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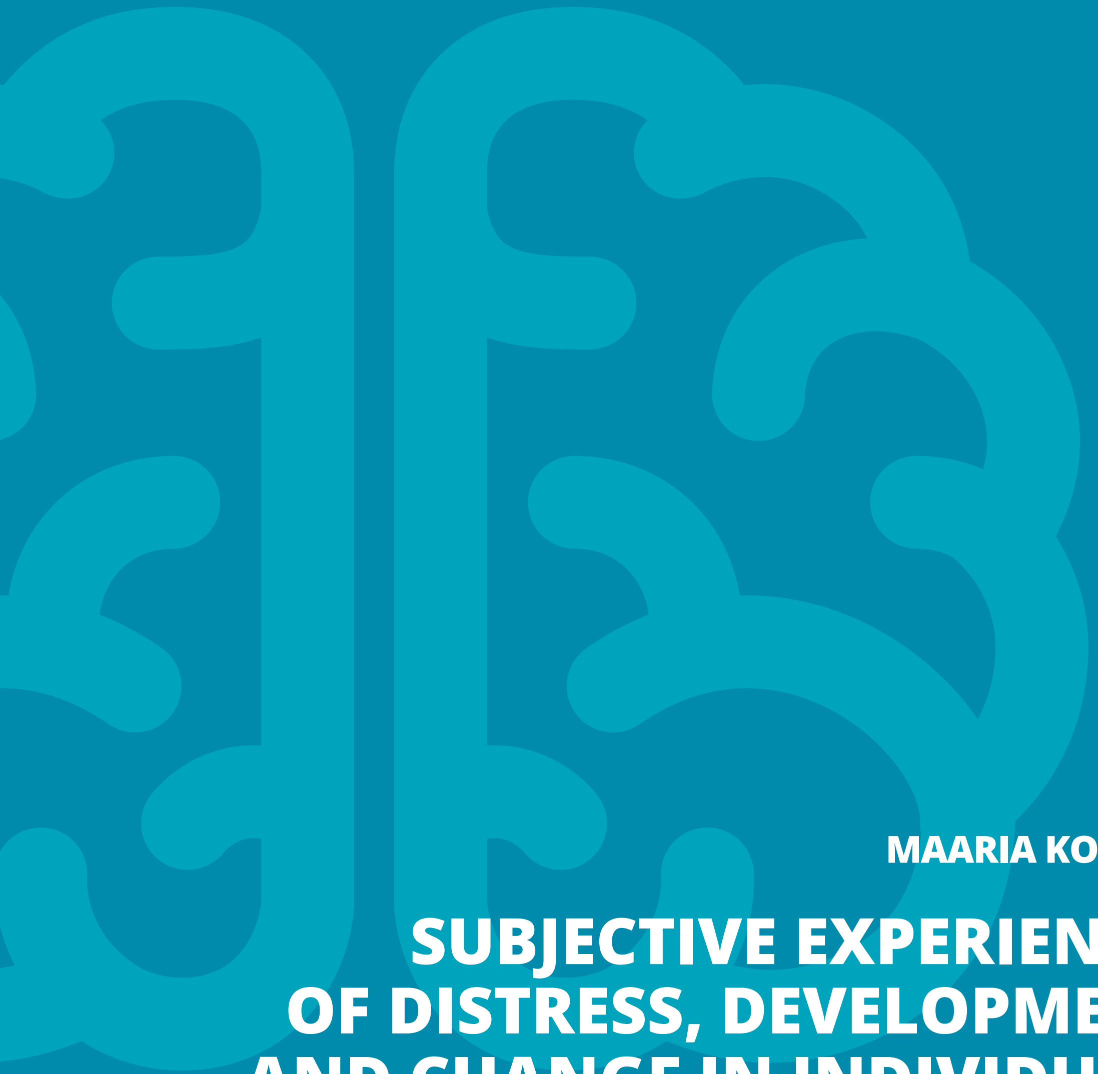

MAARIA KOIVISTO

SUBJECTIVE EXPERIENCES OF DISTRESS, DEVELOPMENT, AND CHANGE IN INDIVIDUALS WITH BORDERLINE PERSONALITY DISORDER

CONTENT-ANALYTIC STUDIES OF PATIENTS’ UTTERANCES

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ABSTRACT

Borderline personality disorder (BPD) is a complex developmental disorder that causes intense psychological pain. Already more than a decade ago, the National Institute of Health and Care Excellence research recommendations urged researchers to enquire service users about their perceptions of meaningful change within their recovery. Research into the first-person perspective of individuals attending mental health treatment may illuminate important aspects that researchers and therapists are unaware of.

The purpose of this study was to explore the personal experiences of distress, development and change in eight individuals with BPD in the context of a 40-session psychoeducational group intervention delivered at a community mental health care center. This naturalistic, mixed methods process–outcome study aimed, through interviews, to trace and describe participants' experiences of meaningful development and change and how they experienced the effect of treatment factors and events on their process. Change in BPD symptom scores was also assessed. These assessments were conducted at the end of the 40-session psychoeducational group intervention and 12 months thereafter.

Moreover, this thesis drew on the videotaped and transcribed group session data (40 sessions, each lasting two hours). Data was approached applying inductive content analysis.

When elaborating on what they had experienced as meaningful in their process of change, participants described the ability to observe, perceive with increased clarity and understand mental events in themselves and other people (i.e., enhanced mentalization/metacognitive functioning), improved ability to stay connected to their own emotions and an increased sense of personal agency. Change in the harsh, self-invalidating or punitive internalizations was experienced as particularly relevant to psychological growth. Conversely, a lack of change in this harsh, self-invalidating attitude towards the self was regarded as a key reason for stagnation or absence of change. With respect to treatment factors, the acquisition of information on BPD and helpful concepts through psychoeducation was reported to facilitate self-observation and organizing of individual perceptions. Participants described how acquisition of information on the development of BPD also facilitated their more compassionate self-understanding. The opportunity to learn from and with peers, a unique asset of group treatment, was perceived as extremely meaningful. Peer experiences were also reported to affect the deep-ingrained sense of self as fundamentally flawed. Regarding interfering factors, aggression in the group was found to hamper a helpful process.

The findings indicated that self-invalidation was a devastating vulnerability relevant to BPD and highlighted the importance of achieving change in the harsh and judgmental attitude towards the self in treatment.

Keywords: Borderline personality disorder; identity; self-invalidation; metacognitive functioning; qualitative research

Medical Subject Headings: Borderline Personality Disorder; Metacognition; Mentalization; Personality Development; Psychotherapy; Qualitative Research

Koivisto, Maaria
Epävakaasta persoonallisuudesta kärsivien kokemuksia psykologisesta kivusta, kehityksestä ja muutoksesta: sisällönanalyyttisiä tutkimuksia
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TIIVISTELMÄ

Epävakaa persoonallisuushäiriö on monimutkainen, kehityksellinen mielenterveyden häiriö, josta aiheutuu merkittävää psykologista kipua. Jo yli vuosikymmen sitten National Institute of Health and Care Excellence (NICE) kehotti tutkijoita kartoittamaan palveluiden käyttäjien kokemuksia siitä, minkä he itse kokevat merkitykselliseksi toipumisessaan. Mielenterveyspalveluita käyttävien yksilöiden kokemusten tutkiminen voi valottaa tärkeitä puolia, joita tutkijat tai psykoterapeutit eivät välttämättä tunnista.

Tämän psykoterapian prosessi-tulostutkimukseen lukeutuvan tutkimuksen tarkoituksena oli selvittää ja kuvailla kahdeksan epävakaasta persoonallisuudesta kärsivän ihmisen subjektiivisia kokemuksia psykologisesta kivustaan, kehityksestään ja muutoksestaan. Tutkimus oli naturalistinen, ja osana sitä tarjottiin 40 istunnon mittainen psykoedukatiivinen ryhmähoito, joka sisältyi psykiatrian poliklinikan tavanomaiseen hoitoon. Tutkimuksessa selvitti, mikä potilaille oli ollut merkityksellistä heidän kehityksensä ja muutoksensa kannalta sekä sitä, miten he kokivat hoidon ja siihen liittyneiden tekijöiden ja tapahtumien myötävaikuttaneen tähän kehitykseen. Tutkimuksessa mitattiin myös muutosta epävakaan persoonallisuuden oireissa hoidon päätyttyä sekä

vuoden kuluttua hoidon päättymisestä. Tutkimusaineisto koostui subjektiivisia muutoskokemuksia sekä oireita kartoittaneista haastatteluista ja videoiduista ja litteroiduista ryhmäistunnoista (40 kahden tunnin mittaista istuntoa). Tutkimusmenetelmänä oli induktiivinen sisällönanalyysi.

Löydökset osoittivat, että potilaat kokivat erityisen merkityksellisenä sen, että heidän kykynsä havainnoida, ymmärtää ja kuvailla sisäisiä kokemuksiaan vahvistui. He kokivat pystyvänsä paremmin ymmärtämään myös muiden ihmisten kokemuksia. Tämän tehostuneen mentalisaatiokyvyn/metakognitiivisen toiminnan ohella potilaat kuvasivat merkityksellisinä muutoksina parantunutta yhteyttä omiin tunnekokemuksiinsa sekä lisääntynyttä toimijuuden kokemusta. Erityisen ratkaisevana psykologisen kasvunsa kannalta he kokivat omatoimisen itsemitätöinnin ja itseä tuomitsevan, rankaisevan suhtautumistavan vähenemisen. Vastaavasti silloin kun toivottu muutos jäi saavuttamatta, potilaat selittivät sitä nimenomaan jatkuvalla omatoimisella itsemitätöinnillä ja vaikeudella saada etäisyyttä sisäistettyyn ankaraan, rankaisevaan suhtautumistapaan suhteessa itseen. Hoitoon liittyvistä tekijöistä korostui tiedon saaminen epävakaasta persoonallisuudesta. Psykoedukaation tarjoamat käsitteet koettiin hyödyllisinä niiden helpottaessa itsehavainnointia ja omien kokemusten jäsentämistä. Epävakaan persoonallisuuden kehittymistä koskevan tiedon saamisen koettiin lisänneen itseymmärrystä ja -myötätuntoa. Erityisen merkityksellisenä potilaat kokivat mahdollisuuden yhteisölliseen oppimiseen ja yhteistyöhön vertaisten kanssa eli ryhmämuotoinen hoito vaikutti tarjoavan ainutkertaisia etuja. Vertaiskokemusten koettiin myös muokanneen aiempaa minäkäsitystä, kuten syvälle juurtunutta käsitystä itsestä perustavaa laatua olevalla tavalla viallisena. Toisaalta aggressio ryhmässä nousi esiin keskeisenä hoitoa ja potilaiden kehitystä häirinneenä tekijänä.

Löydökset osoittivat, että omatoiminen itsemitätöinti on epävakaaseen persoonallisuuteen liittyvä merkittävä haavoittuvuustekijä. Hoidon kohdentaminen siihen sekä ankaraan, tuomitsevaan ja rankaisevaan suhtautumiseen suhteessa itseen vaikuttaa olennaiselta.

Avainsanat: Epävakaa persoonallisuus, identiteetti, omatoiminen itsemitätöinti, metakognitiiviset toiminnot, laadullinen tutkimus

Yleinen suomalainen ontologia: tunne-elämältään epävakaa persoonallisuus; persoonallisuushäiriöt; tunne-elämän häiriöt; metakognitio; identiteetti; psykoterapia; kvalitatiivinen tutkimus

To the memory of my grandparents

You can't mentalize unless

you can trust your own thoughts.

Johnson, E. L., Mutti, M.-F., Springham, N., & Xenophontes, I. (2016). Mentalizing after mentalization based treatment. *Mental Health and Social Inclusion, 20*, 1, 44–51.

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Helsinki, 7 August 2022
Maaria Koivisto

LIST OF ORIGINAL PUBLICATIONS

This dissertation is based on the following original publications:

I Koivisto, M., Melartin, T., & Lindeman, S. (2021). “If you don’t have a word for something, you may doubt whether it’s even real” – how individuals with borderline personality disorder experience change. *Psychotherapy Research, 31*, 7–8, 1036–1050*.* https://doi.org/10.1080/10503307.2021.1883763

II Koivisto, M., Melartin, T., & Lindeman, S. (2022). Self-invalidation in borderline personality disorder: A content analysis of patients’ verbalizations. *Psychotherapy Research. Published online 12 Jan 2022.* https://doi.org/10.1080/10503307.2022.2025627

III Koivisto, M., Melartin, T., & Lindeman, S. Processing of self-concept and identity in individuals with borderline personality disorder: findings from a content-analytic follow-up study. *European Journal for Qualitative Research in Psychotherapy*. In press.

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CONTENTS

ABBREVIATIONS

ADHD	Attention-deficit/hyperactivity disorder
APA	American Psychiatric Association
BPD	Borderline personality disorder
BPDSI	Borderline Personality Disorder Severity Index
BPO	Borderline personality organization
CAT	Cognitive analytic therapy
CBT	Cognitive behavior therapy
CLPS	Collaborative Longitudinal Personality Disorder Study
DBT	Dialectical behavior therapy
DSM	Diagnostical and Statistical Manual of Mental Disorders
ERGT	Emotion regulation group therapy
GAF	Global Assessment of Functioning
GAS	Goal Attainment Scale
GPM	General psychiatric management
HPA	Hypothalamic-pituitary-adrenal axis
ICD	International Classification of Diseases
MBT	Mentalization-based therapy
MSAD	McLean Study of Adult Development
NESARC	National Epidemiologic Survey on Alcohol and Related Conditions
NICE	National Institute for Health and Care Excellence

PD	Personality disorder
PTSD	Post-traumatic stress disorder
RCT	Randomized controlled trial
SI	Self-invalidation
SSDI	Social security disability income
ST	Schema therapy
STEPPS	Systems Training for Emotional Predictability and Problem Solving
SUD	Substance use disorder
TAU	Treatment as usual
TFP	Transference-focused psychotherapy

1 INTRODUCTION

1.1 OBJECTIVES, SCOPE, AND PARADIGM OF THIS STUDY

The purpose of this mixed methods process–outcome study was to explore the personal experiences of distress, development, and change in eight individuals with borderline personality disorder (henceforth BPD) in the context of a psychoeducational group intervention delivered at a community mental health care center. This study also assessed changes in BPD symptoms.

1.1.1 Perspectives on illness and recovery: broadening the paradigm

Mental health recovery is a complex construct, comprising many interconnecting processes and outcomes (Winsper, 2021; Winsper et al., 2020). In a medical meta-model (Wampold & Imel, 2015), the term ‘recovery’ connotes rehabilitating *from* something, often referring to removing symptoms of a disorder and thereby yielding clinical remission. Self-harm and suicidal behavior are examples of such symptoms, the occurrence of which is often monitored in the context of trials involving individuals with BPD. This is how recovery from BPD has predominantly been viewed, viz., in terms of symptom improvement and no longer meeting diagnostic criteria (Ng et al., 2019).

From a personal point of view, however, recovery is often experienced as a process. According to the recovery-oriented perspective, it involves functional (e.g., employment), existential (e.g., self-determination), and social (e.g., social support) domains. These different domains are considered equally important (Whitley & Drake, 2010).

We may benefit from a broad way of looking at illness and recovery. Breadth of the paradigmatic scope may be particularly relevant when aiming to better understand change in complex, developmental disorders, of which BPD is one example. Unsurprisingly, methodological plurality is also advised when studying complex phenomena, including psychotherapy processes. Applying complementing paradigms may be particularly necessary if we endeavor to illuminate the process aspects of recovery, or personally meaningful change (Blatt et al., 2006; Elliott, 2010; Morken et al., 2019a).

1.1.2 Current understanding of change in psychotherapy

To date, it is well established that psychotherapies are effective at treating mental disorders, including personality disorders (hereafter, PDs) (Cristea et al., 2017; Cuijpers et al., 2019). However, demonstrating *that* a therapy is effective at treating a mental disorder does not provide evidence about *why* or *how* it works (Boritz et al., 2019; Cuijpers et al., 2019; Kazdin, 2009). Little is still known about how improvement in psychotherapy is achieved; little progress has been made in elucidating the mechanisms of change. The most common lament in reviews of psychotherapy research is indeed the notable lack of progress in identifying change mechanisms in psychotherapy (Silberschatz, 2017). Kazdin (2009) points out that despite thousands of studies, “there is no evidence-based explanation of how and why even the most well-studied interventions produce change, that is, the mechanisms through which treatments operate”. This knowledge gap pertains to both psychotherapy in general (Silberschatz, 2017) as well as treatment of BPD (Katsakou & Pistrang, 2018).

Examining why or how a therapy works is completely different from examining that it works. Additionally, showing how a therapy works is much more complicated than showing that it works (Cuijpers et al., 2019). Demonstrating a causal relationship between two variables is difficult since there are multiple potential confounding factors in the context of extremely complex, multifactorial endeavors, such as psychotherapy (Llewellyn et al., 2016). This lack of knowledge concerning the “how” question has resulted in different views and models of how therapies work, the so-called ‘mechanisms of change’ or action, but none of these models have sufficient empirical support (Cuijpers et al., 2019).

The question of how a specific treatment produces effects can be studied from a number of approaches. Change process research entails identifying the therapist-level and client-level processes that lead to change in symptoms (Greenberg, 1986). This research can be conducted through the study of significant events in psychotherapy, the microanalysis of both parties' in-session behaviors, or through quantitative statistical designs (Boritz et al., 2019), including the analysis of moderated mediation (Cuijpers et al., 2019). Mediation analyses are the most common approach used to study causal relationships between processes and outcomes in psychotherapy (Nock, 2007). Mediation analyses determine the relationship between interventions, outcomes, and intermediate variables by assessing whether the relationship between the intervention and outcome is significant after variance on the intermediate variable is parsed out (Boritz et al., 2019). However, it needs to be kept in mind that a mediator is a construct that demonstrates a statistical relationship between an intervention and on outcome. Although mediation analyses are sometimes used as a proxy for mechanisms of change, mediators are not in and of themselves mechanisms of change. In contrast, mechanisms of change describe the pathways between mediators and outcome, the processes through which mediators lead to change, the reason why change occurred, or how it came about (Kazdin, 2007; Kazdin, 2009).

To understand what works for whom, how and under which circumstances, complementing research is needed. This research should focus not only on between-person variability but also on within-person variance (Cuijpers et al., 2019). Research that moves beyond aggregate designs to take into account individual variation (for instance, individual patients' needs and goals) and the context (for instance, patient perception of an intervention offered under specific circumstances) is needed since causal pathways of change are likely to differ between patients and to depend on contextual or situational factors (Silberschatz, 2017). Hence, in striving to explore the question above, we also need to go to the level of an individual patient and situation. The identification of critical processes of change is likely to be clinically relevant, since it can help therapists recognize and foster unique opportunities for patient change as they occur during psychotherapy (Elliott, 1983). The examination of such processes or events provides a direct window into what, in the eyes of patients, can facilitate or interfere with change. This, in turn, may yield more detailed understanding and, ultimately, improvement in psychotherapy (Castonguya et al., 2010). Understandably, the strength of evidence provided by this kind of process (or process-outcome) research will inevitably remain lower than in comparative outcome studies demonstrating that therapy works (Cuijpers et al., 2019).

1.1.3 My choice of paradigm

Already more than a decade ago, the National Institute of Health and Care Excellence research recommendations urged researchers to question service users about meaningful change within their recovery (NICE, 2009). My choice of paradigm follows from these recommendations.

In discussing their findings from a high-quality, prospective longitudinal study, Mary Zanarini and associates (2018b), leading researchers in the domain of PD research, posed the question: “Is recovery even a relevant outcome?” They proceed to answer: “It certainly seems to be in psychiatry and mental health care”. Alleviating psychopathology is indeed the primary focus of clinical interventions, such as psychotherapies (Wampold & Imel, 2015).

This thesis attempts to combine two perspectives: the service-users’ and the medical. Using qualitative methodology, the current studies aimed to give a voice to the patients by exploring their idiosyncratic experiences. Development and change are subjective and unique, often including deep experiences that constitute a complex trajectory. A major part of this study is dedicated to in-depth exploration of patients’ subjective experiences. In terms of methodology, I attempt to stay as close to the patients’ experience as possible. In endeavoring to commit to their lived experiences, I predominantly apply description over interpretation.

However, I also wanted to retain the medical perspective, that is, the quantitative assessment of symptom change. BPD is nevertheless a serious mental health condition, and the research subjects in this study were being treated at public mental health care services. Therefore, in addition to the first-person perspective of the patients, it appeared appropriate and necessary to assess whether symptoms of the disorder are affected. An asset of this kind of process–outcome design is that it enables the comparing and contrasting of subjective experiences and symptoms scores.

1.1.4 Research questions

This thesis comprises three studies. The research questions of the first study were the following: How do individuals with BPD experience their own central change processes at treatment end, i.e., shortly after participating in a psychoeducational group? When they experience change, what central change processes do they highlight? When they fail to experience change, how do they explain their lack of change? An additional aim of the qualitative part of the study was to explore how treatment-related factors were perceived to contribute to development and change. The research questions related to the perceived role of treatment factors were the following: How do patients experience the intervention as a group intervention? What elements of the intervention, or events during the intervention, do they find helpful or unhelpful, and how? Finally, the quantitative part of the study assessed change in BPD symptoms.

The second study drew on videotaped and transcribed group sessions (80 hrs). As the approach to the data was inductive, meaning that relevant themes were allowed to emerge freely from the data, the initial research question was: what emerges as the most poignant phenomenon from this data consisting of transcribed group sessions? Since the emerging phenomenon turned out to be self-invalidation, the second study addressed manifestations of it in group discussions.

The third study explored change at a 12-month follow-up. As the approach was inductive, the initial research question was: what emerges as the most pertinent phenomenon from the data consisting of in-depth interviews focusing on participants' first-person perspectives on their development? As self-experience and identity surfaced as themes of this data, the third study set out to explore: 1) how patients described their self-experience or identity 12 months post treatment, and 2) whether and how, compared to treatment end, self-experience or identity changed and was processed over the follow-up. Again, the quantitative part of the study assessed change in BPD symptoms.

