communicated with equally.	2a) All interactions with service users should be aimed to be carried out in a way which empowers them, through giving them choices and enabling them to express their feelings. Some of these changes need to be from a system level, in such things as providing an alternative residential provision which can allow for less restrictive environment and more time for the staff to be able to collaborate with the service users.

2b) Participants identified they wanted support in being able to help themselves to increase independence in the community. There was also some emphasis about the importance of having a consistent member of staff that trust could be built up with.	2b) Empowerment may be achieved by developing of a collaborative plan with the service users, as part of a transitional discharge process. This could include actions about how to implement supportive empowerment into the community and integration into activities that help them to be a part of a wider social organisation outside of mental health services. Ideally there will be 'in-reaching' onto the ward from a member of staff, such as a CC in the community, who could also support that person whilst admitted and help to develop a smoother transition process to enhance continuity. Support in the community should aim to offer skills which help the person to feel more in control of their overwhelming emotions, such as access to DBT; Solution Focused approaches and Compassion-Focused approaches.
Participants identified that part of the difficulty they experienced was due to gaps in available support services and with adequate staffing, which left them feeling there were no therapeutic intervention.	More staffing is needed in all parts of the mental health service from admission into the community to enable staff to spend time with service-users and for there to be consistency in this.
Participants expressed that clinicians may misunderstand the service users' sense of control when in crisis and their need for support.	Although this may be partly a result of the constraints on time and pressures of the services the clinicians work in, it will also be helpful for staff to have greater training and supervision/reflective spaces. As this may improve understanding of people with BPD and clinicians own reactions to them.

4.8 Research recommendations

From this study there also can be recommendations for future research which is required which are discussed below in Table 6.

Table 6: *Future research recommendations*

The research found	Future research recommendation
The participants had the experience of feeling rejected by services when they sought help.	Quantitative investigation in the following areas: i) the amount of people with a diagnosis of BPD seeking help from different services, such as primary care, secondary care, emergency and inpatient services. ii) If they received support from one of these services an assessment of how quickly they were able to access services. iii) If they could not access help what were the reasons for this. iv) What was the experience of people who only ever access the crisis or home-treatment team, without an admission?
Participants felt that many clinicians didn't understand their BPD and were very negative about the possibility of change.	It may be beneficial for there to be more in-depth exploration of what clinicians' understanding is of the BPD diagnosis and their awareness of which treatments are effective. It may be helpful to directly assess the impact of NIMHE, (2003) recommendations to ascertain how much it has been integrated into the curriculums of training for front-line professionals and where there still room for improvement.
The participants explained a sense of being out of control of their feelings when in crisis and separation from their sense of self.	This concept may be warrant further investigation in order to have a better understanding of this lack of control and possibly precipitating factors to it. This may be explored through qualitiative, quantiative and neuropsychological research. It may be that further concepts such as identity and how that changes as a person with BPD fluctuates in their sense of control could be helpful to assess.

Some of the participants had the experience of residential alternatives to inpatient settings, which had been experienced as positive.	More research is needed to gain an understanding of the effectiveness of different forms of residential alternatives to inpatient services and which models of care are the most effective for the specific needs of people with BPD.
Some of the participants had the experience of being empowered and more in control of their feelings through undertaking psychological therapies such as DBT	Further research will be useful to ascertain whether people with BPD are accessing the evidence-based treatments such as DBT and whether there is appears to have positive impacts on hospital admission rates.

4.9 Conclusion

There are many difficulties which have been highlighted by the service users in this study, which centre around participants' experience that clinicians do not understand or care about their needs and services are not designed in an appropriate way to meet them. Participants highlight the need for better bridging of care throughout mental health services, through continuity and empowerment of their needs to transition back into the community. Improvement in all of these areas will be beneficial to services financially and more importantly for the quality of life and recovery of these service users.

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III PUBLIC DOMAIN BRIEFING DOCUMENT

The research was conducted by Clare O'Grady as part of the Doctorate in Clinical Psychology at the University of Birmingham. The research was supervised by Dr Michael Larkin and Dr Eleni Theodosi. There are two chapters to this research project: a literature review and a research study.

The first chapter is a literature review which was carried out to assess the efficacy of 'early interventions' with adolescents with traits of Borderline Personality Disorder (BPD): 12 studies were found to meet the criteria of relevance for the study. The main outcome measures were borderline symptomology, which were in-line with characteristics used to diagnose BPD. Secondary measures were also included, which assessed other symptoms that were closely associated with BPD traits: suicidal ideation, suicidal attempts, para-suicidal behaviours, risk taking behaviours, hospital admissions, internalising (e.g. mood liability) and externalising behaviours (e.g. difficulties with attention). Factors which may help to explain the reason for any differences found in results (mediating factors) were also considered in some of the studies. Overall, the results from this review suggested that the evidence was too sparse at present to draw strong conclusions about whether any one intervention is favourable to another. A reduction in avoiding difficult emotions and increased ability to consider the thoughts and feelings of others were found to be mediating factors, but again, the evidence for this was limited owing to only two papers assessing these factors. More high quality studies are needed to assess the efficacy of these interventions, with outcome measures that are standardised and samples could include participants up to age 25, which is when adolescence is viewed to end from a developmental perspective.

The second chapter is a research study which sought to understand the experiences of females with a diagnosis of BPD who had frequently been admitted to psychiatric inpatient services. Frequent admission was defined as having two admissions within one year, any time with the past three years. Seven participants were interviewed and analysis was undertaken. Overall, participants often felt stigmatised by clinicians in mental health settings and they believed this generally led to difficulty accessing services and having their needs dismissed when they were in crisis. They experienced a sense of a sense of separation from themselves when in crisis, feeling very out of control and vulnerable. However, at times they noted that they would undertake risky behaviours such as self-harming in order to communicate their distress, as they found it to be the only way to have their concerns listened to. Participants also expressed feeling controlled in hospital in way which was not experienced as therapeutic, which often led to wanting to be discharged from the hospital sooner than they may have been ready for. There was a general sense that there was no care or therapeutic intervention in hospital or community owing to limited resources and clinicians not viewing them as worthy of care. There was posited to be no smooth transition from hospital into the community, which made it an unsettling process, as the differences were so stark in their freedom. Finally, participants made note of the limited sense of safety they experienced in the hospital and their sense of disappointment that clinicians discharged them swiftly, despite the fact they may have been in crisis until recently. Better experiences were centred on consistency of clinicians who helped them to empower themselves. It is hoped that this study will highlight the importance of relationships with clinicians that work with individuals with a diagnosis of

BPD; particularly in being able to contain a person in crisis and to provide better longer-term outcomes. A supportive transition from inpatient services to community, with a clear plan of support to empower the individual were posited to be of utmost importance. Additional research is needed to provide further weight to some of the key areas of interest discussed in this thesis.