2 LITERATURE REVIEW

2.1 GENERAL BACKGROUND

In the following section, I will review the history and development of the diagnosis of borderline personality disorder, as well as the etiology, prevalence, clinical picture, comorbidity, clinical course and prognosis, and psychosocial treatment of this disorder.

2.1.1 Borderline personality disorder

Borderline personality disorder (BPD) is a serious mental health condition associated with considerable psychological suffering (Stiglmayr et al., 2005; Zanarini et al., 1998), heightened risk of suicide, and impairment in social and occupational functioning (Leischenring et al., 2011; Storebø et al., 2020). The last 30 years have seen enormous progress in the treatment of BPD, as highly specialized treatment programs have been developed and tested in RCT designs (Cristea et al., 2017). Research has shown that symptoms of BPD are treatable, primarily by psychological, psychosocial, and relational approaches (Choi-Kain et al., 2017). That notwithstanding, the disorder remains highly stigmatized (Gunderson, 2009).

Development of the diagnosis

As an official psychiatric diagnostic concept, BPD is now over 40 years old. Reflecting the beginning of the era of descriptive psychiatry, BPD first appeared in the Diagnostic and Statistical Manual of Mental Disorders III (DSM-III) in 1980 (American Psychiatric Association, 1980). A decade later, this diagnosis officially entered the classification applied in Finland, i.e., the International Classification of Diseases (ICD-10; WHO 1993). In ICD-10, this condition is referred to as "emotionally unstable personality disorder" (F60.3). It is divided into two subtypes: impulsive (F60.30) and borderline (F60.31). The latter in particular shows essential overlap with the current DSM-5 criteria (Ottosson et al., 2002).

Historically, the identification of patients as “borderline” first arose in an era when the psychoanalytic paradigm dominated psychiatry. Back then, classification was tied to analyzability, meaning that patients with neuroses were considered analyzable, and therefore treatable, whereas those with psychoses were considered not analyzable, and therefore untreatable (Gunderson, 2009). Adolph Stern (1938) and Robert Knight (1953) were the two psychiatrists responsible for the introduction of the term ‘borderline’. Referring to the tendency of certain patients to regress into “borderline schizophrenia” states in unstructured situations, Stern and Knight gave initial clinical meaning and characterization to the borderline construct. Specifically, the category to which these “borderline”, regression-prone patients belonged to was schizophrenia (Gunderson, 2009).

In terms of construct refinement, the next steps were taken in 1967 when Otto Kernberg, a psychiatrist and psychoanalyst concerned with the boundaries of analyzability, defined ‘borderline’ as a middle level of personality organization bounded on one side by more severe patients exhibiting psychotic personality organization and on the other, by those having neurotic personality organization. Characterized by primitive defenses (including splitting and projective identification), identity diffusion, and lapses in reality testing, Kernberg’s definition of borderline personality organization was relatively broad (BPO; Kernberg, 1967). Hence, BPO refers to a significantly broader construct than the BPD construct delineated by later diagnostic criteria. Importantly, Kernberg also suggested that individuals with BPO could be successfully treated with psychoanalytic psychotherapy (Kernberg, 1968).

The following decades saw clarification of the boundaries of BPD with other mental disorders. The single most significant refinement occurred when the revised Diagnostic and Statistical Manual of Mental Disorder III (DSM-III-R; American Psychiatric Association, 1987) separated the initial broad construct of ‘borderline disorders’ into two: BPD and schizotypal personality disorder (SPD). However, before this separation, it had already become clear that BPD was not related to schizophrenia (Gunderson, 2009). Subsequently, the boundaries between BPD and affective disorders have been the focus of intensive research. The conclusion from this considerable body of clinical research was that BPD was not simply a variant of depression (Gunderson & Elliott, 1985; Gunderson & Phillips, 1991).

With the advent of DSM-IV (American Psychiatric Association, 1994), research already suggested that BPD was an internally consistent, coherent syndrome (Clarkin et al., 1993; Hurt et al., 1989). Since then, the diagnostic construct has undergone only modest modifications. Originally diagnosed according to eight criteria, the DSM-IV conceptualization remained relatively stable except for the addition of a ninth criterion (transient stress-related paranoia), the removal of intolerance of aloneness, as well as a few minor structural and wording refinements (American Psychiatric Association, 1994). In this era, bipolar affective and trauma disorders were the boundary issues of primary interest (Gunderson & Sabo, 1993; Hodges et al., 2003). This was, at least in part, due to the pejorative connotation and stigma attached to the BPD diagnosis. However, empirical data failed to support the suggestion that BPD and bipolar disorders existed on a spectrum but allowed for the possibility of partially overlapping etiologies (Paris et al., 2007). Similarly, despite the link between psychological trauma and BPD, merely stating that BPD is a complex form of PTSD remained problematic (Lewis & Grenyer, 2009). According to Gunderson (2009), BPD's unclear boundaries remind us of the unwanted truth that psychiatric disorders are heterogeneous and have flexible boundaries.

With the advent of DSM-5 (American Psychiatric Association, 2013), it already seemed fair to conclude that BPD's internal coherence and integrity stood on firm ground (Fossati et al., 1999; Johansen et al., 2004; Sanislow et al., 2002; see also Gunderson, 2009). Criteria for categorical BPD diagnosis remained unchanged in DSM-5 (American Psychiatric Association, 2013). An important addition, however, was the inclusion of a new approach, viz., an alternative model for personality disorders. This model was developed with the aim to address the shortcomings of the prior approach to PDs, including the fact that patients typically meet criteria for more than one PD. Moreover, while representing an uninformative diagnosis, the 'other specified' or 'unspecified' PD category is often the correct diagnosis. Hence, DSM-5 contains two diagnostic approaches, the former categorical one and an alternative, dimensional hybrid model that addresses personality functioning and personality traits. In the former, that is, personality functioning, two broad elements are assessed: self and interpersonal functioning. Both are further split into sub-elements, with self-functioning consisting of identity and self-direction, and interpersonal functioning consisting of empathy and intimacy. In the latter, viz., personality traits, the five domains evaluated are: negative affectivity vs. emotional stability, detachment vs. extraversion, antagonism vs. agreeableness, disinhibition vs. conscientiousness, and psychoticism vs. lucidity. Each of these domains includes sub-facets.

Importantly, BPD will be the sole specific personality disorder to be carried forward to the upcoming ICD-11 (WHO, 2018), intended to be in effect from 2022. In accordance with DSM-5, ICD-11 is also moving towards a dimensional approach where different types of personality disorders are being replaced by a model that focuses on the severity of core personality functioning instead (Storebø et al., 2020). Preliminary studies suggest a substantial overlap between the current categorical and alternative models in DSM-5 (Bach & Sellbom, 2016; Bach & First, 2018; Sellbom et al., 2014), as well as between the dimensional models of DSM-5 and ICD-11 (Bach & First, 2018).

Current understanding of etiology

BPD can be attributed to psychosocial and biological factors (such as temperament) that are assumed to interact in a complex way (Doering, 2019; Storebø et al., 2020). Literature indicates that BPD tendencies are influenced roughly equally by additive and nonadditive genetic (35% – 50%) and nonshared environmental (50% – 60%) sources (Distel et al., 2008; Distel et al., 2009; Kendler et al., 2008; Kendler et al., 2011).

In terms of psychosocial adversity, over 90% of subjects with BPD report exposure to abuse and/or neglect during childhood (Battle et al., 2004; Zanarini et al. 1997; Zanarini et al., 2002). Compared to patients with other PDs, patients with BPD report substantially more adverse events, or circumstances (Yen et al., 2002) including verbal, emotional, and physical abuse, and neglect by both their caretakers (Zanarini et al., 2000). The only prospective, longitudinal, community-based cohort study to examine PD symptoms from childhood to adulthood indicated that low parental affection and aversive parental behavior in the early years of development substantially increased the risk of BPD in adulthood (Johnson et al., 2006). Similarly, research has established a robust association between BPD and insecure attachment (Agrawal et al., 2004). Regarding psychosocial adversity, BPD is diagnosed at a higher percentage rate among those who come from families with lower incomes (Tomko et al., 2014).

With respect to temperament, research has robustly associated high negative affect, low effortful control, low agreeableness, and low conscientiousness with BPD (Jovev et al., 2013; Joyce et al., 2003; Paris, 2005; Saulsman & Page, 2004). Particularly, temperament extremes are associated with PDs (De Fruyt et al., 2006; Jovev et al., 2013). Despite considerable estimated heritability for the disorder, so far, a direct role of genetic polymorphisms has not been found (Amad et al., 2014). It is proposed that it may not be BPD itself that is genetically determined, but rather endophenotypes predisposing for the disorder, i.e., impulsivity, aggression, affective dysregulation, or emotional information processing (Siever, 2005). These genetic vulnerabilities then interact with environmental influences, and these interactions probably shape biological abnormalities and neuropsychological impairment, finally yielding symptoms of BPD (Amad et al., 2014).

A variety of neurobiological alterations have been identified in BPD. Firstly, alterations in central nervous system structure and function have been found. Secondly, neuroendocrine dysfunctions, exerting possible later influence on psychosomatic and somatic disorders, also occur. More specifically, neuroimaging studies consistently reveal that individuals with BPD show increased amygdala activity in combination with decreased activity of dorsolateral prefrontal brain regions (Krause-Utz et al., 2014; Schulze et al., 2016). However, the exact molecular nature of this fronto-limbic network dysfunction needs clarifying (Leischenring et al., 2011). Moreover, increased sympathetic activation and decreased parasympathetic activation is found in BPD. Findings from a meta-analysis suggest that lowered resting state vagal tone may be an important trait characteristic underlying BPD (Koenig et al., 2016). In terms of neuroendocrine alterations, BPD has been associated with altered hypothalamic-pituitary-adrenal (HPA) axis functioning. Evidence is, however, inconsistent, and a recent meta-analysis suggests that individuals with BPD display a complex picture of HPA axis dysfunction. More specifically, the findings of this meta-analysis show augmented continuous cortisol output but blunted cortisol responses to psychosocial challenges (Drews et al., 2019). The causes of this complex picture remain unclear; hypotheses have nonetheless been put forward.

Current theories conceptualize the development of psychopathological outcomes as due to the summative effects of risk and protective factors (Rutter, 2006), or individual sensitivity to positive and negative environmental influence (Ellis et al., 2005). That is, it is hypothesized that sufficiently positive factors might ameliorate or even counterbalance adverse ones. These findings suggest that children with a high capacity for self-regulation and interpersonal affiliation might be protected from developing future psychopathology, even in the presence of adverse childhood environments (Jovev et al., 2013).

Prevalence

The prevalence of BPD in the general population has been assessed in large-scale studies with strong methodology, and this research has yielded a point prevalence ranging from 0.7% to 3.5% (Coid et al., 2006; Jackson et al., 2000; Lenzenweger et al., 2007; Moran et al., 2006; Quirk et al., 2017; Tomko et al., 2014; Ten Have et al., 2016; Torgersen et al., 2001; Winsper et al., 2020). Among primary care patients, BPD occurs in 6% (Aragonès et al., 2013; Dubovsky et al., 2014; Gross et al., 2002; Hueston et al., 1999). In clinical populations, BPD is substantially more prevalent. Among psychiatric outpatient services, it is estimated to occur in one out of four (Korzekva et al., 2008; Lana et al., 2008). However, it may remain underdiagnosed (Melartin et al., 2009). No reliable estimate is available for the prevalence of BPD among psychiatrically hospitalized patients (Borderline Personality Disorder: National Finnish Treatment Guideline, 2020).

Recent research suggests that BPD usually begins in childhood, and that younger people are affected as much as, or even more than, adults (Neacsiu et al., 2017). There is ample evidence to suggest that the diagnosis of BPD is valid in adolescence (Winsper et al., 2016). When adolescents are included in studies exploring the prevalence of BPD, it is found to peak at around 14 to 17 years with a linear decline into adulthood (Storebø et al., 2020). Studies delimiting to adult populations demonstrate a different profile, that is, a decline in prevalence after the age of 30 (Tomko et al., 2014). Nonetheless, BPD continues throughout lifespans and can also be found in older individuals (Chanen et al., 2007; Newton Howes et al., 2015; Sharp & Wall, 2018; Videler et al., 2019).

An early meta-analysis of clinical studies showed that females constitute 76% of individuals with BPD (Widiger & Trull, 1993). However, most research into the prevalence of BPD in the general population fails to confirm this gender difference (Grant et al., 2008; Lenzenweger & Willett, 2007; Ten Have et al., 2016; Tomko et al., 2014; Torgersen et al., 2001). A study with a large representative sample even found a higher weighted prevalence of BPD in males compared to females (1% vs. 0.4%; Coid et al., 2006). While reasons for the discrepancy between the prevalence in the general population vs. prevalence in clinical population await explanation, cogent hypotheses have been put forward. For instance, Sansone and Sansone (2011), as Skodol and Bender (2003), posit that the reason for the discrepancy may lie in sampling. More specifically, women with BPD are more likely to be over-represented in mental health services in which many psychiatric studies are conducted, whereas men with BPD are more likely to be over-represented in substance abuse treatment programs and/or jails but under-represented in mental health services (Sansone & Sansone, 2011; Silberschmidt et al., 2015). This is largely due to different comorbidities, since compared to women with BPD, men with BPD more often suffer from comorbid substance use disorders and antisocial personality disorder. Evidence concerning the other possible explanation, viz., clinician bias, is mixed (Sansone & Sansone, 2011).

Clinical picture

The nine DSM criteria of BPD seem to indicate a statistically coherent construct (Sanislow et al., 2002). Despite statistical and construct coherence, BPD is a heterogeneous diagnosis. This is reflected in the fact that with nine DSM criteria and a threshold of five criteria required for a diagnosis, 151 theoretical possible combinations filling these criteria exist (Skodol et al., 2002; Oldham et al., 2006). Thus, two individuals sharing a diagnosis of BPD may have only one criterion in common. This suggests that there may be subtypes among BPD sufferers (Leischenring et al., 2011).

Since factor analytic studies have established both a one-factor model and a three-factor model (disturbed relatedness, behavioral dysregulation, and affective dysregulation), an underlying multidimensional structure of BPD, consisting of three homogeneous components, might exist (Sanislow et al., 2002). Hence, disturbed relatedness, behavioral and affective dysregulation can represent BPD's overall symptom dimensions.

On behavioral dysregulation, self-mutilation is extremely common, occurring in 90% of BPD patients during their lifetime (Goodman et al., 2017; Zanarini et al., 2008). Among adolescent in-patients with BPD, self-mutilation is even more prevalent (95%; Goodman et al., 2017). Suicidal behavior is reported to occur in up to 84% of individuals diagnosed with BPD (Goodman et al., 2012; Soloff et al., 2002), with an average of 3.3 suicide attempts per patient (Soloff, ym. 2000; Brodsky, ym. 1997). Between 5% and 10% will eventually take their own life (Black et al., 2004; Temes et al., 2019; Tidemalm et al., 2005; Zanarini et al., 2003; Zanarini et al., 2008). Findings from a prospective, longitudinal study with long follow-up and strong methodology have importantly shaped our current understanding of suicide risk in BPD; this estimate has decreased from the previous 10%.

According to leading researchers and theorists in the field, a key feature of BPD is the intense inner pain the individual lives with on a chronic basis (Fertuck et al., 2016; Zanarini, 2008; Zittel Concklin & Westen, 2005). This core pain often consists of a sense of being aggrieved that is difficult, though not impossible, to assuage (Zanarini & Frankenburg, 1994; Zanarini et al., 2003). According to Zanarini (2008), this pain to a large extent represents lost loves that have gone awry. It may even constitute part of the individual's identity. Zanarini also describes how individuals with BPD are devoted to this pain, often insisting that others, too, pay attention to it. Eloquently, she also discusses BPD sufferers' dual attitudes towards this suffering: on the one hand, they desperately need others to acknowledge and validate the unique depth of this suffering (Zanarini et al., 1990), but on the other, they feel ashamed of it (Zanarini, 2008).

The inner psychological pain also encompasses a negative self-view (Fertuck et al., 2016) and low self-esteem (Korn et al., 2016; Lynum et al., 2008; Roepke et al., 2011; Winter et al., 2018), shame (Karan et al., 2014; Rüsch et al., 2007), self-stigma (Grambal et al., 2016; Quenneville et al., 2020; Rüsch et al., 2006), and a high degree of self-blame and self-neglect combined with reduced self-love (Klein et al., 2001). Zanarini also proposes that a harsh superego characterizes the inner experience of individuals with BPD (Zanarini, 2008).

Another central facet of BPD consists of efforts that individuals make to either hide their pain or express it (Zanarini, 2008). In psychotherapy, these efforts are often conceptualized as coping strategies (e. g., Young et al., 2003). Some of these efforts are behavioral and impulsive in nature. In addition to overt self-destructive strategies that are often regarded as the most alarming, substance abuse, promiscuity, and disordered eating are also common and, ultimately, often destructive. Many coping strategies are interpersonal in nature. Individuals with BPD may actively search for the restoration of their past, i.e., for lack of validation or love gone awry, believing that restoration is possible and will make them whole. According to Zanarini, they unfortunately often look for this restoration in all the wrong places (Zanarini, 2008), ending up in vicious cycles where previous traumatic invalidation is repeated in the present.

Comorbidity

BPD is highly comorbid with axis I and axis II disorders in both clinical and community samples (Coid et al., 2006; Lenzenweger et al., 2007; Tomko et al., 2014). Even in community samples, BPD is rarely diagnosed alone

(Tomko et al., 2014). More specifically, 85% meet the criteria for at least one past-year axis I disorder, while 74 % meet the criteria for another lifetime axis II disorder (Grant et al., 2008; Lenzenweger et al., 2007; Tomko et al., 2014). BPD is most frequently associated with mood and anxiety disorders, substance use disorders (SUDs), eating disorders, attention-deficit/hyperactivity disorder (ADHD), and other specific PDs (Leischenring et al., 2011; Storebø et al., 2020; Tomko et al., 2014).

Some comorbidities are clinically highly relevant in their ability to affect the course and prognosis of BPD. One example of a particularly dangerous comorbidity is BPD along with an affective disorder or SUD, or both, as this combination is associated with heightened risk of successful suicide (Black 2004; Doyle 2016; Yen 2004). Moreover, Zanarini et al. (2004) reported that the absence of SUDs at a 6-year follow-up was the strongest predictor of the remission of BPD.

BPD’s extensive comorbidity with other psychiatric conditions raises the question of possible commonalities underlying these different disorders. The so-called common cause model (Durbin & Hicks, 2014) suggests that BPD traits and symptoms of comorbid disorders are derived partly from shared neurobiological influences. With respect to the BPD–MDD comorbidity, recent neuroimaging work suggests that variability in structure and function of the prefrontal cortex, anterior cingulate, hippocampus, and amygdala may represent a neurobehavioral risk factor for the development of neuroticism that has downstream effects on BPD and MDD comorbidity (see Bornovalova et al., 2018). With respect to externalizing disorders, extant research has established a strong link between PDs and SUDs (e.g., Sher & Trull, 2002; Trull et al., 2000). Possible shared pathways between PDs and SUDs include shared temperamental traits of emotional dysregulation (Chugani et al., 2020) and behavioral disinhibition (Bornovalova et al.,2005), shared genes (Bornovalova et al., 2018; Distel et al., 2012; Kendler et al., 2011), and certain neurotransmitters (see Smith & Cottler, 2020).

In addition to frequent psychiatric comorbidity, BPD also shows excessive comorbidity with somatic diseases (Doering, 2019). In a nationally representative sample, after adjusting for sociodemographic variables and common Axis I and II disorders, the presence of BPD was significantly associated with arteriosclerosis, hypertension, hepatic disease, cardiovascular disease, gastrointestinal disease, arthritis, venereal disease, and “any assessed medical condition” (El-Gabalawy et al., 2010). Accordingly, another prospective follow-up study that distinguished between “ever-recovered” and “never-recovered” BPD subjects found that failure to recover from BPD was associated with a heightened risk of chronic medical illnesses, adverse health-related lifestyle choices, and costly health services utilization. In this study, recovery was conceptualized to involve good social and vocational functioning in addition to symptomatic remission. The findings of this study indicated that after a decade of prospective follow-up, never-recovered subjects were significantly more likely than ever-recovered ones to suffer from a medical syndrome, obesity, osteoarthritis, diabetes, urinary incontinence, or multiple medical conditions. In terms of health choices, never-recovered subjects were significantly more likely to report daily pack smoking, weekly alcohol use, lack of regular exercise, daily sleep medication use, or pain medication overuse compared to ever-recovered subjects (Keuroghlian et al., 2013).

Clinical course and prognosis

For a long time, BPD was considered a chronic and untreatable disorder, although this belief has been challenged since the 1980s by four large-scale follow-back studies of the long-term course of BPD (McGlashan, 1986; Paris & Zweig-Frank, 2001; Plakun et al., 1985; Stone, 1990). More recent data from two large, well-designed prospective longitudinal studies, viz., the McLean Study of Adult Development (MSAD) and the Collaborative Longitudinal Personality Study (CLPS), also indicate a high remission rate in terms of symptom recovery. Reporting on the 10-year outcome of their samples, these landmark studies identified a very similar course, demonstrating that periods of symptomatic remission are extremely common. Specifically, the CLPS found that 85% of subjects with BPD achieved a period of remission that lasted at least 12 months. During the first year, the mean number of criteria met for BPD decreased from 6.7

(baseline) to 4.3. From then on, a steady decrease was observed at a rate of 0.29 criteria per year to a low of 1.7 at 10 years. Only 9% of patients with BPD remained stably disordered (≥5 criteria) at 10 years (Gunderson et al., 2011). Similarly, the MSAD found that 93% of BPD subjects achieved a period of remission lasting at least two years (Zanarini et al., 2010a). When the follow-up time was prolonged by six years, that is, reporting on 16-year outcomes, the MSAD found that 99% of BPD subjects had achieved a remission lasting 2 years or more *at some point* and that 78% of BPD subjects had achieved a remission of eight consecutive years (Zanarini et al., 2012). The above-mentioned outcomes are called *cumulative remission rates*, defined as the percentage of subjects who achieve a particular time-period of remission, i.e., 1 year in CLPS, or 2 years in MSAD, at some point during the longer follow-up (Zanarini et al., 2012).

Recently, a third prospective study, viz., the Pittsburg study that explored suicidal behavior in BPD found that 69% of BPD subjects achieved remission when followed for 10 or more years (Soloff & Chiappetta, 2019). This remission rate is lower compared to the CLPS and MSAD. One potential explanation for this finding is the lower socio-economic status of subjects in the Pittsburg study compared to those in the CLPS and MSAD (Soloff, 2019). Finally, Álvarez-Tomás et al. (2019) conducted a meta-analysis of studies reporting prospective results on the long-term course of BPD. Including both naturalistic and post-treatment follow-up studies, they concluded that 50-70% of subjects with BPD experience symptomatic remission within five or more years of prospective follow-up (Álvarez-Tomás et al., 2019).

Fluctuation in symptoms

The above-described encouraging findings notwithstanding, BPD seems to show a waxing and waning course, with alternating periods of symptom remission, and relapse (Álvarez-Tomás et al., 2019). Findings from the other landmark study, viz., the CLPS, indicated even short-term fluctuation in the amount and severity of PD features present or expressed at a given moment (Shea et al., 2002). Moreover, recurrences occur even after longer periods of remission. Findings from the CLPS indicate that 12% of those experiencing remission subsequently relapsed during the 10-year follow-up (Gunderson et al., 2011). In the MSAD, 30% of subjects who had attained a stable diagnostic remission lasting two years experienced a recurrence by the 10-year follow-up. (Zanarini et al., 2010a). When followed for additional six years, i.e., at a 16-year follow-up, cumulative rates of recurrence for BPD patients ranged from 36% after a two-year remission to 10% after an eight-year remission (Zanarini et al., 2012).

Symptomatic instability, even among subjects with good outcomes, is additionally supported by qualitative patient narratives (Soloff, 2019). Similarly, a meta-synthesis of qualitative studies exploring patients' experiences of illness and recovery describes improvement as a gradual and dynamic process, including steps forward as well as setbacks, as opposed to a linear one (Katsakou & Pistrang, 2018).

Level of functioning

To understand the research findings related to functional improvement in BPD, the concepts of 'remission' and 'recovery' first need to be clarified. Symptomatic *remission* is substantially more common than sustained *recovery* from BPD, if recovery is conceptualized to involve good social and vocational functioning in addition to no longer meeting the diagnostic criteria for BPD (e.g., Zanarini et al., 2012).

In the MSAD, the definition of recovery*,* or good psychosocial outcome, included a Global Assessment of Functioning score (GAF; American Psychiatric Association, 1987) of 61 or higher (i.e., "some mild symptoms or some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships"). For research purposes, this description of recovery was operationalized even further: "to be given this score or higher, a subject typically had to be in remission from his or her primary axis II diagnosis, have at least one emotionally sustaining relationship with a close friend or life partner/spouse, and be able to work or go to school consistently, competently, and on a full-time basis, including being a houseperson" (Zanarini et al., 2012). Compared to the MSAD, the CLPS defined good psychosocial functioning somewhat differently and by a GAF score of at least 71 (Gunderson et al., 2011). It states: “If symptoms are present, they are transient and expectable reactions to psychosocial stressors; no more than slight impairment in social, occupational, or school functioning” (First et al., 1996).

On the results pertaining to functional improvement (or lack thereof), it seems evident that good psychosocial functioning involving both social and vocational competence is difficult for individuals with BPD to achieve and maintain over time (Zanarini et al., 2010b). More specifically, the MSAD found that approximately one third of subjects with BPD attained good functioning (i.e., recovery) after six years (Zanarini et al., 2005), approximately 50% after ten years (Zanarini et al., 2010), and approximately 60% after sixteen years (Zanarini et al., 2012), with no additional increase found when the follow-up was extended up to 20 years (Zanarini et al., 2018). The CLPS findings indicate that while, at baseline, no BPD subjects had good functioning, after a 10-year follow-up, they had moved from poor to a satisfactory range of functioning. However, by this 10 years, only 21% had attained good functioning, as defined by a GAF score of 71 or higher for two months or more. Thus, findings from the CLPS suggest that despite improvement, psychosocial functioning often remains impaired (Gunderson et al., 2011). As already noted, the CLPS outcome of good social functioning, requiring a GAF score of at least 71, is more ambitious than in the MSAD. Hence, the 10-year psychosocial outcome findings from the two landmark studies are consistent, since the MSAD found that 24% of BPD patients achieved a GAF score of 71 or higher after 10 years of prospective follow-up (see Zanarini et al., 2018).

A meta-analysis by Álvarez-Tomás and associates (2019) also concludes that average levels of functioning improve slowly in the long-term. More specifically, significant improvement in long-term functioning over time was found with a medium mean effect size ($g = 0.66$ [0.43, 0.89], $p < .001$). A high degree of heterogeneity across studies was, however, observed (Álvarez-Tomás et al., 2019).

Fluctuation in psychosocial functioning

While average functioning in BPD is shown to improve slowly, research findings indicate that, at an individual level, subgroups of patients episodically experience substantial fluctuations in their ability to function. In the CLPS, change in the level of functioning was more the norm than stability (Gunderson et al., 2011). Perhaps the most striking finding is the loss of former functioning. For instance, in the MSAD, of BPD subjects who had good baseline psychosocial function, 87% had lost it by a 10-year follow-up. Moreover, only a minority (40%) of those who initially had good psychosocial functioning before losing it regained it over the years of follow-up (Zanarini et al., 2010b). Furthermore, at the 16-year follow-up, the rate of loss of recovery after a two-year remission was 44% (Zanarini et al., 2012). Researchers discuss these disheartening figures in light of how difficult it is to regain good psychosocial functioning after a period of not accommodating to the demands of full-time work or school (Zanarini et al., 2010b).

Vocational functioning

As already noted, psychosocial functioning is multifaceted, including both social and vocational realms. A major finding has been that patients with BPD are substantially more compromised in their vocational functioning than social. Specifically, the results of the MSAD 10-year follow-up indicated that over 90% of BPD patients' poor psychosocial functioning was due to poor vocational, but not social, performance. In fact, 98% of those who did not have good baseline psychosocial functioning and who did not attain it over the decade of follow-up failed to do so because they were never able to function well and in a sustained manner at a full-time job or academic program (Zanarini et al., 2010b). In other words, in the MSAD, failure to achieve full-time employment, not relationship failure, was the primary cause not attaining a good psychosocial outcome (Zanarini et al., 2009; Zanarini et al., 2010b). Similarly, in the 10-year follow-up of the CLPS, about one third of the subjects with BPD were employed full-time while 64% were unemployed; the mean GAF score was 57, corresponding to a fair level of functioning (Gunderson et al., 2011). To conclude, the rate of full-time occupation (work or school) at the 10-year follow-up was approximately equal in both prospective, longitudinal studies (Gunderson et al., 2011).

The findings from both of these studies also indicate that individuals with BPD have significantly more difficulties in vocational functioning compared to other axis II comparison subjects (Gunderson et al., 2011; Zanarini et al., 2012). Specifically, in the MSAD, subjects with BPD were more than four times as likely as axis II comparison subjects to rely on social security disability income (SSDI) at baseline and more than twice as likely to be receiving disability payments at the 10-year follow-up mark (Zanarini et al. 2009). Overall, about 40% of BPD patients were receiving social security disability payments at baseline and at every follow-up point, indicating that the prevalence of receiving these payments was relatively stable among BPD patients over the course of a 10-year follow-up. At the time of the 10-year follow-up, 44% of subjects with BPD were on disability payments but almost 60% were able to support themselves financially.

On the reliance on SSDI benefits, in the MSAD, the individual level picture was different to the overall picture. At an individual level, the reliance on federal benefits to support oneself was neither stable nor chronic, but fluctuating. Approximately 40% of subjects with BPD were able to get off disability, but 43% of subjects who had experienced a “disability remission” subsequently started to receive these payments again, and 39% of subjects with BPD who were not receiving disability payments started to receive them at a later phase of the 10-year follow-up. In total, approximately 60% of subjects with BPD were on disability payments at some point over the 10-year follow-up. It is however notable that receiving disability payments was not necessarily equal to inability to function. For instance, 55% of subjects with BPD who relied on federal support were, however, able to work or school 50% of the time or more. Hence, if the ability to work part-time is taken into account, the figure is different. However, individuals with BPD who were never on disability benefits functioned substantially better in all areas (Zanarini et al., 2009).

A recent nationwide 9-year register-based study (n = 67 075) investigated the long-term labor-market attachment of all individuals diagnosed with BPD during first admission to Danish mental health services in comparison to other psychiatric disorders. Controlling for baseline characteristics and co-occurring secondary psychiatric diagnoses, the BPD group had 32% less chance (OR = 0.68; 95% CI [0.61, 0.76]) of being in work or education after nine years. Individuals diagnosed with BPD also demonstrated more impairment in long-term vocational outcome than those with other PDs (Hastrup et al., 2019), a finding in line with the findings of MSAD and CLPS (Gunderson et al., 2011; Zanarini et al., 2009). The Danish study indicated that individuals with BPD showed lower attachment to the labor-market than other psychiatric disorders, except for schizophrenia, schizotypal and delusional disorders, and SUDs (Hastrup et al., 2019).

Association between symptom recovery and psychosocial functioning

The disparity between symptomatic and functional (including psychosocial and vocational) improvement in BPD is a perplexing issue (Soloff, 2019). While initial findings from both the CLPS and the MSAD suggested an association between symptomatic recovery and improved psychosocial functioning, results from the Pittsburg study (Soloff & Chiappetta, 2019; see also Soloff, 2019 for a discussion) failed to support this association. This is in line with more recent findings from the CLPS (Gunderson et al., 2011).

In the Pittsburg study, 150 subjects with BPD were followed prospectively from 2 to 31 years, for a mean of 9.9 years (Soloff & Chiappetta, 2019). This study found that diagnostic remission from BPD was neither necessary nor sufficient to achieve good interpersonal relationships or full-time employment, the two pillars of psychosocial recovery. More specifically, 66% of subjects with BPD attained symptom remission. A poor psychosocial outcome was defined by a final follow-up Global Assessment Scale score (GAS; Endicott et al., 1976) of less than or equal to 50, whereas a good outcome was defined by a final follow-up GAS score greater than or equal to 70. Of the good outcome subjects, 71.8 % achieved diagnostic remission in BPD. Hence, 28.2% attained good psychosocial outcome without remitting from BPD, while 35.5% of poor outcome subjects achieved remission in their BPD symptoms. This finding, i.e., the relatively low correlation between symptom remission and psychosocial functioning, remains unexplained. Soloff (2019) proposes that one reason for this might be that the standardized quantitative reports of diagnostic remissions may not fully capture the clinical reality of BPD. Hence, this highlights the need to complement quantitative research with qualitative (Soloff, 2019).

To conclude, BPD has a better prognosis than historically thought. Nevertheless, problems with functioning often persist, with full-time vocational functioning being particularly difficult to achieve. The association (or lack thereof) between symptom amelioration and functional improvement still needs explanation.

Treatment use

Utilization of treatment has been investigated in diverse study designs, including epidemiological, cross-sectional follow-back studies, and prospective longitudinal studies. A large British epidemiological study with a nationally representative sample estimated that 56.3% of individuals with BPD had sought help from a professional for mental health concerns in the *past year* (Coid et al., 2009). Another epidemiological study also drawing on a representative general population sample (National Epidemiologic Survey on Alcohol and Related Conditions; NESARC) conducted in the United States found that 74.9% of persons with BPD reported presenting to a physician, therapist, counselor, or other mental health professional for diagnosable mental health concerns during their *lifetime* (Tomko et al. 2014). The lifetime rate substantially exceeds the past-year rate, thereby making comparison difficult. The lifetime rate, i.e., 74.9% of receiving therapy/consultation among individuals with BPD reported by the NESARC study is in line with the 10-year therapy utilization rate (73%) reported by Hörz et al. (2010) in a prospective, longitudinal study (MSAD) comprising initially treatment-seeking patients. These populations were, however, different: general population (Tomko et al., 2014) vs. baseline inpatients (Hörz et al., 2010).

Bender et al. (2001) explored the treatment histories of a total of 664 subjects in a retrospective study design and found that, compared with patients with depression and other PDs, patients with BPD had received significantly more treatment in all forms, except for family/couples therapy and self-help. Besides the previously mentioned family/couples therapy and self-help, the types of treatments examined were individual and group psychotherapy, day treatment, psychiatric hospitalization and half-way house programs.

Another cross-sectional study that compared the treatment use of 130 subjects with BPD, other PDs, a mood or anxiety disorder, and healthy controls found that the BPD group was characterized by significantly greater use of both psychiatric and nonpsychiatric treatments than any other groups. Individuals with BPD reported having used more individual and group psychotherapy, day treatment, half-way house programs, medical outpatient visits and psychiatric medications than participants in the comparison groups, both in the past 6 months and over their lifetime. BPD patients also reported increased time spent in psychiatric hospitalization. Although there was no difference in the number of hospital admissions for non-psychiatric reasons, compared to other groups, subjects with BPD spent more days in hospital during their lifetime (Ansell et al., 2007).

Differences in cohorts and reporting intervals make the comparison of findings pertaining to treatment use from the three longitudinal studies difficult, viz., the McLean Study of Adult Development (MSAD), the Collaborative Longitudinal Personality Disorder Study (CLPS), and the Pittsburg study. All subjects in the CLPS were “treatment seeking” or recently treated at the time of recruitment. In the first 25 to 36-month interval, 64% of subjects with BPD were in psychotherapy and 68% received medication consultations (Bender et al., 2001; Bender et al., 2006.) Baseline treatment utilization was even higher in the MSAD study since they were all initially inpatients. Compared to the CLPS and MSAD studies, only 16% of the Pittsburg subjects had any outpatient treatment over a 10-year follow-up (Soloff & Chiappetta, 2019), which may be attributed to the unavailability of long-term treatment in the public health sector as well as unaffordability of private care for most of these subjects (Soloff, 2019). The CLPS reported on the use of mental health treatments over a prospective three-year period in a total of 633 subjects. When participants with BPD, schizotypal, avoidant, and obsessive-compulsive personality disorders were compared with participants with major depression, participants with BPD were significantly more likely to use most types of treatment, including individual therapy, emergency department visits and psychiatric hospital services, than those with major depression (Bender et al., 2006). The MSAD found that, when all patients were followed for 6 years, the utilization of intensive day- and inpatient treatments declined after the fourth year, both among BPD patients and the comparison group consisting of individuals with other personality disorders. However, at the 6-year follow-up, 70% of BPD subjects were still in psychotherapy and taking medication, even though 70% of patients in treatment were diagnostically remitted (Zanarini et al., 2004; Zanarini et al., 2006). Thereafter, the use of outpatient treatment remained quite stable, as indicated by the 10-year follow-up results of this study. Hence, a specific pattern was noticed among individuals with BPD: a decline in inpatient treatment after the fourth year, but continuous and prolonged use of outpatient treatment despite high rates of diagnostic/symptomatic remission (Hörz et al., 2010).

In summary, individuals with BPD often require long-term treatment despite apparent diagnostic remission. Soloff (2019) states that “in both the MSAD study and the CLPS, treatment was not a predictor of diagnostic remission or good psychosocial outcomes, despite high rates of treatment utilization in both studies”. There is still limited understanding of what factors account for high rates of sustained treatment utilization years after diagnostic/symptomatic remission. One can only speculate whether extended treatment use might relate to trait-like BPD symptoms such as affective and/or developmental/attachment problems, or to the fact that most subjects with BPD were not attending any evidence-based treatment programs specifically designed for their needs. More specifically, at the 10-year follow-up, almost none of the patients in the MSAD had participated in a treatment program specifically designed for BPD (Hörz et al., 2010).

Accordingly, studies reporting on the results from the CLPS state that remission occurred in the absence of sustained or BPD-specific treatments (Bender et al., 2006; Gunderson et al., 2011).

A few cost-effectiveness studies have explored treatment utilization by BPD patients after attending evidence-based treatments. Schema therapy (ST) and dialectical-behavior therapy (DBT) have shown notable reductions of health care costs of approximately 10,000 euros per patient per year (van Asselt et al., 2008; Wagner et al., 2014). Cost savings in the DBT study were mainly due to substantial reductions in inpatient hospitalization, but also partial hospitalization treatment costs, an effect that lasted throughout the follow-up year (Wagner et al., 2014).

Treatment of BPD

An important advance in the field was 20 years ago when the American Psychiatric Association (APA) published the first practice guidelines for the treatment of BPD (American Psychiatric Association, 2001). The same decade witnessed the publication of additional guidelines, viz., the National Institute for Health and Care Excellence (NICE) guidelines for the treatment of BPD (National Institute for Health and Care Excellence, 2009). Both recommend psychotherapy as first-line treatment for patients with BPD. APA guidelines suggested symptom-specific algorithms for pharmacological treatment of various dimensions of BPD, i.e., selective serotonin reuptake inhibitors (SSRIs) for affect dysregulation or impulsive-behavioral dyscontrol, mood stabilizers for impulsive-behavioral dyscontrol, and antipsychotic drugs for cognitive-perceptual symptoms (American Psychiatric Association, 2001). Pharmacological interventions for BPD are not prescribed in the more recent NICE guidelines, however. These guidelines only recommend pharmacologic treatment in case of comorbid conditions (National Institute for Health and Care Excellence, 2009).

For psychosocial interventions, highly specialized treatment programs have been developed and tested in randomized controlled study designs. Today, dialectical-behavior therapy (DBT; Linehan, 1993), mentalization-based therapy (MBT; Bateman & Fonagy, 2004), schema therapy (ST; Young et al., 2003) and transference-focused psychotherapy (TFP; Kernberg, 1975) are the established “big four” evidence-based treatments for BPD. In recent meta-analytic work, these treatments have been found to be roughly similarly efficacious (Cristea et al., 2017; Storebø et al., 2020). A few other therapeutic interventions have also shown promise. The most prominent of these are cognitive-analytic psychotherapy (CAT; Ryle, 1997), Systems Training for Emotional Predictability and Problem Solving (STEPPS; Blum, 2008), and emotion regulation group intervention (ERGT; Gratz et al., 2014) (see Storebø et al., 2020).

Many of these BPD-specific psychological interventions share some common features. Most (though not all) involve multimodal therapy, meaning that they often combine individual and group treatment modalities. Common features include taking active measures to minimize premature non-completion, planning for crisis interventions, and aiming to promote agency. BPD-specific psychological interventions are also highly focused on patient’s affect (both in-session and out-session) and the therapeutic relationship, with a relatively active therapist implementing interventions within a supportive and validating atmosphere (Bateman et al., 2018; Livesley 2012; Weinberg et al., 2011).

Empirically based psychosocial treatments

In the following section, empirically based psychotherapies for BPD will first be reviewed. Thereafter, I will briefly describe other evidence-based psychosocial treatments for BPD, including general psychiatric management (GPM) and psychoeducation. Finally, I will offer suggestions regarding the development of rehabilitative interventions for BPD.

Empirically based psychotherapies

Dialectical-behavior therapy

DBT is a structured psychotherapy that was developed using some of the principles of cognitive-behavior therapy (CBT). In addition, DBT draws heavily on zen-buddhistic tradition and mindfulness as well as dialectical philosophy. DBT aims to balance the acceptance of one’s own reactions with active behavioral change. The idea is to enhance the patients’ ability to a build a life worth living and to tolerate painful emotions by focusing on improving their skills in distress tolerance, emotion regulation, interpersonal behavior, and mindfulness. In DBT, patients learn to distinguish when to trust and when to doubt their perceptions. That is, they learn self-validation to replace their habitual self-doubt or self-invalidation. It is assumed that mindful observation and description can help this distinction (Linehan, 1993).

The treatment structure is multimodal. In addition to individual therapy, skills training groups, therapists' consultation teams, and phone coaching for patients are included (Linehan, 1993).

Mentalization-based therapy

MBT is an attachment theory-based psychodynamic psychotherapy which aims to increase reflective functioning, or mentalizing skills, thereby helping individuals with BPD to monitor and understand their own reactions, as well as those they evoke in others. The hypothesis is that enhanced mentalization skills will ultimately improve the capacity for emotional regulation (Allen, 2013; Bateman & Fonagy, 2004).

MBT was originally developed to be delivered in a daytime hospital setting, comprising of individual therapy provided by psychiatric nurses, as well as different group sessions, but to date, intensive outpatient programs are also available. These, too, have been tested in RCTs (Bateman & Fonagy, 2009). Even outpatient treatment includes weekly individual sessions combined with weekly group sessions.

Schema therapy

ST is an integrative form of psychotherapy that incorporates concepts and approaches from CBT theory, attachment theory, and object relation theory. Moreover, therapy techniques from expressive psychotherapies, particularly gestalt therapy, are adopted and actively applied (Young et al., 2003).

The theory of ST posits that BPD is characterized by early maladaptive schemas (i.e., life themes) and schema modes. The former refers to *trait*-like cognitive structures, an example of which is “I am bad”, whereas the latter refers to fluctuating facets of personality that can be understood as cognitive-emotional-behavioral *states.* Examples of schema modes typically encountered in BPD are the vulnerable/abandoned child, the angry child, the detached protector, and the punitive parent. According to the theory, the mode of the healthy adult is often underdeveloped in BPD sufferers (Young et al., 2003).

Since the BPD-related difficulties are assumed to arise as a consequence of a mismatch between a child's basic needs and their environment's capacity to respond to these needs, an overarching goal in ST is to help BPD sufferers have their emotional and attachment needs met in adaptive ways. Other aims are to help patients identify their schemas, modes, and self-defeating coping strategies. These are processed in therapy applying experiential techniques especially, along with cognitive and behavioral techniques (Young et al., 2003; Arntz & van Genderen, 2020).

With respect to treatment modalities, ST can be delivered in either individual or group therapy. Both modalities have been tested in randomized controlled trials (Storebø et al., 2020). Today, a conjoint format that combines both individual and group therapy is common (Tan et al., 2018).

Transference-focused psychotherapy

TFP strives to enhance integration in patients' representations of themselves and others. Additional aims are the modification of primitive defense mechanism operations and the resolution of identity diffusion (Kernberg, 1975). TFP posits that failure in integration results from the predominance of internalized aggressive object relations over idealized ones, and from the excessive use of primitive defense mechanisms such as projection, splitting, or dissociation. This type of therapy relies on techniques of clarification, confrontation, and transference interpretation. It is delivered in individual sessions (Storebø et al., 2020; Yeomans & Delaney, 2008).

Systems Training for Emotional Predictability and Problem Solving (STEPPS)

In STEPPS, BPD is conceptualized as difficulties in emotional intensity and regulation. The aim of this therapy is to enhance awareness of a patient's own experiences, including cognitive “filters”, i.e., schemas. Additionally, it is proposed that improved self-observation needs to encompass various triggers that have the potential to yield (dysregulated) behavior (Blum et al., 2008).

To achieve these aims, STEPPS combines group-based psychoeducation with skills training. Also drawing on a systemic approach, STEPPS seeks to involve and engage the significant others of BPD sufferers (Blum et al., 2008).

The delivery format is a 20-session seminar-like group, often in conjunction with pre-existing treatment as usual (Blum et al., 2008).

Cognitive-analytic therapy

CAT assumes that individuals with BPD experience rapid switching from one self-state to another, which is hypothesized to occur in a dissociative manner. The theory proposes that this partial dissociation, provoked by childhood traumas or deprivation, results in the persistence of separate self-states. Some examples of these separated or fragmented self-states are abuser rage, victim rage, and zombie (Golynkina & Ryle, 1999). Hence, the CAT concept of self-states shares many similarities with the ST concept of schema modes.

To understand how a target problem (e.g., self-harm) is established and maintained, the patient and therapist work on identifying procedural sequences, chains of events, and the patient's emotions, thoughts, and motivations. Moreover, an aim is to identify reciprocal roles, i.e., how early experiences are being replayed later in life. CAT is typically provided in an individual therapy format (Gleenson et al., 2012; Ryle, 1997; Storebø et al., 2020).

Emotion regulation group intervention

Emotion regulation group treatment (ERGT) is intended for individuals with BPD and deliberate self-harm (Gratz et al., 2006; Gratz et al., 2014). In ERGT, BPD-related problems are viewed as stemming from problems in emotion acceptance and regulation. This treatment draws heavily on acceptance and commitment therapy (ACT; Hayes et al., 1999) and DBT (Linehan, 1993). Furthermore, ERGT includes aspects of emotion-focused therapy (EFT; Greenberg, 2002) and behavior therapy (Gratz et al., 2006; Gratz et al., 2014).

The aim of ERGT is to enhance the awareness and understanding of emotions and facilitate acceptance of them. This is achieved through skills training. Importantly, the aim of learning and applying skills is to block (dysfunctional) emotion-based behavior but not the emotion itself. The basic tenet is that emotions can just be observed and accepted (Gratz et al., 2006; Gratz et al., 2014).

A typical delivery format for ERGT is a 14-week psychoeducational group intervention, as an addition to patients' treatments as usual (Gratz et al., 2014).

General psychiatric management

General psychiatric management (GPM; Gunderson & Links, 2014) intends to be a good-enough, common sense generalist treatment alternative for BPD. Drawing from diverse schools of thought, viz., attachment theory, psychodynamic, and behavioral therapy, it seeks to integrate evidence-based principles for treating BPD. In GPM, BPD is understood as an interpersonal, or attachment, disorder associated with notable interpersonal hypersensitivity (Gunderson & Lyons-Ruth, 2008). This treatment focuses on the actual relationships of the patient, with a particular emphasis on emotion regulation. The ability to function in the social, as well as vocational, realm is another central target of the treatment.

GPM typically consists of weekly contact with a psychiatrist or psychologist, case management, psychoeducation for patients and their families, family sessions, and pharmacological treatment as needed.

Patients are encouraged to combine various group treatments and self-help groups, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), with GPM (Links et al., 2015; Links & Gunderson, 2014).

Psychoeducation

Psychoeducation is a viable treatment option for individuals with moderate to severe BPD (Ridolphi et al., 2019). To date, the role of psychoeducation in alleviating BPD symptoms has been the subject of a handful of RCTs. Importantly, psychoeducation seems to yield benefits both in clinical (Ridolphi et al. 2019) and non-clinical samples (Zanarini et al., 2018). Different delivery methods, including via the web (Zanarini et al., 2018) and live groups (Ridolphi, et al., 2019), have demonstrated effectiveness.

Other: Need for psychosocial rehabilitation

Since sustained periods of active illness can interfere with developmental tasks and leave individuals with BPD with “scars” that obstruct satisfactory community-based activities, active endeavors to improve functional outcomes is the challenge faced by the next generation of psychosocial treatments for BPD. Future studies of therapeutic outcomes need to assess functional gain, but more importantly, future BPD therapies need to address functional impairment, i.e., incorporating social learning and rehabilitation strategies (Gunderson et al., 2011).

2.2 BACKGROUND OF THE FIRST STUDY: BPD SUFFERERS’ FIRST-PERSON PERSPECTIVES ON DEVELOPMENT, CHANGE, AND THE ROLE OF TREATMENT FACTORS IN THE PROCESS

This stream of research addresses, for instance, the following questions: When individuals with BPD experience changes in treatment, what is their subjective experience of meaningful change? What kind of inner change processes lie between pathology, change, and positive outcome? (Morken et al., 2019a). What is the role of treatment-related factors or events in this process? The rationale underlying this research relates to the fact that, having experienced a psychosocial intervention from the inside, patients can shed light on processes of which therapists themselves may not be aware (Morken et al., 2019b). Patients’ experiences of meaningful change, as well as their experience of how treatment-related factors contribute to this change, can further a holistic understanding of the therapy process (Morken et al., 2019a). Illuminating potential, relevant treatment targets or even mechanisms of change, this stream of research addresses the “what”, and may to some extent even address the “how”, questions of psychotherapy research. Of utmost importance, according to Morken et al. (2019b), is that research into the first-person perspective of the patients can also help to tailor therapeutic approaches so that iatrogenic damage could be minimized, and premature treatment discontinuation reduced.

A major, relatively recent advance in this field was the publication of a meta-synthesis of 14 qualitative studies exploring individuals’ experiences of their treatment for BPD and their perceptions of recovery (Katsakou & Pistrang, 2018). In the studies included in this meta-synthesis, treatment was delivered in either individual or group format, or a combination. Treatments included DBT, MBT, art therapy, peer support groups, and standard community mental health services. The meta-synthesis concluded that BPD sufferers make changes in four main areas: developing self-acceptance and self-confidence, controlling difficult thoughts and emotions, practicing new ways of relating to others, and implementing practical changes and developing hope. On helpful and unhelpful treatment characteristics, the meta-synthesis identified that therapy aiding in making sense and furthering understanding of own experiences was regarded as helpful. Specifically, enhanced self-understanding allowed participants to become more accepting and compassionate towards themselves. Being listened to, understood, and taken seriously, as opposed to being judged, was also important for participants. Moreover, focus on change was deemed helpful but not being an equal partner in treatment was unhelpful. The latter included, for instance, therapy goals imposed on participants, or a type of therapy perceived as too rigid and inflexible. On the other hand, when participants felt they were included, they felt trusted, valued, and empowered. Regarding the nature of change, rather than being a dichotomous outcome (i.e., recovery vs. absence thereof), change was experienced as an open-ended journey, that is, a dynamic and gradual process that consisted of small steps, setbacks and achievements (Katsakou & Pistrang, 2018).

Although some studies included in the Katsakou & Pistrang (2018) meta-synthesis described helpful and unhelpful treatment characteristics, most studies focused on general experiences of recovery. Hence, processes of recovery through treatment were rarely described (Katsakou et al., 2019). Accordingly, Katsakou and Pistrang (2018) conclude that, although the studies included in their meta-synthesis identified areas where people diagnosed BPD made progress, these studies provided little information about *how* those improvements were reached.

After the publication of the Katsakou & Pistrang meta-synthesis (2018), a few papers reporting on the first-person perspective of individuals with BPD, with a focus on personal experience of change and treatment, have been published. A major asset of these later studies is a greater focus on internal processes and a more nuanced description thereof. Using study design similar to ours, Morken et al. (2019a) explored personal experiences of psychological change processes in 13 female patients with BPD features and comorbid SUD after attending mentalization-based treatment in Bergen, Norway. Specifically, from the patients' perspectives, their central change processes involved a new way of relating to their own mind, new self-regulatory capacities, and self-agency. Participants began to attend to their feelings and were also able to feel them instead of avoiding them. Emergent meta-processing skills included the ability to differentiate between feelings and thoughts and reflect on actions instead of just acting. These meta-skills apparently enabled patients to pause and think, giving them the sense of having choice over their own behavior. This meta-processing also seemed to contribute to improved relationship experiences, as participants now were able to question themselves: "What is my contribution to what just happened between us?" The skills also seemed to enable participants to interpret other people more flexibly, understanding that others have their own mind that is different; participants not necessarily perceived others through their own feelings, i.e., using feelings as testimonies on the state of mind of others.

Importantly, these changes prevented patients from being victims of their own mind-states and mal-perceived external forces and placed them in a position where they were agents, steering their own reactions. As evident from the above description, Morken et al. assume that these changes have complex interrelationships with one another (Morken et al., 2019a).

In addition to personal experience of development, Morken and associates (2019b) also reported on patients' experiences of treatment-related factors. This study also drew on the previously mentioned sample of 13 female patients with BPD features and comorbid SUD after attending MBT. The main findings indicated that patients appreciated learning to simultaneously consider multiple, alternative perspectives, such as different possible explanations for problematic situations. They described how their new ability to hold multiple perspectives in mind simultaneously had a calming effect on them. For participants, the notion that other people think differently and have their own, different frames of reference was eye-opening, as it challenged the previous "one perspective that was the rule". Furthermore, patients felt normalized after listening to co-patients. Peer experiences were thus helpful in gaining feelings of normalcy and yielded deep effects, including a more positive self-image. More specifically, patients achieved more self-worth and self-acceptance by bonding and identifying with peers with similar problems. The authors describe this as a process where patients moved from a position of being alone in the world, with an identity that was experienced as extreme, abnormal, and colored by shame, to a position where they were not alone and not that bad. Peer experiences also contributed to the development of new mindsets by increasing patients' abilities to have multiple perspectives in mind during emotional stress, as described above. Regarding therapists' actions, patient accounts revealed that negative unspoken concerns (either in the context of individual or group therapy) need to be put into words. That is, therapists need to have the courage to be frank and direct in their communication and address also negative phenomena such as tension in the group, or destructive utterances. Negative feelings towards therapists and co-patients should be asked about and dealt with. Patients reported that when failed to be adequately addressed, these negative feelings and thoughts escalated and could eventually became an obstacle to therapy. In addition, therapist actions that demonstrated a close following of the patients' perspective in the here and now, provision of explicit validation, and ability to tolerate and deal with strong affect, were regarded as helpful.

Katsakou et al. (2019) later reported on a sample of 48 individuals with BPD and 15 therapists. The service user (i.e., patient) sample of this study was identical to one that was included in the meta-synthesis delineated above. However, therapists were now also included in the sample and exploration focused on processes of change, as opposed to areas of change that were previously reported. The treatments that were provided included specialist as well as routine, generalist care: DBT, MBT, CBT-informed, and community mental health care treatment. Regarding the findings, the first domain described three parallel processes that constituted service users' recovery journeys: fighting ambivalence and committing to taking action, moving from shame to self-acceptance and compassion, and moving from distrust and defensiveness to opening up to others. The second domain described four therapeutic challenges that needed to be addressed to support this journey: balancing self-exploration and finding solutions, balancing structure and flexibility, confronting interpersonal difficulties and practicing new ways of relating, and balancing support and independence. Perhaps the most important extension to findings in the previously reported meta-synthesis was the description of service users moving from shame to self-acceptance and from distrust and defensiveness to opening up to others. However, the information provided on the details of these processes was scarce.

Tan et al. (2018) explored 36 BPD sufferers' experiences with ST in international, multicenter study design. The intervention was a two-year-long ST program. Of the study participants, 38% were male. In terms of findings on personal development, the reported gains were increased insight, better connection with one's emotions, improved self-confidence, increased cognitive flexibility in terms of taking alternative perspectives, and being less harsh to oneself. Specifically, 86% of participants described how they felt that ST had facilitated their understanding of the self and their internal processes. Therapy was indicated as helpful in providing patients with concepts and explanations on the BPD condition and in making sense of various events and situations. 72% of participants described a greater capacity to cope and apply skills learnt without turning to less helpful ways of coping, and half of the patients reported changes in the connection with their emotions. That is, they were able to get in touch, or reconnect, with emotions previously warded off. These changes, i.e., increased connection with and/or awareness of one's emotions, were generally described as a shift from intellectualizing to experiencing. 47% reported improved self-confidence and assertiveness. This change was described as a general increase in confidence in facing one's difficulties, rather than avoiding them, the ability to speak up for oneself, and accomplish what one was unable to do before. 42% reported diminished harshness towards themselves. This occurred particularly after gaining an understanding of where this harshness stemmed from.

In terms of therapy-related factors, Tan et al. (2018) found that 81% of participants regarded the quality of therapeutic relationships as significant in influencing therapy outcomes. Non-judgmental attitude and attentiveness to a patient's needs were examples of therapist behavior cited as helpful. 14 % also expressed feelings of dissatisfaction and frustration in the therapeutic relationship, particularly because they felt misunderstood (e.g., due to therapist imposing his or her own assumptions on the patient). Revisiting traumatic memories was often experienced as scary, although many participants reflected on the necessity of doing so. Patients found the ST group component useful in enabling learning and applying schema-related concepts, and coping skills. The possibility of practicing these skills with other group members was found to be helpful. 89% discussed the sense of connection among group members, and 67% believed that being in the company of similar people allowed them to bond and develop an understanding that they were not alone in experiencing such difficulties. On the other hand, a minority (17%) described feeling left out and not understood, as they believed they had "nothing in common" with other group members due to being in different stages of life. Daring to expose oneself and be vulnerable within the group was quite often experienced as challenging (28%). Trust could also be lost after negative feedback from peers, and patients reported the need to withhold issues and hide vulnerable parts of themselves. The finding that a particular incident/conflict involving a few patients in the group left others feeling unsafe speaking their minds and subsequently contributing less suggests that such events can stifle personal growth. It also implies that tension can linger even if, on the surface, a conflict appeared to be resolved. Furthermore, comparing oneself with other group members evoked mixed feelings in participants. This study by Tan et al. (2018) also addressed gender issues in treatment. Despite some initial discomfort, the findings suggest that in the long term, having both genders in the group was beneficial because participants learnt that both genders can struggle with similar issues, and because it corrected stereotypical views and distrust.

To conclude, from studies exploring the first-person perspective of individuals with BPD on development, change, and the contribution of treatment factors, participants tend to experience very similar phenomena when exposed to different modern BPD-specific treatments. Interestingly, participation in ST (Tan et al., 2018) yields almost identical experiences as participation in MBT, as described by Morken et al. (2019a, 2019b). On research methodology and quality, I agree with Katsakou and Pistrang (2018) who suggest that more detailed accounts of change processes are needed in order to provide rich and nuanced descriptions of how therapeutic change occurs.

2.3 BACKGROUND OF THE SECOND STUDY: LITERATURE ON SELF-INVALIDATION, STIGMA, AND SELF-STIGMA

2.3.1 Self-invalidation

Self-invalidation (hereafter, SI) refers to doubting or questioning the authenticity of one’s feelings, ideas, or experiences (Livesley, 2017). It can be hypothesized that SI encompasses different dimensions, such as implicit and explicit facets, along with temporal fluctuation. With respect to temporal fluctuation, Linehan (1993) describes how individuals with BPD may initially observe themselves accurately but thereafter discount their perceptions owing to self-mistrust. Thus, Linehan refers to the ability to maintain trust in what was observed (and apparently at least tentatively validated) a moment ago. However, due to absence of empirical research, the dimensions of SI, including its temporal fluctuation, deliberateness, or the level of awareness individuals have over their SI, remain poorly understood.

SI can manifest itself in the form of overt judgmental thoughts, such as "I am a bad person" or "I don't deserve to feel better" (Manning, 2019). Other manifestations include trivializing one's distress (Livesley, 2017) or oversimplifying the ease of problem solving, which is expressed by denying one's problems or blaming oneself for having them (Miller et al., 2017). Individuals' internal representations of the self may be polarized and distorted (i.e., 'all-bad') (Kernberg, 1975) and they may turn against the self with self-blame and self-hatred (Koerner, 2012), or, in the belief that they deserve to die, even want to commit suicide as self-punishment (Miller et al., 2017).

DBT posits that SI in individuals with BPD stems from an invalidating environment that fails to teach a child when to trust his or her own emotional and cognitive responses as reflections of valid interpretations of individual and situational events (Linehan, 1993). Individuals then adopt the characteristics of the invalidating environment. Mistrusting their own internal states, they rely instead on the environment for clues on how to respond (Safer et al., 2009).

ST describes a severe self-punitive state, the so-called mode of the punitive parent, in which individuals condemn themselves as bad or evil or as deserving of punishment. This mode is hypothesized to form an internalization of one or both parents' rage, hatred, loathing, abuse, or subjugation of the individual as a child (Arntz et al., 2005; Young et al., 2003). This mode affects information processing in different phases. As Valkonen (2018) states, in the mode of the punitive parent, it seems as if self-observation is executed mainly from an extremely critical observer position, or from an observer position that is *occupied by* an internalized other, that is, a punitive parental introject. Stemming from an abusive other, self-observation displays an extremely negative or harshly critical tone that renders it highly problematic (Valkonen, 2018). Besides affecting self-observation, the punitive parent mode is characterized by specific patterns of thought that typically concern the invalidity of one's own opinions/wishes/emotions along with beliefs that one has no right to express these (Arntz et al., 2005). ST also identifies the so-called mode of compliant surrender. According to ST theory, this submissive mode, hypothesized to be driven by fear, attempts to protect the individual from further exposure to invalidation, rejection, conflict, or abuse, thereby functioning as safety behavior (Arntz et al., 2005; Young et al., 2003).

In a similar vein, MBT assumes that due to traumatic experiences in the attachment relationship, individuals with BPD feel evil or hateful because they have internalized evil as part of the self (the “alien self”). More specifically, persecution from the maltreating person is experienced from within; a part of the self-structure feels a desire to destroy the rest of the self (Bateman & Fonagy, 2004). This can be understood as an extreme manifestation of SI.

SI is not without consequences. It is proposed that the ability to evaluate one's behavior non-defensively and to trust one's own self-evaluations is crucial to personal growth and well-being (Linehan, 1993). Conversely, it is hypothesized that insidious doubt concerning one's own perceptions (Livesley, 2003), responding to one's emotional states with negative secondary emotions including shame, disgust, or anger (Miller et al., 2017), and a tendency to look for external sources of validation all interfere with the development of an adaptive self-system (Safer et al., 2009). In addition, it is assumed that this self-invalidating cognitive style may hinder self-understanding (Livesley, 2017) as well as the establishment of personal goals and development of a sense of agency (Livesley, 2003).

SI is therefore an important target, particularly in evidence-based psychotherapies stemming from the cognitive-behavioral framework, viz. DBT and ST. In DBT, targeting SI requires that the therapist constantly searches for the validity in patients' responses and communicates this validity to them (Fruzzetti & Ruork, 2019; Koerner, 2012), with the aim to help them learn to trust their own responses (Linehan, 1993). Moreover, therapists are alerted to instances of SI in patient processing, since the intention is to increase a patient's awareness of the different ways in which they are engaging in SI (Livesley, 2017). Exploring problematic situations together and helping patients to be descriptive and work on discerning when to trust and when to doubt their information processing are examples of DBT strategies in the treatment of SI (Linehan, 1993). In ST, the treatment of SI mainly consists of mode work. The goal is to process the traumatic experiences of the so-called mode of the vulnerable or abandoned child and ultimately, replace the modes of the punitive parent and compliant surrender with the mode of a healthy adult who values the patient and cares about his or her emotions and needs (Arntz & van Genderen, 2020; Young et al., 2003).

2.3.2 Stigma and self-stigma

Self-stigma pertains to self-concept and identity and can be understood as a specific form of SI.

A short history of stigma in BPD

Much of the literature on the topic of stigma to date has focused on schizophrenia and depression, or a generalized category of mental illness (Bonnington & Rose, 2014; Masland & Null, 2021). Significantly fewer studies on the emergence of psychiatric stigma in individuals with PDs exist (Catthoor et al., 2015; Furnham et al., 2015), with literature on treatment provider stigma constituting an exception. That is, for a long time, it has been suspected that BPD may be viewed negatively among health care workers, and therefore, attitudes of providers towards these patients have garnered attention in the field of research.

Although the term "borderline" was initially intended to describe psychopathology at the border of psychosis and neurosis (Stern, 1938), in practice, it became a literal stigma (Masland & Null, 2021). As mentioned previously, in the era of psychoanalysis, this demarcation line was tied to the analyzability of a patient: patients with neuroses were considered analyzable and therefore treatable, while those with psychoses were considered not analyzable and therefore untreatable. Specifically, the condition to which borderline patients were “borderline” was untreatable schizophrenia (Gunderson, 2009). To potentiate this discrimination, in many cases, the term “borderline” was used to mark patients, usually women, who were difficult, disliked, and presumably untreatable (Stone, 1977). Moreover, the language used to describe these patients was often harsh and colored by pejorative connotations, including “constitutional aggression” (Kernberg, 1975) or “infantile personality” (Stern, 1938), thereby creating a fertile ground for discrimination (Masland & Null, 2021).

Stigma and self-stigma: definitions

Recent literature emphasizes the importance of the awareness of societal stigma as conceptually distinct from personal beliefs or self-stigma (McKeague et al., 2015). A stigma is the perception of a negative attribute that becomes associated with global devaluation of the person (Katz, 1981). According to Goffman’s analysis, those who are stigmatized are diminished “from a whole and usual person to a tainted, discounted one”. This affects the stigmatized individual, thereby leading to spoiled identity (Goffman, 1963).

In the last two decades, attempts have been made to expand and reorient stigma's theoretical lens to focus on meso and macro, in addition to micro, socio-cultural structures and power (e.g., Bonnington & Rose, 2014). Specifically, the concept of power was incorporated into the stigma concept in response to criticism from disability theorists who argued that stigma was not about “personal tragedy”, but rather the social oppression of difference (Bonnington & Rose, 2014). Consequently, the stigma concept from Link et al. (2004) describes the co-occurrence of labelling, stereotyping, separating ‘us’ from ‘them’, negative emotional reactions of others and those labelled, status loss, and discrimination within a power situation that allows all these processes to unfold.

Self-stigma is the introjection of the negative public perception, reflecting a maladaptive process where individuals accept societal prejudices and integrate this evaluation into their own self-concept (Livingston & Boyd, 2010). Diagnostic labels can have a devastating effect on an individual’s sense of self through a process of internalized stigma

(Lam et al., 2016). Self-stigma is associated with a host of negative outcomes, including shame (Rüsch et al., 2014), self-directed prejudice, depression, social isolation, reluctance to seek help (Catthoor et al., 2015), lower quality of life, lower levels of hope, lower self-esteem, lower self-efficacy, lower empowerment, lower social support, and a higher severity of psychiatric symptomatology (Livingston & Boyd, 2010).

PDs, BPD, and public stigma

Evidence suggests that PDs may be even more stigmatized than other psychiatric diagnoses (Magallón-Neri et al., 2013; Sheehan et al., 2016). Catthoor et al. (2015) found that treatment-seeking adolescents with PDs experienced more stigma than treatment-seeking adolescents with other severe and treatment-refractory psychiatric disorders and that BPD was the strongest predictor of experiences of stigma.

Particularly relevant to stigma in PDs may be the belief that these individuals should be able to exhibit control over their behaviour. This belief results in symptoms being interpreted as manipulation or rejections of help (Aviram et al., 2006; Sheehan et al., 2016). Due to this, individuals with PDs may be viewed as misbehaving rather than suffering from a psychiatric condition. According to a relatively recent survey study, the public reacts less sympathetically to individuals described as having a PD and is less likely to think that these individuals need professional help than those with other psychiatric disorders (Furnham et al., 2015).

However, in terms of labelling, research findings also suggest that in some contexts, diagnostic labels may reduce negative attitudes about BPD. The absence of a diagnostic label may catalyze negative attitudes, whereas a diagnostic nominator may provide an explanation for behavior that would otherwise be difficult to understand (Masland & Null, 2021).

BPD and treatment provider stigma

Treatment provider stigma is a particularly pernicious form of stigma (Bonnington & Rose, 2014; Lam et al., 2016; Nehls, 1999; Sheehan et al., 2016). Both prior and recent studies are consistent in highlighting the negative attitudes and behavior of health care professionals towards people with PDs, and particularly those with BPD (e.g., Gallop & Wynn, 1987; Gallop et al., 1989; Lam et al., 2016; Lawn et al., 2015). Profession is not a distinguishing factor either; psychiatric nurses, social workers, psychologists, and psychiatrists are all sources of harmful attitudes towards people with BPD (Bodner et al., 2015; Latalova et al., 2015; Sansone & Sansone, 2013).

Historically, clinicians tended to describe BPD sufferers in pejorative terms that included “difficult,” “treatment resistant,” “manipulative,” “demanding,” and “attention seeking” (Gallop & Wynn, 1987; Nehls, 1998; Stone et al., 1987). Several studies since 1980s have found that the label of BPD is enough to change the behavior of treatment providers. From among this literature, I will briefly review a few studies.

Gallop et al. (1989) compared nurses’ responses to hypothetical patients with BPD and schizophrenia. They found that while a significant proportion of nurses was more likely to remain sympathetic towards patients with schizophrenia, their responses to statements made by patients with BPD were belittling or contradicting. These researchers suggested that the behavior of a BPD sufferer is interpreted as manipulative and not “mad.” Gallop et al. (1989) also proposed that the nurses’ behavior could reflect a defensive reaction, the function of which is to protect themselves against own feelings of helplessness, anger, and frustration. Strikingly, they proposed that the nurses felt they could respond in a belittling manner because it was acceptable with patients with BPD.

In a similar vein, Lewis and Appleby (1988) reported that psychiatrists were less favorable towards a vignette containing information that the patient had seen a psychiatrist two years prior and was given a diagnosis of PD compared to other scenarios in which the attribute “personality disorder” was left out. Results from this sample suggested that when a diagnosis of PD is present, clinicians formed pejorative, judgmental, and rejecting attitudes. Regarding treatment provider stigma, studies published decades later agreed with prior findings. For instance, using an experimental study design, Lam et al. (2016) demonstrated that the label of BPD was associated with clinicians’ significantly more negative judgments about the outcome of a hypothetical uncomplicated panic disorder. When this hypothetical panic disorder case was labelled BPD, it was associated with elevated estimates of general risks, in terms of harm to self and others, and lower ratings of likely future engagement in therapy and outcome.

Attempts to understand the causes and details of treatment provider stigma are needed if we endeavor to reduce this detrimental form of stigma. Hinshelwood (1999), among others, hypothesized that PD patients are considered difficult because they evoke personal reactions that challenge the clinicians' assumptions about their professional identity. Studies lend support to this hypothesis. Specifically, in an early study, Gallop and Wynn (1987) asked 25 psychiatric nurses and 12 psychiatric residents to identify behaviors and characteristics of "difficult patients." Content analysis of these responses yielded two themes representing the personal experiences of the nurses and residents with these patients: lack of control and incompetence. In an effort to protect themselves, the nurses tended to personalize their reactions, wanting action from their patients, whereas the residents objectified and distanced themselves, which seemed to reduce the intensity of the experience. Importantly, both reactions ultimately attributed the problematic experiences to the patient (Gallop & Wynn,1987). Later, Wilstrand et al. (2007) found that nurses reported fear and frustration in reaction to self-harming behavior. Consequently, professional staff working with individuals with PDs tend to initiate self-protective behaviors, e.g., retreating emotionally, often under the guise of a scientific attitude. Aviram et al. (2006) noted how this description of an emotional retreat by mental health workers resembles voluntary distance from stigmatized individuals as described by Goffman (1963). Besides treatment providers' difficulties in processing their own emotional reactions, beliefs that individuals with PDs do have self-control are present among mental health professional (Lewis & Appleby, 1988). Lewis and Appleby (1988) concluded that "those labelled as personality disordered appear to be denied the benefits of being regarded as ill, but also denied the privilege of being regarded as normal."

Aviram et al. (2006) discuss that while the stigmatizing descriptors used to describe BPD sufferers may reflect certain aspects of patients' real behavior, they can have an impact on the treatment provider's prior expectations. Left unexamined, these descriptors potentially become a justification for stigmatization and hence for discrimination, and other potential negative outcomes. The extent to which the provider's distancing (or other reactions) is influenced by stigma is an important question that highlights the possibility that the stigma associated with BPD can have an independent contribution to poor outcome with this population. This phenomenon could be particularly relevant to the treatment of BPD, a hallmark of which is an exquisite sensitivity to rejection and abandonment (Aviram et al., 2006).

BPD and self-stigma

Recent research suggests that the level of self-stigma is high in BPD sufferers. Grambal et al. (2016) compared self-stigma in inpatients suffering from mood disorders (including bipolar disorder), schizophrenia spectrum disorders, anxiety disorders, and BPD. They found that patients with BPD suffered from the highest level of self-stigma. However, only the comparison between anxiety disorders and BPD was significant. Factors connected with the higher level of self-stigma were the lack of a partner, the number of hospitalizations, and the severity of the disorder (Grambal et al., 2016). Recently, Quenneville et al. (2020) compared self-stigma in patients with bipolar disorder, ADHD, and BPD. They found that patients with BPD reported more self-stigma than those with bipolar disorder and ADHD.

Vulnerability factors leading to internalized stigma still need to be defined. Importantly, stigmatizing labels seem to engender self-stigma and a negative self-concept for some individuals but not others (Crocker, 1999; Moses, 2011). Among adolescents briefly hospitalized for psychiatric reasons, Moses (2011) found that, compared to men, females may be more vulnerable to stigma. Moreover, this study reported that subgroups vulnerable to higher stigma were those dependent on others for self-worth validation, those with previous experiences with social devaluation, and those with limited sources of identification (Moses, 2011). In discussing their findings related to the serious burden of stigma in adolescents with

PDs, Catthoor et al. (2015) describe how young people's identities depend on definitions offered by others. They discuss how this lack of a strong sense of self that is clearly delineated from others may make adolescents extra vulnerable to incorporate negative critique on their behavioral and emotional problems into their self. These findings and discussions are of great interest concerning BPD, since BPD shares some of the above-mentioned vulnerability factors. Specifically, previous exposure to devaluation, lack of a stabile sense of self-worth, as well as lack of a unique sense of self with clear between-person boundaries characterize many individuals with BPD. Quenneville et al. (2020) suggest that the interpersonal hypersensitivity (Gunderson & Lyons-Ruth, 2008) inherent to BPD might contribute to vulnerability to internalized stigma by inducing hypervigilance to signs of rejection or criticism.

On resilience factors, reporting on a sample of individuals with schizophrenia, Lysaker et al. (2008) noted that features of self-esteem related to lovability by others were closely connected with reduced feelings of being alienated from others due to a psychiatric disorder. To conclude, in addition to research into vulnerability factors, research illuminating resilience factors that protect against the effects of stigma would be welcomed.

Stigma reduction interventions

Literature on interventions targeting self-stigma is still sparse (Quenneville et al., 2020). Nonetheless, anti-stigma interventions are emerging. The target population of these interventions can either be stigma sufferers (e.g., Clarke et al., 2014; Egan et al., 2014; Lebowitz et al., 2012; Mittal et al., 2012; Yanos et al., 2015), the public, or treatment providers. To date, limited evidence suggests that BPD-specific training may improve clinicians' attitudes about BPD (e.g., Commons Treloar & Lewis, 2008; Keuroghlian et al., 2016; Krawitz, 2004; Masland et al., 2018; Miller & Davenport, 1996; Shanks et al., 2011).

In terms of the content of anti-stigma interventions, quite recently, hopes were high for the potential of so-called 'biogenetic' explanations of mental conditions. However, the genetic and other biological explanations seemed to have mixed blessing for the stigma of mental disorders. Meta-analytic evidence indicates that while these biogenetic explanations reduce the blame attached to sufferers, they also increase aversion, perceptions of dangerousness, as well as pessimism about recovery (Loughman & Haslam, 2018). Lougham and Haslam (2018) consider that these relationships may arise since biogenetic explanations recruit essentialist intuitions, which have known associations with prejudice and the endorsement of stereotypes. Kverme et al. (2019) recommend a different approach, viz., educational efforts that would motivate mental health professionals to develop more humanistic approaches that increasingly recognize the traumas individuals with BPD have survived.

2.4 BACKGROUND OF THE THIRD STUDY: SELF-CONCEPT AND IDENTITY IN BPD

According to Jørgensen (2009), identity can be conceptualized as (1) an inner psychological structure, (2) the specific content of the self and psyche, and (3) an ongoing process. For instance, the self-schema “I am a failure” is an example of the specific content of identity. Structure refers to the level of integration in the content, i.e., in the concept of self and others. Lastly, process refers to how information about the self, others, and one’s own past, present, and future is continuously being processed (Jørgensen, 2009).

The boundary between identity and two closely related yet dissimilar concepts of ‘self-concept’ and ‘self-esteem’ requires definition. Baumeister (1999) defines identity as ‘who you are’, self-concept as ‘your ideas about yourself’, and self-esteem as ‘how you evaluate yourself and how you feel about yourself’.

It is argued that a person’s self-concept is characterized both by explicit, i.e., consciously accessible self-related content and processes as well as implicit, unconscious self-related attitudes, feelings, and cognitions. These explicit and implicit processes are not necessarily congruent (Spitzer et al., 2020). This may be particularly relevant in individuals with BPD, since implicit, automatic information processing is likely to override explicit processing in guiding their perceptions and interpretations of the self and the world and influencing their behavioral responses under stressful circumstances (Hofmann et al., 2009; Schmidt et al., 2015; Spitzer et al., 2020).

2.4.1 Self-concept and identity in contemporary psychotherapies for the treatment BPD

The importance of a disturbance in self-concept for BPD is reflected in various clinical models, in which alteration in self-concept is regarded as the core component of the disorder (Evans et al., 2015). Early psychodynamic theories viewed identity in BPD as diffused, referring to lack of integration in the concept of self and significant others (Kernberg, 1975; Yeomans & Delaney, 2008). TFP posits that this failure of integration results from the predominance of internalized aggressive object relations over idealized ones and the excessive use of primitive defense mechanisms, such as projection, splitting, or dissociation (Yeomans & Delaney, 2008). The individual is thus left with one-dimensional, contradictory, or fragmented internalized representations of the self and others, and difficulty in discerning more subtle variations (Kernberg, 1975).

In ST theory, content, as well as structure variation, in the self-concept is proposed. As previously described, the theory posits that BPD is characterized by early maladaptive schemas and schema modes. The former refers to *trait*-like cognitive structures while the latter refers to fluctuating facets of personality that can be understood as cognitive-emotional-behavioral *states*. An individual's schema modes may be integrated into a cohesive whole or dissociated; the degree of integration varies (Young et al., 2003).

Similarly, as previously mentioned, the theory of CAT assumes that partial dissociation due to childhood trauma or deprivation results in the persistence of separate self-states (Golynkina & Ryle, 1999). The CAT concept of self-states shares many similarities with the ST concept of schema modes. Despite individual differences, the TFP, ST, and CAT models share the view that self-concept is unstable and fragmented in BPD (Evans et al., 2015).

Two other evidence-based treatments for BPD, i.e., DBT and MBT, seem to place no substantial emphasis on the centrality of identity disturbance. They nonetheless describe the negative content of patients' self-experiences. In addition, both therapies aim to facilitate integration. In DBT, difficulties within the self and identity are hypothesized as stemming from invalidating environments in which children fail to learn how to trust and validate their own observations and emotions as valid reflections of reality, thereby leaving identity fragile. According to Linehan (1993), attempts to inhibit mental contents engendering the inability to experience, process, and integrate traumatic events may also contribute to the lack of a strong sense of identity.

In MBT, it is assumed that intensive negative self-representations encountered in BPD are due to trauma, neglect, or failed parental mirroring of the child (Löf et al., 2018). Due to incongruent mirroring of the child's mental states, the child may internalize the caregiver's mental state as an "alien self", yielding discontinuity within the self (Fonagy, 2002). With respect to self and identity as a process, indications of the failure of self-organization become particularly apparent in moments of wavering mentalization (Fonagy et al., 2012). Individuals may then attempt to alleviate the incoherence within the self through externalization. That is, they may project the alien part (for instance, "badness" or "abuser") of the self onto another individual, who then becomes the carrier of these intolerable or unacceptable alien parts. They may also attempt to alleviate the incoherence by suicidal acts (Allen et al., 2008; Fonagy et al., 2012).

2.4.2 Extant research into self-concept and identity in BPD

Studies have consistently indicated that individuals with BPD have a negative explicit self-concept (Beeney et al., 2016; Gad et al., 2019; Sieswerda et al., 2005), and low self-esteem (Korn et al., 2016; Lynum et al., 2008; Roepke et al., 2011; Winter et al., 2018). They tend to generate extremely negative self-evaluations (Vater et al., 2015) and experience shame (Karan et al., 2014; Rüsch et al., 2007), self-stigma (Grambal et al., 2016; Quenneville et al., 2020; Rüsch et al., 2006), and a high degree of self-blame and self-neglect combined with reduced self-love (Klein et al., 2001). Recently, Spitzer et al. (2020) found that women with BPD showed significantly more shame- and guilt-prone implicit self-concepts compared to healthy controls. They found that such women also scored higher on explicit measures of shame and guilt.

In terms of identity as content, beliefs encompassing the themes of rejection, abandonment, unlovability, loneliness, and experiencing the self as bad and deserving punishment have been found to be highly BPD discriminative (Arntz et al., 1999; Arntz et al., 2004).

On the structure of identity, empirical evidence thus far provides partial support for the schema mode model proposed by ST theory (for a review, see Sempértegui et al., 2013). This model highlights the modes of the vulnerable child, the angry child, the detached protector and the punitive parent (Young et al., 2003). However, BPD sufferers also score high on many other schema modes if these are included in the study design (Leppänen et al., 2016b; Sempértegui et al., 2013). Therefore, the question of the potential disorder-specificity of schema modes remains open.

On the stability of self-esteem, Santangelo and associates (2017) found that the estimated odds of acute changes in self-esteem were eight times higher in BPD sufferers compared to healthy controls. Findings from this study also suggested a pattern characterized by sudden dramatic worsening and slow recovery of self-esteem in individuals with BPD.

Importantly, studies are now beginning to address how self-referential information is processed. Findings from this line of research suggest that BPD is characterized by negative processing biases. Specifically, Winter et al. (2015) found that, during a self-referential encoding task, adults with BPD judged positive and neutral self-relevant words as being more negative. In a similar vein, Auerbach et al. (2016) demonstrated that, compared to healthy young people, BPD sufferers endorsed, recalled, and recognized more negative and fewer positive self-relevant words. Using a controlled real-life social interaction design, Korn et al. (2016) explored the impact of social feedback on self-evaluations. It was found that BPD sufferers, when receiving feedback on their character traits, integrated undesirable feedback for themselves to a greater degree than healthy controls did. Naturally, negative self-referential processing biases are deleterious; selectively attending to negative self-relevant material may contribute to the development of a negative self-image (e.g., feeling damaged or deficient) and further entrench maladaptive schemas related to unlovability and worthlessness (Auerbach et al., 2016).

There have been fewer qualitative studies addressing the lived experience of self-concept and identity from the subjective perspective of BPD sufferers. Using narrative analysis, Adler et al. (2012) compared the narrative identities of twenty middle-aged (mean age 59 years) individuals with features of BPD to the narrative identities of a comparison group of twenty individuals with no such features. It was found that, compared to matched controls, the narrative identities of the individuals with features of BPD were significantly lower in the themes of agency, communion fulfillment (but not communion), and overall coherence. These findings suggest that identity disturbance in BPD may be construed as problems constructing a coherent personal narrative that features an agentic protagonist who is able to fulfill his or her communal needs (Adler et al., 2012). To quote the authors, “BPD life stories portrayed a protagonist who was batted around at the whims of his or her circumstances”, unable to influence life’s direction (i.e., low agency). This disempowered protagonist has trouble fulfilling his or her deep wishes for connection (i.e., low communion fulfillment, despite no differences in overall communal language compared to comparison subjects). More specifically, the authors described how the stories themselves lacked a strong sense of narrative coherence: the reader/listener was often not oriented to new episodes as the story unfolded, the sequencing of events could be hard to discern, affect was intense at times while notably lacking at others and left the listener/reader unclear as to which elements were the most salient (Adler et al., 2012). However, of note, the study design precluded conclusions about the direction of the relationship between identity disruption and diagnostic status. That is, it is possible that features of BPD lead to narrative identity disruptions, that narrative identity disruptions lead to the development of features of BPD, or that a third variable is responsible for both presentations.

Another relevant qualitative study explored the identities in individuals with symptoms of BPD. Using thematic analysis of interviews, Agnew and associates (2016) studied the lived experiences of five women. Within all participant narratives, there was a picture of participants feeling lost, unreal, or conflicted. They could also feel broken, destructive, and helpless. Traumatic experiences engendered a sense of the inevitability of abuse and one's own inability to prevent it, highlighting the lack of perceived control. Often, abuse continued from childhood to adulthood, thus being repeated with new significant others. This study captured some aspects of the consequences of trauma and dissociation to self and identity. More specifically, participants spoke about the blocking, disconnection, and a glazing over of some traumatic events in their lives and the disconnection between aspects of childhood and adulthood. Regarding disconnection, some participants described thinking about some negative life experiences as if it happened to someone else. However, connection within the self was also evident in some accounts, as others referred to their ability to hold on to connection to their sense of self, including their early life experiences. Reflecting a conflicting sense of self, participants described an internal struggle within themselves involving conflicting ideas of morality and wickedness, goodness and badness, and childishness and adultness. Moreover, they described alternating moods and swinging from periods of inactivity, seclusion, and negativity to periods of complete positivity, activity, and involvement with others. All participants spoke about attempts to keep their physical and psychological self hidden from others for fear of being judged negatively, being hurt, or abused.

On relatedness, participants in Agnew et al.'s (2016) study described confusion and blurring of the physical, emotional, and psychological boundaries separating themselves from others. Specifically, for instance, they noticed a difficulty separating themselves from others emotionally; they were aware of the strong impact of others' emotional states on their own mental states. How they related to others could also manifest a cyclical, repeated pattern. For instance, participants described an attachment pattern characterized by shifts between depending heavily on others and pushing them away. Pushing significant others away could be motivated by testing behavior: “Do you still love me now?” Extreme deeds were used to test how far the partner could be pushed. Participants understood their suffering as having relational origins; all participants described prior experiences with critical and controlling significant others. The interconnected nature of these themes with one another was observed on many occasions. One example of this interconnectedness is that deficient self-separation and blurring of self-other boundaries seemed to have an impact on participants’ abilities to regulate many aspects of their lives.

In terms of agency, Agnew et al. (2016) noticed a surprising lack of narratives associated with change following insight. Specifically, although change in narratives did occur, they were mainly absent. Similarly, this was an anomaly also found in the narrative study by Adler et al. (2012), who also described a low sense of agency and lack of change in narratives. Agnew et al. (2016) discuss whether this may connect to a lack of perceived control. Otherwise, due to heterogenous methodologies, these qualitative studies are difficult to compare.

Finally, a relevant research question is whether treatment can affect the content, structure, or processing of the self-concept. A randomized controlled trial comparing BPD patients assigned to DBT or to the so-called “community treatment by experts” (CTBE) revealed that participants in both conditions started therapy with an overall hostile, critical, and punishing introject. However, over the course of the treatment and 1-year follow-up, the patients assigned to DBT reported significantly greater self-affirmation, self-love, self-protection, as well as less self-attack (Bedics et al., 2012). Roepke et al. (2011) compared a 10-week inpatient DBT treatment program to a waiting list. They found that compared to wait-list controls, patients in the treatment group showed significant enhancement in self-concept clarity and in some facets of self-esteem. Moreover, a naturalistic study revealed that BPD patients who had a very negative self-image at intake displayed improved self-image on all aspects of the SASB

(Structural Analysis of Social Behavior; Benjamin, 1974) after 18 months of MBT (Löf et al., 2018).

To conclude, it is well established that self-concept and identity are often extremely negative in BPD sufferers. Self-esteem may show a pattern of acute dramatic worsening in response to various triggers, and slow recovery. Distinguishing between explicit and implicit processing of self-concept seems to be important. This explicit-implicit distinction needs to be addressed in future research on self-concept in BPD. However, our understanding about *how* change in identity and self-concept occurs in treatment, and how competencies in this area could be brought out in therapy, is still extremely scarce. Qualitative research into the lived experiences of BPD sufferers may help further the development of useful treatment strategies that target these problems.

2.5 METHODOLOGICAL BACKGROUND

2.5.1 Process–outcome study in psychotherapy research

While outcome studies predominantly attempt to answer the question of *what* or *how much* works, process research focuses on *why* and *how* an intervention leads to change or fails to work (Boritz et al., 2019; Castonguay et al., 2010). Process–outcome research, then, attempts to combine both these perspectives to change. The challenge and potential contribution of process–outcome research to psychotherapy research is the identification of the exact, core or critical processes leading to change (Llewellyn et al., 2016).

In psychotherapy research, outcome generally refers to the change in a patient's behavior, experiences, or characteristics after therapeutic intervention (Llewellyn et al., 2016), while process originally referred to in-session events leading to patient change (Greenberg, 1986). Later, the definitions of process and outcome have increased in breadth. According to Crits-Christoph et al. (2013, p. 299), process–outcome research explores "both the events in psychotherapy sessions, or the constructs thought to change during or in between therapy sessions" and their association with subsequent change in “problems, symptoms and functioning”. Thus, a broad variety of different process elements can be explored. These include (a) therapist processes (e.g., specific therapy techniques) that facilitate patient change; (b) patient processes (e.g., types of patient actions, topics brought for discussion, or level of motivation) that facilitate patient change; (c) interpersonal processes between the therapist and patient that facilitate patient change (e.g., empathy, warmth, congruence, and alliance); and (d) service contexts (e.g., social, historical, cultural, and political contexts) that facilitate change processes (Elliott, 2010). Reflecting the breadth of process–outcome research, the effects (immediate or delayed) of any of the above-described processes can be explored either within or between sessions. Moreover, researchers can choose whose perspective is studied. That is, each of these research questions can be examined from the perspective of the patient, the therapist, or a third-party observer, and these perspectives can also be compared (Llewellyn et al., 2016).

Thus far, quantitative studies have dominated the process–outcome research field. Nevertheless, qualitative, as well as combined quantitative and qualitative, research designs also play an important role in the development of the understanding of process–outcome relationships. Qualitative approaches provide an opportunity to gather in-depth information from patients and hear their individual perspectives and lived experiences of therapy (Llewellyn et al., 2016).

Like more general psychotherapy research, process–outcome research is also fraught with challenges. A central challenge is that the study designs used often preclude drawing conclusions about whether a causal relationship exists between a process variable and an outcome variable. To a large extent, process–outcome research has been correlational. Correlational process–outcome research can, for instance, investigate whether the number of therapist interventions focusing on patient emotions correlates with patient outcomes. However, it needs to be kept in mind that correlation between two variables does not necessarily imply causation (Llewellyn et al., 2016). For instance, in the above-described design, a detected correlation between the number of therapist interventions focusing on patient emotions and good outcomes would not automatically imply that therapist interventions targeting patient emotions *caused* this change. Another challenge is that the counting of simple frequencies does not do justice to the qualitative weight of different events (Timulak, 2010).

2.5.2 The place for different research paradigms in psychotherapy research

In psychotherapy research, efficacy and effectiveness are best investigated using a quantitative approach. RCTs are needed to understand whether a treatment works or is inert. This study design is based on the homogeneity assumption. That is, uniformity is assumed to exist between patients sharing the same diagnosis, therapists sharing the same theoretical orientation, or certain types of specific interventions (Silberschatz, 2017). In the context of clinical psychotherapy trials, selecting patients carefully or rating therapist adherence to a specific therapeutic intervention are examples of striving for homogeneity within an intervention. According to Silberschatz (2017), assuming homogeneity, however, leads to ignorance of the fact that the effectiveness of therapy will vary considerably depending on the therapist delivering the treatment as well as on the person using this service. Silberschatz (2017) cites Cronbach, who, in his presidential address to the American Psychological Association in 1957, pointed out that it is misleading to speak broadly of treatment effects, since these effects will vary depending on the person being treated. More specifically, individuals will respond differently to the same situation or intervention; two patients receiving the same treatment may respond differently and for different reasons. In psychotherapy, multiple variables operate simultaneously and are difficult to discern and control for. The meaning of an intervention may differ considerably depending on how, when, under what circumstances, by whom and to whom it is delivered. According to Rice and Greenberg (1984), patients will respond differently to the same interventions depending on how they perceive the situation, and in terms of their goals and intentions. For instance, Blatt et al. (2010) found that differing levels of perfectionism significantly affected therapy outcomes in ostensibly homogeneous samples of individuals with depression. Accordingly, another study found that depressed individuals who framed their goals in terms of avoidance showed significantly less improvement than their counterparts who framed their goals in terms of approach (Wollburg & Braukhaus, 2010).

After RCTs demonstrated that a specific treatment is worth delivering, complementing research paradigms may be helpful in obtaining a nuanced understanding of change in psychotherapy. One example of such complementing approaches is the so-called events paradigm (Rice & Greenberg, 1984) where the research focus is on key events or clinically significant moments in psychotherapy sessions. Significant events research (Elliot, et al., 1985) is similar to research on helpful and hindering processes. It represents a specific approach to studying client-identified important moments in the therapy process. The underlying rationale is the idea that the events are the moments of the most fruitful therapeutic work in the case of helpful events, or the most problematic points in the case of nonhelpful (hindering) events (Timulak, 2010). The examination of such events provides a direct window into what can, as experienced by psychotherapy participants, facilitate or interfere with change; this, in turn, may lead to a better understanding and, ultimately, to improvement in psychotherapy (Castonguya et al., 2010).

Within the psychotherapy field, a tradition for qualitative research has gradually developed throughout the last three or four decades (Finlay & Evans, 2009; Frommer & Rennie, 2001; Mc Leod, 2011). Qualitative research methods are increasingly recognized as highly useful in psychotherapy research for investigation of the experiential world of research subjects, as well as personal growth processes, i.e., the “what” and “how” questions of process and change. Addressing “what” and “how” questions can provide a valuable addition to studies based on “how much” questions concerned with the overall efficacy of psychological interventions (Binder et al., 2012). Exploration of the experiential world of patients, service-users, or professionals within the mental health field will inform us about the perceived relevance of interventions: how personal and interactional struggles are experienced as important and necessary conditions for change and growth processes in psychotherapy, or how relational processes constitute specific contexts of change for patients (Binder et al., 2010; Moltu & Binder, 2010).

2.5.3 The place of content analysis within the family of qualitative approaches

Qualitative approaches form a broad family of approaches. They share a common philosophy characterized by person-centeredness and an open-ended starting point (Holloway & Todres, 2003). Also common is that they share the goal of endeavoring to understand a particular phenomenon from the perspective of those experiencing it (Vaismoradi et al., 2013). Embracing multiple realities, committing to participants' viewpoints, committing to in-depth understanding of these phenomena, executing inquiries with minimal disruption to the natural context of the phenomenon, and reporting findings in a style rich in participant commentaries are key aspects delineating qualitative methodologies (Streubert Speziale & Carpenter, 2007). In terms of procedures and techniques, qualitative approaches also overlap to a considerable extent. Overall, similarities of specific approaches may be more important than differences (Vaismoradi et al., 2013).

Qualitative approaches still differ from one another, however. Here, I will not review the philosophical differences underlying specific qualitative streams but rather briefly describe some salient pragmatic differences. These pertain to interpretation-description ratio and possible quantification of data in addition to qualitative analysis. More specifically, according to Sandelowski & Barroso (2003), use of grounded theory (Glaser & Strauss, 1967; Rennie et al., 1988) and hermeneutic phenomenology (Heidegger, 1962) require a high level of interpretive complexity, whereas the application of qualitative descriptive approaches, including descriptive phenomenology (Giorgi, 1970), content analysis (Krippendorff, 2004), and thematic analysis (Braun & Clarke, 2006), is suitable for researchers wanting to employ a relatively low level of interpretation. However, unlike Sandelowski and Barroso (2003), Braun and Clarke (2006) state that thematic analysis applies minimal description to data but rather interprets various aspects of the research topic. In addition to this description-interpretation ratio, another significant difference between thematic analysis and content analysis pertains to the quantification of data (Vaismoradi et al., 2013). That is, application of a content analytic approach to the data enables both qualitative analysis and quantification (Gbrich, 2007). Thematic analysis, by contrast, provides a purely qualitative, detailed, and nuanced account of data (Braun & Clarke, 2006).

2.5.4 Selection of approach for this thesis

My choice of approach was influenced by two aspects: 1) the degree of data transformation during the analytic process, from description to interpretation, and 2) the possibility to quantify the data. More specifically, following my desire to predominantly give voice to the patients and thus describe the data applying a relatively low level of interpretation (data-sensitivity; Kyngäs, 2020a), content analysis emerged as the method of choice. However, I also admit that local influences may have affected my selection of approach. Since content analysis has obtained a firm foothold in Finnish nursing research over the past decades (Kyngäs, 2020a), it was quite a natural choice for qualitative research.

3 METHODS

This process–outcome study was conducted in community mental health care services (henceforth the center) in Jyväskylä, Central Finland. Applying a mixed method research design, the qualitative component of the study aimed, through analysis of videotaped group sessions and in-depth interviews, to trace and describe patients' first-person experiences of distress and meaningful development and change. The qualitative component also explored how patients experienced the effect of different treatment factors on their change process. The quantitative component of the study assessed change in BPD symptom scores at a baseline level, at the end of the 40-session psychoeducational group intervention, and one year after treatment end. This mixed method study design enabled comparison and contrasting of qualitative and quantitative findings.

3.1 PROCEDURE AND SETTING

3.1.1 Recruitment

Participants were recruited from the center whose services form part of Jyväskylä municipality's secondary, specialized psychiatric services. Professionals working at the center were approached, informed about the study, and asked to refer patients aged 18–65 years with BPD symptoms for potential recruitment. The study design was naturalistic; the professionals, as part of their routine work, informed patients with BPD symptoms about the possibility to participate in the study. The intervention that formed part of the study is routinely offered to BPD patients being treated at the center. Hence, it was not controlled for in this study. Patients were thus recruited for the study and group treatment simultaneously.

Potential participants were assessed in order of referral between July and August 2017. Due to restricted resources, only one treatment group of eight patients could be studied. Therefore, when the number of eligible participants reached eight, recruitment ceased. Hence, saturation could not be taken into account in sampling (Saunders et al., 2018).

Inclusion and exclusion criteria

The inclusion criterion was a BPD diagnosis based on the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5; American Psychiatric Association, 2013). Exclusion criteria were a DSM-5 diagnosis of a psychotic disorder or a substance abuse disorder necessitating pre-treatment detoxification. Exclusion criteria were evaluated only clinically, with no other structured evaluations.

Based on the Finnish version of the Borderline Personality Disorder Severity Index (BPDSI; Arntz et al., 2003), the referred patients were assessed for eligibility. No other diagnostic assessments were executed. Based on the eligibility interview, we excluded one patient whose diagnosis was post-traumatic stress disorder (PTSD). I conducted all the eligibility interviews except for one (conducted by Sari Lindeman).

3.1.2 Treatment

Group intervention

The intervention, previously known as the Oulu BPD model, was originally developed in Oulu, Northern Finland to meet the needs of individuals with BPD being treated at public mental health services (Leppänen et al., 2016a). This treatment consists of 40 weekly 2-hour psychoeducational group sessions, which were implemented between August 2017 and June 2018. The group was facilitated by two experienced psychiatric nurses who delivered the treatment as part of their routine work at the center.

The treatment framework integrates elements drawn from cognitive and behavioral models designed to treat BPD. One of the main components of the intervention is patient education in ST using the concept of schema modes. The intervention also includes education in the development of BPD, DBT skills, as well as ideas drawn from metacognitive therapy for personality disorders, in particular, the concept of interpersonal cycles and rapidly changing representations of the self and others (Dimaggio et al., 2007).

Treatment as usual

In addition to group treatment, all participants continued their pre-existing treatment as usual (TAU) at the center. This treatment consisted of weekly individual sessions provided by psychologists or psychiatric nurses and medication. It would, if needed, also continue post intervention, often with reduced frequency. TAU was not controlled for. While some of the individual therapists were familiar with BPD treatment or this treatment model, others were not.

3.1.3 Participants

Seven of the eight subjects included in the study were female. They were aged 23-42 (mean 30, median 26) at the beginning. At the start of the study, the subjects' mean BPDSI score was 31.1, indicating moderate to severe symptoms. On average, the patients suffered from substantial functional impairment, as reflected in the fact that only two were working or studying upon entry to the study. One was attending a work trial for occupational rehabilitation and five were receiving disability payments. No structural assessment of functioning was performed, however.

3.1.4 Data collection

The treatment was delivered at the center, and all group sessions were videotaped with two cameras to ensure that all participants could be observed. All interviews were also conducted at the center. Specifically, at the end of the treatment, participants were interviewed. These interviews were executed between June and October 2018 after the treatment had ended and were videotaped. The 12-month follow-up in-depth interviews were conducted between June and July in 2019 and were videotaped.

The quantitative diagnostic assessments, viz. the BPDSI interviews, were conducted three times: pre- and post-intervention, and 12 months after the treatment had ended. All the baseline BPDSI interviews were audiotaped except for one, which was due to technical error. All the post-intervention and 12-month follow-up BPDSI interviews were videotaped.

Assessments

In-depth interviews

Data was gathered through semi-structured in-depth interviews in which patients were asked to reflect on their experience of personal development or meaningful change, or lack thereof, over the past year during the group intervention (treatment end interview) and over the 12-month post-treatment follow-up period (follow-up interview). The questions used in the in-depth interviews conducted at treatment end are presented in Table 1, and those used at the follow-up are depicted in Table 2.

Table 1. Interview questions asking about subjectively perceived development and change (treatment end)

1.	How would you describe your personal development or growth during the past year when you were attending the group sessions or, if you have not experienced any change, how would you describe that?
2.	What do you feel was most pertinent to your development or change? What, if anything, was of crucial importance in this process? What else may have contributed to your personal development? (Or if you experienced no development, why do you think that was?)
3.	Do you feel the group influenced your development or change? If so, what specifically promoted your positive growth or recovery?
4.	Was there anything about the group that you feel hindered your growth or recovery?
5.	(If there was some progress), could you tell me how you plan on using this new learning in the future?
6.	Is there anything that was previously hard for you that you are nowadays able to deal with in a new way?
7.	Is there anything that you are still struggling with? What kinds of things or moments or situations are you still finding it hard to deal with?
8.	What about life outside the treatment context? Does that play a role in your development and, if so, how great a role?

Table 2. Interview questions asking about subjectively perceived development and change (12-month follow-up)

1.	How would you describe your personal development or sustained growth (or lack thereof) during the past year?
2.	Is there anything that was previously hard for you that you are nowadays able to deal with in a new way?
3.	Is there anything that you are still struggling with? What kinds of things or moments or situations are you still finding it hard to deal with?
4.	During the past year, how you have been using what you learned in the group?
5.	What about life outside the treatment context? Does that play a role in your development and, if so, how great a role?

The Borderline Personality Disorder Severity Index interview

The Borderline Personality Disorder Severity Index (BPDSI; Arntz et al., 2003) is a clinician-rated interview evaluating the frequency and severity of BPD symptoms over the preceding three-month period. With the intention to track short-term changes and treatment effects, the aim is to provide a quantitative index of current symptom severity. The BPDSI is one of the outcome measures recommended by the NIMH workgroup (Zanarini et al., 2010c).

The BPDSI is based on the DSM criteria of BPD. It consists of 70 items organized into nine subscales: 1) abandonment, 2) unstable relationships, 3) identity disturbance, 4) impulsivity, 5) parasuicidality, suicide plans and attempts, 6) affective instability, 7) emptiness, 8) outbursts of anger, and 9) paranoid and dissociative ideation. Among validated interview instruments to assess BPD symptoms, BPDSI is the only one to evaluate each criterion using multiple items (Leppänen et al., 2013).

For each item, the frequency of occurrence over the preceding three months is rated on an 11-point scale running from 0 (never) to 10 (daily). The answers are then either classified and scored from never (0 points) to daily (10 points) or rated on a 5-point Likert scale (Giesen-Bloo et al., 2010). Exemplified using the subscale of "outbursts of anger", one of the interview questions pertaining to this subscale is: “During the past 3 months, how often did you attack others (physically)?” The answer is then classified and scored as follows: never (0 points), once in 3 months (1 point), twice in 3 months (2 points), three times in 3 months or once in a month (3 points), from four to five times in 3 months or once in 3 weeks (4 points), from six to seven times in 3 months or once in 2 weeks (5 points), eight to ten times in 3 months or twice in 3 weeks (6 points), once a week or 11–15 times in 3 months (7 points), several times a week but less frequently than half of the week (8 points), more frequently than half of the week or almost daily (9 points), daily (10 points) (Leppänen et al., 2013). A 5-point Likert scale, ranging from 0 to 4 points is applied to the rating of identity disturbance answers. Scores for the nine DSM criteria are then derived by averaging the item scores; the BPDSI total score is the sum of means of the nine criteria scores (Giesen-Bloo et al., 2010).

With a specificity of 0.97 and a sensitivity of 1.00, previous research has found a cut-off score of 15 between individuals with BPD and controls (Arntz et al., 2003). Recovery is defined as achieving a BPDSI score of less than 15. Reliable change, which reflects clinically significant improvement, is achieved when improvement (i.e., decrease in the total score) is at least 11.7 points (Nadort et al., 2009).

3.2 DATASETS

This thesis utilizes four different datasets. The first dataset consists of transcriptions of the treatment end in-depth interviews. This data consists of responses to the semi-structured interviews in which patients were asked to reflect on their experience of personal development or meaningful change (or lack of it) over the past year during the group intervention. The first study draws on this dataset.

The second dataset consists of videotaped and verbatim transcribed 12-month follow-up in-depth interviews asking patients to reflect on their sustained development and change (or lack thereof). The third study draws on this dataset.

The third dataset is composed of the videotaped and verbatim transcribed group sessions. This data consists of 40 sessions, each lasting two hours. The second study draws on this dataset.

The fourth dataset consists of BPDSI interview scores (baseline, treatment-end, and 12-month follow-up scores). These quantitative data are used in the first and third studies.

3.3 DATA ANALYSIS

Qualitative content analysis was applied to all qualitative data, viz. the in-depth interview and the group session data. In the first study, we were determined to explore participants' experiences of their personal development and change and the perceived role of treatment-factors in this change. The preliminary approach was nevertheless inductive, meaning relevant themes were allowed to emerge from the data. In the second and third studies, the approach was even more inductive. More specifically, we sought to trace what was most poignant for participants without having any predetermined idea what this might be. Using an inductive approach to the data of the third study that consisted of 12-month follow-up in-depth interviews and 12-month follow-up BPDSI scores, the emerging theme was self-concept and identity development. The inductive approach to the data of the second study consisting of videotaped group sessions yielded self-invalidation as a relevant theme.

In all three studies, I immersed myself into the videotaped data and transcribed it verbatim. The data of the second study consisted of the videotaped group sessions, and for those I only transcribed sections that contained interaction. In other words, due to a lack of additional transcribers, sections comprising mere psychoeducation (i.e., facilitators lecturing) were left untranscribed.

In analyzing the data, I followed the guidelines for inductive content analysis described by Kyngäs (2020b). The analysis was conducted according to the following steps: data reduction, data grouping, and formation of concepts, i.e., data abstraction. In the data reduction phase, I extracted the parts of the transcribed text that covered data pertaining to the corresponding research question and compiled them into a single text. Initially, a unit of analysis was selected. In these studies, this was a meaning describing a single, relatively circumscribed, coherent idea. Most typically, a unit of analysis comprised one or a few sentences. In the data reduction phase, I read through the raw data sentence by sentence and marked instances of open codes. The following segment [*Because the punitiveness was so intense, I feel kind of lost without it now … It was like the engine, or gearbox … Then you remove a huge piece, and the whole dynamics change … I'm still processing all this … The worst part is: Who am I, then? But it's not a panicky "Who am I?" but it's more like "Let's see who I might be"*] is one example of a unit of analysis of the third study. (Please note that the dots denote filler words that were preserved in the original data but, for the sake of convenience, removed for this presentation.) This unit of analysis was initially coded "feeling lost – who am I, then?" Thereafter, in the data grouping phase, all utterances sharing the same meaning were assigned the same code. The similarities and differences in the content of these open codes were then compared to determine which codes could be grouped together to form larger sub-concepts. "Feeling lost when the dominant self-script was questioned" is one example of such a sub-concept. Based on the similarities and differences in the content of the sub-concepts, the data abstraction phase continued until no shared meaning (or not enough shared meaning) between sub-concepts was left, and thus core categories could be constructed (Kyngäs, 2020b). "Challenges to the processing of self-concept and identity" is an example of such a core category of the third study.

I frequently returned to the transcribed in-depth data. Although paralinguistic elements were included in transcriptions, transcriptions inevitably remained deficient in the finest nuances (i.e., prosody, direction of gaze, etc.). Hence, to augment vivacity and thus understanding, I returned to the videotaped data as well. I reviewed 80% of the videotaped data together with my supervisor Tarja Melartin. Furthermore, we discussed, and occasionally revised, my preliminary codes and even clustering decisions. Sari Lindeman read the transcribed data and negotiated the clustering. No other validation measures were undertaken.

In the first and third studies, the in-depth and BPDSI interviews were implemented in close succession, with the BPDSI immediately after the in-depth interview. I scored the BPDSI soon after the interview. Since I conducted all interviews except for one initial BPDSI interview (conducted by Sari Lindeman, as previously mentioned), the scoring of the BPDSI was not done blind. That is, when analyzing the qualitative data, I was aware of the participants’ remission statuses.

4 RESULTS

4.1 FINDINGS FROM THE FIRST STUDY: PERCEPTIONS OF DEVELOPMENT, CHANGE, AND TREATMENT FACTORS

The aim of the first study was to investigate: 1) how patients experience their development and change (or lack thereof) soon after the treatment was ended, and 2) how they perceive the contribution of treatment-related factors or events in their process. The main perspective of interest was the lived experience of the participants. A secondary aim was to track change in BPD symptoms. At the end of the treatment, all eight participants (100 %) were interviewed.

4.1.1 Change in BPD symptoms

Regarding remission from BPD, four patients (50%) were considered remitted based on their BPDSI interviews conducted soon after the intervention had ended. Two patients (25%) were considered to have experienced a reliable, or clinically meaningful, change and two (25%) remained unchanged (Figure 1).

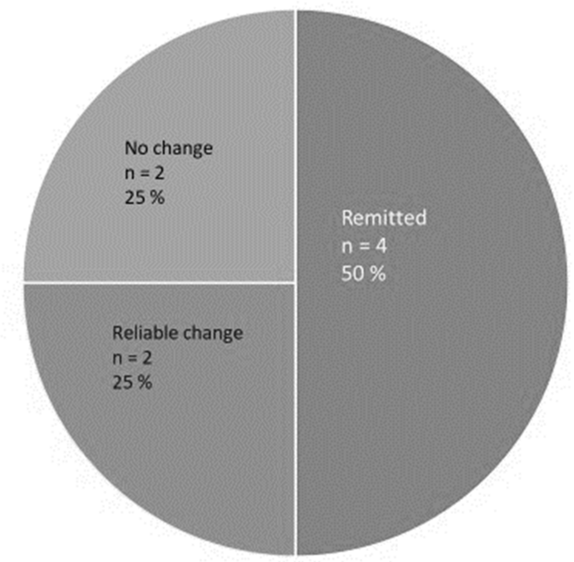

Figure 1. Remission from BPD. Remission is defined as achieving a BPDSI score of less than 15. Reliable, or clinically meaningful, change is achieved when improvement (decrease in BPDSI score) is at least 11.7 points (study I)

4.1.2 Subjective experience of meaningful development and change

The qualitative content analysis on subjectively perceived meaningful change yielded three core categories: 1) improved ability to observe and understand mental events in oneself and others, 2) decreased disconnection from emotions, emergence of new or adaptive emotional reactions and decrease in maladaptive ones, and 3) a new, more adaptive experience of self, and agency.

Improved ability to observe and understand mental events in oneself and others

Enhanced self-observation and an improved ability to understand mental events in oneself and others was regarded as very helpful. All participants, regardless of their symptom change, described changes related to this category. Most often, this was expressed as an ability to perceive one´s experiences with increased accuracy and clarity in the present moment and to organize them. For instance, following a challenging interpersonal interaction, patients described how they could notice feelings of hurt or anger arising. They were able to describe in their own mind what happened, how they reacted to this trigger, and what action urges they were experiencing (e.g., urges to withdraw or lash out), and subsequently plan for desired actions.

As evident from the example described above, a host of positive outcomes seemed to associate with an improved ability to observe mental events. It enabled choice over their own actions: participants could, for instance, choose to pause, postpone their knee-jerk reactions, while reflecting on how to respond to a situation that triggered emotions. It seemed that improved self-regulation was an outcome of improved, more compassionate self-observation. Moreover, when able to understand mental events as representations, as opposed to absolute truths (e.g., '*I am not a valid person*' is an early maladaptive schema), participants became less incapacitated by their mental states and hence more able to modulate their behavior to match the requirements of the situations they encountered in their daily lives.

Furthermore, an improved ability to understand mental events in oneself and others was associated with improved self-other differentiation, and it affected participants' relationships in a positive way. Participants understood that each person has his or her own mind – his or her own thoughts and feelings – and they became more capable of letting others just have them: "*Ok, this is his thought at the moment*". The ability to mentalize reduced the perceived sense of threat or anger previously attributed to differing perspectives and increased the acceptance of different mindsets.

Decreased disconnection from emotions, and emergence of new, adaptive emotional reactions and decrease in maladaptive ones

The content analysis yielded a second core category, the theme of which was the processing of emotions. Seven out of eight participants, i.e., all but one who remained unchanged according to the BPDSI, described an improved ability to maintain connection with their emotions without having to cut them off. Their awareness of the various strategies they used to disconnect from their mental contents also increased. Now that they were willing to attempt to establish increased contact with their mental states, they were deliberately working to implement change in the conscious parts of their avoidance strategies.

In addition to emotion processing strategies, participants reported new, adaptive emotions and a decrease in less adaptive emotions. Hope, self-compassion, and pride were mentioned as new emotions. In this study, the weakening of internalized punitiveness contributed to the emergence of these new emotions. A decrease in this internalized harshness also seemed to contribute to the observed decrease in self-hatred, guilt, and shame. Concerning hopelessness, a very prevalent secondary emotion among BPD sufferers, we observed the emergence of a new counteracting feeling, hope. Not all participants, however, identified hope as a discrete emotion, but a decrease in hopelessness or an increase in hope was indirectly evident in many accounts, e.g., in how they expressed their willingness to be alive. This was evident in the cessation of their previously unrelenting suicidal ideation, in their increased trust in their own skills and competence to manage daily hassles, or in their new ability to plan for the future. Sadness over what life had been, as well as adaptive anger towards perpetrators or those who neglected or invalidated participants’ emotions and emotional needs were also recounted as new, adaptive emotions.

A new, more adaptive experience of self, and agency

The content analysis yielded a third core category that reflected change in the experience of self. By comparing qualitative and quantitative findings, only participants classified as either remitted or having achieved a clinically meaningful change were found to have described experiences in this category.

Participants identified attenuation in the prior extremely harsh way of relating to oneself as a very meaningful change. Importantly, this internalized punitiveness and self-deprecation was ubiquitous at treatment start; change in it appeared to affect relevant change on various other domains. Specifically, participants' previous lives were often governed by submission to this harsh, self-berating voice. This internalization resulted in other-oriented behavior and fearful avoidance of challenges ad inertia, since acting brings about the possibility of making a mistake. Hence, this internalization obstructed agency, but its attenuation started to enable initial work towards one's own goals. Furthermore, participants realized their need for improved self-care, since self-care was no longer forbidden by harsh internalization. The decrease in internalized harshness and punitiveness also enabled participants to experience self-worth and feelings of self-compassion.

The previous weak sense of self included a lack of goals and feeling non-existent, invisible, or without a direction. Importantly, this weak sense of self encompassed difficulty in the identification and validation of thoughts, opinions, emotions, and needs. It engendered intolerance of loneliness, since when alone, "there was no mirror". Hence, patients lost sense of who they were and experienced bewilderment and confusion. However, absorbing and adopting others' ideas and opinions resulted in a chameleon-like, ever-changing self-experience that was also painful. The emerging ability to identify and validate ("stick to") their own perceptions and preferences seemed pertinent to the process where the self became more stable, continuous, and strong.

Interrelationship between different aspects of perceived meaningful change

Complex interrelationships between different aspects of meaningful change were observed. The following, related to paralyzed agency/inertia, seeks to provide one example of the complex interrelations between different aspects or components of change. It seemed that participants had to first gain meta-awareness towards an internal voice that conveyed the message "*you are not a valid person*", since without an ability to meta-process mental events, no alternative perspectives were possible. In other words, participants had to become able to distinguish between their mental representations and absolute truths. When they were able to pause and reflect ("*this is the voice of the invalidity schema but it doesn't* *necessarily have to be the only truth"*), they could avoid habitual reactions (including despondency, hiding, or inertia) and act in a compassionate way towards self ("*I notice how these imprints of my former learning are still inhibiting me and holding me back, and it makes me sad and makes me feel I need to take care of myself"*). To conclude, it seemed that enhanced meta-awareness, or mentalization, in combination with emergent self-compassion, began to enable an approach orientation instead of the previous avoidance orientation that had functioned as an attempt to feel safe. Acting – and possibly even failing at something – now became possible since they were no longer so closely connected to punishment. A more compassionate attitude towards the self and the ability to perform seemed to relate to both the reduction of internalized harshness and the ability to reflect on it. Participants' functioning was then no longer paralyzed by their prior learning (e.g., self as bad and not deserving of good). However, the ability to act was also associated with the ability to stay in contact with one's own emotions without having to block them. Previously, according to patient accounts, disconnected, numb states were very prevalent. In these detached mental states, no goals or actions made sense to participants. As they were unable to feel anything, they were also unable to gather the motivation to be agentic. Moreover, the findings suggested that active use of new skills also contributed to a sense of mastery and increased sense of agency. More specifically, being able to affect one's emotions and mental states, relationships, and life, participants no longer felt disempowered. I hope this example, which is only one among numerous that could have been presented, highlights the extremely complex, interconnected nature of change where gains in one area seemed to engender gains in another.

4.1.3 Treatment-related factors and events perceived as helpful or hindering

The first study also sought to explore participants' perceptions of the role of treatment-related factors in their change process. The qualitative content analysis yielded two core categories of helpful factors: 1) learning, and 2) normalizing. Accordingly, two core categories reflecting hindrances to development were found: 1) aggression in the group, and 2) inflexibility of the treatment. To the extent that the data enabled, we also attempted to describe *how* these treatment-related factors and events were perceived to affect the recovery process.

Learning

On helpful treatment factors, it was found that acquiring information was considered helpful. More specifically, conceptual knowledge aided in making sense of and organizing experiences that were elusive or previously taken as facts. Learning about how BPD is assumed to develop as the result of traumatic invalidation, for instance, was particularly helpful. Patients reported on how they learned to observe how they continued to invalidate themselves. However, they had now learned to question, and thus ultimately reduce, this habitual self-invalidation. Obtaining information on the proposed BPD-specific mental states as well as attachment trauma related interpersonal cycles seemed to further compassionate understanding towards the self and aid in gaining healthy distance from these mental states, or vicious circles.

Perhaps somewhat surprisingly, merely obtaining information seemed to initiate 'deep' processing, including the retrieval of memories, and activation of salient emotional processing. It stimulated new, adaptive emotional reactions, such as assertive anger or sadness over what had been and still was missing in patients' lives. Hence, under no circumstance was learning only a cognitive or passive process where the patient was simply receiving information. Rather, it seemed that psychoeducation provided the initial impetus that activated rich cognitive-emotional processing, and that patients were active agents in constructing and processing this new information together. Specifically, they were eager to learn from and with peers, thereby producing an atmosphere of collaborative learning.

Normalizing

The second treatment factor that was experienced as beneficial to personal development was normalization of participants' experiences. More specifically, it seemed that the BPD-related conceptualizations offered in the psychoeducational part of the group were experienced as normalizing. This seemed to set the tone for more compassionate self-observation and relating to oneself. In addition to the content and tone of the information delivered, peer experiences were also particularly pertinent to normalization. Participants suffered from serious shame, and their former sense of self was extremely negative. Being able to bond with others with similar difficulties and hear how they also struggled but managed to deal with their difficulties seemed to be of utmost importance. This appeared to validate and normalize not only participants' emotional experiences, but even their whole self, and this could translate into a new sense of agency: "*If others can, perhaps I will be able, too. Perhaps I'm more like normal, and not kind of a problem case, as I used to believe*". To summarize, patients started to experience themselves as more normal, capable of enduring ordinary disappointments and failings as part of life and to keep working towards their goals even when experiencing emotions.

Aggression in the group

Treatment-related factors that were perceived to hamper development also emerged. Besides being beneficial, peer experiences were also experienced as the most important hindrance to development and change, inducing hurt or even harm. Importantly, the two participants who reported being most disturbed by aggression in the group also reported no benefit from the treatment as assessed by the BPDSI.

In this study, the group was heterogeneous with respect to participants relying on rational (as opposed to emotional) processing. Participants also differed in their use of coping strategies. Use of overcompensation (e.g., sarcastic comments or talking about one's own intellectual capacity) hurt some participants whose self-esteem was shaken. However, the group process was also traumatic for those who relied on overcompensation since they became scapegoats for the group. More specifically, the group requested its participants to expose their vulnerability to a similar extent, a request that was impossible for members who tended to rely on rational-intellectual processing and overcompensation strategies. Evidently, the name of this category, "aggression in the group", fails to describe the self-protective functions of aggression and the vulnerability underneath it. An unfortunate outcome of aggression expressed in the group was indeed participants' strengthened reliance on their old interpersonal coping strategies. The feeling that they had to protect themselves seemed to interfere with sharing their underlying adaptive primary emotions or needs.

Inflexibility of the treatment

Another treatment-related factor that was perceived as a hindrance to development and change was inflexibility of treatment. This finding refers to a single but extended rupture in the group therapeutic relationship. Specifically, some participants experienced the wording of the mindfulness exercises practiced at the beginning and end of each session as aversive. They had previously attended other groups where these exercises varied between sessions and according to participants' own suggestions, and they wanted to discuss this possibility in the present group. Some other group members, on the contrary, wanted to limit the amount of time spent on discussing potential revisions. Eventually, the original wording was retained, which left some group members with the feeling that genuine negotiation was not possible. They felt other participants' wishes were sided with and valued more highly than theirs. They recognized how they interpreted this episode as a repetition of their childhood experience of not being heard or taken seriously. This caused a rupture in the group therapeutic alliance that was never fully repaired.

4.2 FINDINGS FROM THE SECOND STUDY: SELF-INVALIDATION AS MANIFESTED IN THE GROUP INTERACTION

Applying an inductive approach, the second study drew on the videotaped group sessions (40 sessions, 80 hours). Since self-invalidation (henceforth SI) emerged as an extremely prevalent, and apparently relevant, phenomenon, I decided to choose it as a target for further analyses. Thus, the second study sought to describe manifestations of SI in group discussions.

The findings indicated that SI was ubiquitous in the cognitive-emotional processing and behavior of the participants, dominating their mental worlds and permeating various domains in their life. A total of 534 utterances related to SI were found. The content analysis yielded three core categories of SI: 1) a self-critical and harsh attitude towards self, 2) a deficient sense of normalcy, and self-doubt, and 3) self-stigma. Figure 2 depicts these core categories and their relative proportions.

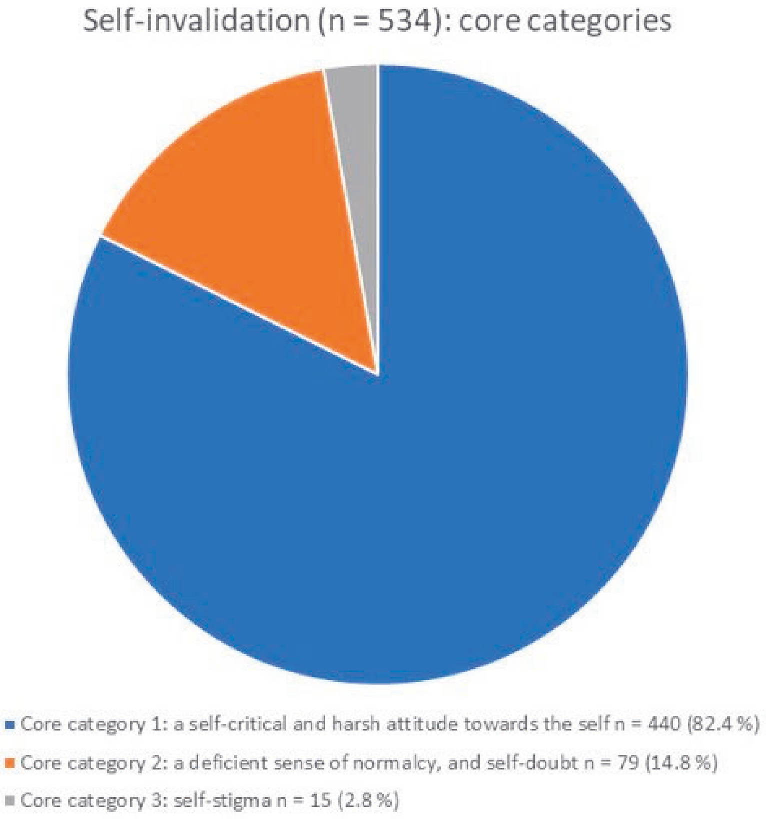

Figure 2. Self-invalidation: Core categories and their relative proportions (study II). N refers to the number of utterances related to the respective category.

4.2.1 A self-critical and harsh attitude towards the self

All eight participants exhibited self-disparaging and punitive processing and behavior. Four subcategories were identified: a) self-critical and harsh self-observation and self-talk, b) self-erasing, compliant behavior, c) initial self-validation followed by self-erasure, and d) deliberate display of counterfeit reactions as a coping strategy. The relative proportions of these subcategories are presented in Figure 3.

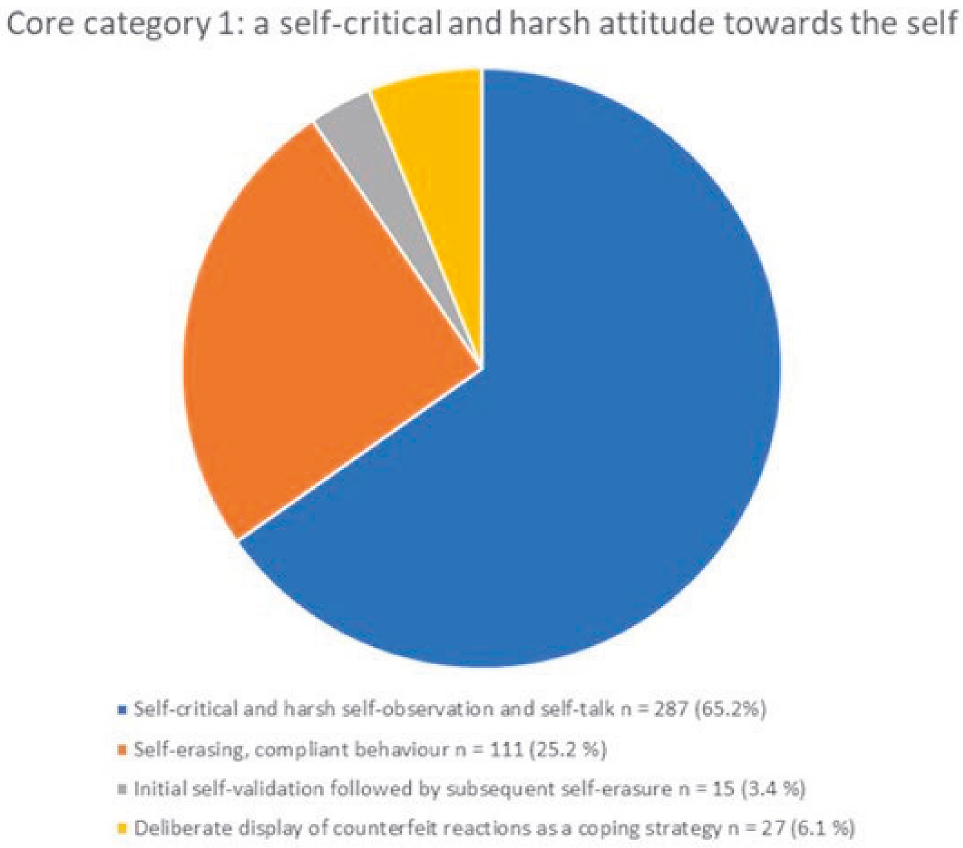

Figure 3. Core category 1: Subcategories and their relative proportions (study II). N refers to the number of utterances related to the respective category.

Self-critical and harsh self-observation and self-talk

All eight participants exhibited extremely critical and self-disparaging cognitive-emotional processing. This could manifest itself in the form of explicit self-talk that participants were aware of, but could also occur on an automatic level, thereby escaping meta-awareness. Participants could, for instance, feel confused about having destroyed good moments, but later realize how this behavior was the consequence of SI operating outside of, or at the edge of, awareness. Typical triggers for the activation of the harsh processing were distress ("*this shouldn't be a problem for anyone"*), interpersonal interaction, and performance and the success or rejoicing in it.

The self-critical processing style was associated with a host of unfavorable consequences, including difficulty identifying emotions (the ones that this processing style prohibited) and secondary emotional reactions (fear, shame, guilt, anger, and resentment). It was also associated with feeling vulnerable, insecure, worthless, blunted, invisible and non-existent, dysfunctional, and not deserving anything good.

Self-erasing, compliant behavior

Seven of the eight participants talked about self-erasure. This subcategory describes the behavioral consequences of the harsh processing style, reflecting a submissive response to the feared punitive internalization. At the behavioral level, a central example of self-erasing behavior was inadequate self-care. It could manifest as deliberate sleep deprivation, disordered eating, and generation of negative experiences in concert with denying oneself positive experiences. Others' real or imagined needs were also prioritized over own, causing subservient behavior while agentic behavior was obstructed due to the fear of negative interpersonal consequences, for example, invalidation by others, or loss of connection.

Regarding underlying motivations, self-erasing behavior could reflect indifference, or lack of orientation towards the self, or it could be due to the projection of one's own deprived needs and vulnerabilities onto others. In the latter case, patients attempted to avoid inducing similar negative experiences in others that they themselves had to endure as children. That is, they were careful not to invalidate others by withholding something they thought the other person needed, but in doing so they could violate their own boundaries.

Self-erasing, other-oriented behavior was associated with interpersonal, as well as self, consequences. Participants could feel resentful and angry at others who were portrayed as selfish or inconsiderate. Moreover, self-erasing behavior maintained and strengthened the experience of a neglected and confused self, lacking goals and direction, and self-worth.

Initial self-validation followed by subsequent self-erasure

This subcategory refers to temporal fluctuation, that is, experiencing self-doubt and self-erasure following the initial validation one's emotions, thoughts, or actions. The behavior itself (self-erasure) is analogous to that in the previous subcategory. Of eight patients, five displayed initial self-validation followed by subsequent self-erasure.

Self-validation followed by self-erasure was also found in group interaction. Neutral responses, perhaps experienced as lack of validation, sufficed to induce this, and the participants recanted, apologized, readjusted, or critically reflected on their personal contribution: "*Am I being too talkative?"* or "*I'm talking way too much"*.

Deliberate displays of counterfeit reactions as a coping strategy

"Previously, I only talked to my therapist about issues I assumed she wanted to hear".

Three of the eight patients described experiences or behaviors in this subcategory. In this subcategory, as in the previous one, trust is initially experienced in one's own reactions. However, unlike in the previous subcategory, this self-validation is maintained, with the individual deliberately displaying other, feigned reactions including feigned self-invalidation, inauthentic positive emotions, or counterfeit opinions.

The findings indicated that displays of feigned positive reactions or inauthentic SI served as coping strategies, aiming to protect from the pain of anticipated invalidation by others and related feelings of disappointment, shame, or humiliation. The motivation underlying this behavior was to appease the (supposedly) invalidating other who, for instance, approved only expressions of positive emotions or failed to share the joy of success. Hence, besides protection of the self, the purpose of this strategy was to maintain contact with the invalidating others. Displaying counterfeit behavior entailed consequences for both oneself and one's relationships, however. The discordance between felt, inner states and those presented to others had an alienating effect on participants' relationships. Displays of counterfeit reactions led to a vicious circle where one’s emotions and needs were misperceived – and thereby invalidated – by others.

4.2.2 Deficient sense of normalcy, and self-doubt

Content analysis yielded a second core category of SI that was characterized by doubting one’s perceptions. Six out of eight patients described experiences related to this core category. Participants would doubt and invalidate their own reactions because they lacked a sense of normalcy. Two different causes of a deficient sense of normalcy emerged. First, participants were prone to second-guessing their perceptions, suspecting that these were merely caused by their emotional reactivity, excessive emotional needs, distorting of information, or other manifestations of BPD: “*How can I tell a misinterpretation due to BPD apart from a valid reaction?”* Secondly, they described childhood environments deficient in templates for normative reactions, validation of their reactions, and guidance, leaving them perplexed in trying to determine normalcy and calibrate their reactions: “*Since my feelings were never validated, I’m unable to tell whether it’s ok to feel something”.*

4.2.3 Stigma and self-stigma

The third core category concerned the stigma and self-stigma associated with being diagnosed with BPD. All eight patients talked about it. They were painfully aware of the public (societal) and health care provider stigma related to BPD. Data from this study indicated that participants were sensitive to hints of potentially stigmatizing labels from group dialogues and would then quickly apply them to themselves (“*my life looks like a soap opera; I’m a drama queen”*), thereby inducing additional feelings of worthlessness, shame, and self-invalidation.

4.3 FINDINGS FROM THE THIRD STUDY: DEVELOPMENT AND CHANGE IN SELF-CONCEPT AND IDENTITY OVER THE FOLLOW-UP YEAR

Using an inductive approach, meaning that relevant findings were allowed to freely emerge from the data, the qualitative part of the third study addressed change in self-concept and identity since this was the theme that emerged from participants' follow-up narratives conducted 12 months after the treatment was ended. The quantitative part of the third study tracked symptom change.

Five subjects were reached for follow-up interviews. Hence, the retention rate of the original sample of eight was 62.5%. The three participants we were unable to reach had ceased treatment at the center, and one had moved away.

4.3.1 Change in BPD symptoms

Overall, participants' BPDSI scores showed a slight continuous decrease over the 12-month follow-up period. Compared to scores at treatment end, the mean decrease was 1.4 points. Over the follow-up, four patients (out of the remaining five) showed improvement in their BPD symptoms as assessed by the BPDSI, while one patient's scores increased by 3 points.

4.3.2 Processing of self-concept and identity: the first-person perspective of the participants

Four participants showed continuous, albeit fluctuating, development in their identity over the 1-year follow-up period. The fifth participant, who showed no change at treatment end, also reported no gain at follow-up. In other words, if a change process regarding identity was initiated during treatment, change was evident already at treatment end.

A total of 221 utterances related to the processing of self-concept and identity were found. Five core categories were identified: 1) from extremely negative and fluctuating self-concept to improved self-worth and stability, 2) self as actor: sense of agency, 3) decreased disconnection from and integration into self of emotions and emotional needs, 4) the importance of understanding the origins of the negative self-concept, and 5) challenges to the processing of self-concept and identity.

From extremely negative and fluctuating self-concept to improved self-worth and stability

All five participants described experiences related to this category. Of the total of 221 utterances, 67 (30.3 %) were in this category, including utterances referring to the absence of change in self-concept or identity. All participants described their former identities as characterized by a sense of being bad or fundamentally flawed. Previously, this was taken at face-value without questioning. In addition to being extremely negative, the baseline self was insecure and fragile: participants' narratives showed other-orientedness and hence an experience of self that constantly fluctuated according to current interpersonal experiences.

Findings indicated that change in the hitherto harsh, judgmental attitude towards the self seemed an integral part of positive change. This finding was evident in both those who showed development in identity processing and those who experienced no development. More specifically, one patient whose BPDSI scores indicated no change largely attributed this outcome to the persistence of a harsh attitude towards the self.

Self as actor: sense of agency

All five subjects referred to a sense of agency. With a total of 55 utterances, this category accounted for 24.9 % of all utterances related to self-concept and agency. Participants ascribed their inability to set goals and work towards these in a sustained manner to an inner voice that invalidated their dreams, self-esteem, and sense of self-competence, thereby blocking healthy agency. Clearly, these harsh internalizations obstructed agency by inducing a serious fear of making mistakes. Many accounts revealed how participants had learned that failing at something engenders intolerable shame, humiliation, or arbitrary punishment. Consequently, as participants felt unable to bear emotions associated with this predicted course of events, inertia appeared as a secure solution.

In the present study, change in agency often seemed related to a decrease in the self-berating, harsh inner voice. This decrease in internalized self-invalidation and the punitive way of relating to oneself enabled participants to become aware of their authentic needs, goals, and dreams, and to validate these. However, an improved sense of agency was a complex process involving multiple aspects. More specifically, three participants recounted their emergent ability to set their own goals, assert their boundaries, or use their skills: *"For the first time in my life, I've set goals regarding my drinking", or" every single day, I use the skills I learned in the group".* The resulting sense of mastery was experienced as rewarding. Feeling able to affect their emotions and work towards their authentic life goals, these individuals also felt themselves more integrated. This development also translated into observable behavior change and functional improvement. One participant, for example, was able to start working again after receiving disability payments for five years. At the time of the follow interview, s/he had been working steadily for nearly a year.

Decreased disconnection from and integration into self of emotions and emotional needs

The ability to be in contact with one's own inner experiences without having to block aspects of them is one aspect pertinent to self-concept and identity. The 22 utterances produced by three participants on the topic of being more in contact with their emotions, needs, and other people, and thus less disconnected, accounted for 10 % of all the utterances related to self-concept and identity. The follow-up findings showed that participants continued their deliberate efforts to implement change in their habitual ways of protecting themselves, e.g., in the various means to detach and avoid one's own emotional experiences or stimuli from the outside world and conceal the self. Since they longed for connection and understood the beneficial consequences of connecting in different areas, they now attempted to approach and maintain connection with their own mental contents as well as other people (who were often perceived as triggers).

The importance of understanding the origins of the negative self-concept

Gaining new understanding of the development of their negative self-concept and identity disturbance was an integral part of change. All five participants described how understanding the developmental origins of their negative self-concept or identity disturbance had been important to them. The 25 utterances observed in this core category accounted for 11.3 % of the total of 221 utterances related to self-concept and identity.

Regarding understanding the history of their identity disturbance, four subjects also referred to their parents’ and significant others’ untreated mental disorders and SUDs. Participants’ narratives revealed serious maltreatment in the past: distorted mirroring of a child, and parental reactions based primarily on the parents’ own mental states with a lack of mentalization of the child’s mental states or needs. Projection of detrimental negative attributes onto the child, name calling, and humiliation in front of others were additional examples of reported maltreatment. Participants described, for instance, how their behavior was mainly driven by fear of parental (and later others’) reactions, with attempts to make oneself invisible serving as a coping strategy. Participants understood that, due to adversity, their opportunity for healthy development of identity were seriously hindered. Consequently, in the present, long-term work on “who I really am” was required.

Challenges to the processing of self-concept and identity

Intelligibly, change in self-concept and identity was a pervasive and sustained process involving difficulties in addition to achievements. The 52 utterances produced by all five participants on the challenges encountered in the processing of self-concept and identity accounted for 23.5 % of all utterances related to self-concept and identity. Five subcategories were identified: a) oscillating between old and new ways of experiencing and behaving, b) feeling lost when the dominating self-script was questioned, c) feeling exquisitely exposed and vulnerable when less disconnected, d) the detrimental effects of enhanced self-understanding without self-compassion, and e) diagnosis as an additional self-stigma.

When attempting to apply their new learning, participants sometimes reported the recurrence or intensification of their previous behavior patterns. If they, for instance, validated their emotions or needs, the resurgent voice could criticize them for “wrong-doing”, thereby inducing uncertainty and internal struggle. In the short term, participants could avoid this struggle by slipping back into their old behavioral patterns. The “owning” of emotional *needs* seemed the most difficult step in the process of connecting. More specifically, longing for closeness, touch, or attention often induced embarrassment, shame, disgust, or fear of being exposed or weak. Participants attempted to keep emotional needs outside of awareness, but the use of this strategy prevented their integration into self.

Fading of the dominant self-script could engender confusion. Since the punitive internalizations had previously occupied participants’ minds, after obtaining meta-awareness, and thus a healthy distance to these, participants were left with puzzlement: “*Who am I, eventually?”*, “*What is included in me?”*

As previously mentioned, participants actively worked on their experiential and behavioral avoidance. However, reducing protective avoidant coping strategies and thus allowing oneself to experience more could elicit episodes of exquisite vulnerability.

It was also found that enhanced self-observation that lacked self-compassion and self-acceptance was detrimental. Looking back at one’s previous behavior patterns could retrigger a serious sense of badness and intense shame. For one participant, this seemed to associate with relapse in BPD symptoms; I had the impression that perceiving one’s problems with increased clarity but insufficient self-compassion influenced this deterioration.

Lastly, being diagnosed with BPD could affect participants’ identities in unhelpful ways, inducing further self-stigma. One patient felt that this label tainted her self-concept and induced an additional sense of being bad, and shame.

5 DISCUSSION

The studies in this thesis explored the subjective experiences of psychological distress, development, and change in BPD sufferers who attended psychoeducational group treatment at a community mental health care center.

5.1 DISCUSSION OF METHODOLOGY

The present study was a mixed methods process–outcome study conducted in a naturalistic treatment setting. The in-depth interview, as well as group session data, were analyzed using content analysis.

5.1.1 Qualitative research and content analysis: an inductive starting point

In contrast to quantitative research, where the formulation of hypotheses at the beginning of a study is viewed as an indispensable means of subjecting the loading of a variety of observations and inevitable selectivity to systematic control, qualitative research is characterized by a demand for 'unprejudiced' observation. This ideal, viz., a predominant rejection of hypotheses as a precondition for qualitative research, stems from the awareness that prior knowledge influences observation and action. The requirement for a suspension of hypotheses or prior knowledge (from an epistemological viewpoint, both have identical effects) can be understood not only as an attempt to enable the greatest possible openness to the specific meanings and relevance of the actors being studied, but also as an endeavor towards openness to the possible 'other' in the specific field of research (Meinefeld, 2004).

Openness and induction are related concepts. According to Lune and Berg (2017), to present the perceptions of others (i.e., the producers of messages) in a forthright manner, a reliance on induction is necessary (Lune & Berg, 2017). An inductive approach means that relevant themes are allowed to emerge freely from the data. In content analysis, the starting point may be either inductive or deductive (that is, theory driven). Inductive and deductive approaches to the data can be understood as a continuum. Kyngäs (2020a) illustrates this with a line (Figure 4) where the left end represents an inductive starting point while the right a deductive one.

Figure 4. Line of the research starting point (Kyngäs, 2020a, p. 9).
Note: Problems in the definition of the research approach occur when the starting point moves closer to X.

For all three studies pertaining to my thesis, the starting point was inductive. In the first study, we were, however, predetermined to explore the perceptions of eight participants on their meaningful development and change at the end of treatment. An additional aim was to explore participants' perceptions of the role of treatment-related factors to their process. Due to these research questions, the starting point moved from the left (i.e., a 'pure' inductive approach) slightly closer to X (Figure 5). The starting point for the second study was the most open and inductive, that is, situated on the left end of the continuum. In study II, I immersed myself in the group session data with only one question in mind: what will emerge from this data? Concerning study III, we were again determined, in advance, to explore the lived experiences of the participants on their perceived meaningful development and change 12 months after treatment end. Hence, compared to study II, the starting point moved somewhat closer to X.

Figure 5. Line of the research starting points in the present thesis.
Note: Numbers refer to the number of the study (^{1} = study I, etc.).

5.1.2 Triangulation

It is proposed that researchers may obtain a richer, more substantive picture of reality by combining several lines of sight. Drawing on multiple lines of sight is called triangulation (Lune & Berg, 2017). Triangulation may involve multiple theories, multiple data gathering techniques, multiple researchers, multiple methodologies, or a combination of these four categories of research activities (Flick, 2004; Lune & Berg, 2017). The intention is to extend knowledge of the research issue, and, in particular, elicit divergent ones. It is advised that the combing of diverse perspectives or activities is performed carefully and purposefully (Flick, 2004).

In this thesis, triangulation manifested itself in the combination of qualitative and quantitative research techniques. Quantitative techniques were applied in two distinct ways. Firstly, in the first and third studies, symptom change was assessed through BPDSI interviews at treatment end (study I) and 12 months thereafter (study III). Here, triangulation enabled the comparison and contrasting of qualitative narratives on subjective experiences of development with a quantitative measure of symptom change. Secondly, in the second and third studies, qualitative content analysis was complemented with quantitative content analysis (Mikkonen & Kyngäs, 2020). The quantitative content analysis was performed at a later stage with the aim of increasing the objectivity and transparency of the findings. It was conducted by calculating the frequencies at which utterances appeared within each sub- and core category.

Regarding researcher triangulation, 80% of the videotaped data (the in-depth interview as well as group session data) was watched together with my supervisor Tarja Melartin. I coded the data and created the categories independently, but elusive questions were negotiated in dialogical interchange as Tarja Melartin was well versed in the raw data. Peer examination or systematic computation of agreement was not used however and hence, inter-coder reliability was not assessed.

5.1.3 Reflexivity

It is being recognized that the ideal of openness in qualitative research can only be met in an approximate way (Meinefeld, 2004). Researchers and readers need to accept the fundamental restriction that every observation takes on meaning from the researcher's own meaning schemas. What is oriented towards, and hence noticed, as well as what is left out of awareness is unlikely to be random but rather selected and affected by a researcher's prior knowledge and preconceptions. Qualitative research literature recommends reflexivity as a tool aimed at reducing the distorting effects the personal biases of researchers (Morrow, 2005). To improve the trustworthiness of qualitative research, the explicitness and rigor with which prior knowledge and attitudes towards the research subject are reflected and expressed is particularly relevant. However, prior knowledge and preconceptions can only partially be made explicit, and this reflection can scarcely be standardized. Moreover, reflexivity *per se* does not guarantee openness to the content, since, even applying this tool, aspects of prior knowledge and prejudices will remain implicit and unrecognized, thereby leading to selective observation and interpretation (Meinefeld, 2004).

Using reflexivity as a tool, I noticed, for example, that in analyzing the data of the second study (group sessions), the relevance of self-invalidation to the psychopathology of BPD, as well as fear of adding stigma to this already stigmatized population, were indeed coloring my mindset. Since I attempted to take care not to select research subjects in line with my personal preferences and biases, I questioned the choice of studying self-invalidation in dialogical interchange with my supervisors Sari Lindeman and Tarja Melartin. An alternative, a competing theme to self-invalidation, namely, aggression displayed in the group interaction, was also considered. Nevertheless, I noticed a slight reluctance to report on aggressive group behavior due to fear of adding stigma to this already stigmatized population, although I recognized that highlighting the diverse facets of this problem need not lead to increased stigma or may even facilitate understanding. Despite the indisputable relevance of aggression displayed in the group, aggression did not manifest nearly as frequently as self-invalidation in this data. Ultimately, since self-invalidation was a recurring and poignant phenomenon that manifested in 39 out of 40 sessions, it was selected as the focus of the second study.

As mentioned in the Methods section, one advantage of content analysis is that it enables an approach the data that favors description over interpretation. Since this thesis focused on the first-person perspective of the patients, I wished to remain faithful to their voice. However, I noticed tension between my desire to remain close to the participants' lived experiences while in part interpreting this by applying the theory and language of psychotherapy. In other words, due to my familiarity with the topic, all studies faced the risk of becoming more deductive in nature (Kyngäs, 2020a). That is, my prior knowledge on the hypothesized factors related to change in psychotherapy probably shaped the data collection and analytic processes. Concerning data collecting, I probably made some choices on whether to further inquire into topics quickly and disregarded others as less relevant. As already mentioned, this is regarded as unavoidable in qualitative research where researchers are interpreters of basically ambiguous human experience (Binder et al., 2012). In trying to understand research participants' experiences, some reconstruction of meaning is necessary, and the results of phenomenological exploration are co-created (Binder et al, 2012; Morken et al., 2019a).

In studies I and III, the exploration phase was conducted in an interview context where experiences were recalled and relived in an interpersonal situation between the interviewee and me. In qualitative research, an interview is much more than a data-gathering method. Reflection on the interview relationship is an essential part of the research process, since the quality of this relationship determines which parts of the participant's experience become accessible and which remain unarticulated (Binder et al., 2012). In the exploration phases of the first and third studies, I was confronted with my pre-existing assumption that the interview relationship should be relatively neutral. Had it remained neutral, the amount of information gathered would have been scarce. More specifically, I noticed that in order to be able to reflect upon their experiences and deepen their descriptions, some interviewees needed a lot of validation. Subtle signals on my part influenced them. If, for instance, my response was delayed due to a focus on note taking, or if I otherwise failed to validate their recounts, some were extremely quick to second-guess and invalidate their experience and could even shut down. My specific concern was that validation, although benign, is also a powerful intervention. Utterances are never validated to an equal extent; what is validated is selective. Hence, the interviewer may risk steering the interview according to his or her personal interests or biases, thereby disproportionately intruding his or her own mindset on the interview.

Besides the need to reflect on neutrality-validation quotient in interview contexts, I was also confronted with the need to reflect on the use of language. That is, the intervention that formed part of the studies pertaining to the present thesis was mainly based on schema therapy, and some participants described their development using the language of ST. Since I am also versed in ST, we had a common language. This fact, too, was probably a mixed blessing in the sense that shared language may have facilitated the exploration of some experiences while, on the other hand, it may have influenced the findings of this thesis to the benefit of experiences reflecting schema therapy goals at the cost of something else. To summarize, I attempted to monitor the complexities related to the interview relationship and adjust my own behavior as appropriate for specific moments. Overall, I sought to adopt a stance of a benevolent, validating follower who would provide some minimal structure to the interview.

5.1.4 Limitations and strengths

This thesis has limitations, the most important of which concerns data saturation, which refers to a point where information obtained from participants becomes repetitive and further data collection thus fails to yield new information (Kyngäs, 2020a). We were, however, unable to take saturation into account during sampling since the sampling criteria were established before the start of this investigation. Moreover, due to financial constraints, only one group of eight participants could be studied. Purposeful sampling of critical or extreme cases was also not possible. This is an advised procedure with the aim to achieve maximal possible variation (Merkens, 2004). Despite this limitation, the sample nonetheless comprised typical, critical, and extreme cases.

The most serious limitation concerns the high attrition rate in study III, as three participants were lost at the 12-month follow-up. It is impossible to tell whether those missing might have given a different picture of continuous development compared to the five that were reached. On the other hand, according to Saunders et al. (2018), the extent to which saturation is viewed as an event or a process varies. Strauss and Corbin (1998) indeed regard saturation a matter of *degree* (italics added), arguing that there will always be potential for the new to emerge. This phenomenon was evident in study I: even when new codes were no longer identified, new thick descriptions (Geertz, 1973) added *depth* to the analyses. Overall, most participants provided rich and detailed information and were thus appropriate in terms of the research questions.

A further limitation is that the findings of this thesis may inevitably reflect the content of the psychoeducational intervention that formed part of the study; the fact that the intervention was mainly based on schema therapy may have influenced findings. One example of this limitation is that patients were acquainted with the concept of schema modes in the group and taught to observe and work on them. Hence, their descriptions of development and change were, to some extent, affected by this perspective.

As previously mentioned, as an attempt to increase credibility, the data of studies II and III were quantified (Mikkonen & Kyngäs, 2020). These quantifications indicated that the five participants in study III provided a total 221 expressions related to the research question, viz., the processing of self-concept and identity. Hence, regardless of the high attrition rate, the number of codes was relatively high.

Besides quantification of the data and reflexivity, I attempted to increase credibility by backing every assertion or interpretation with a few excerpts from the data. This way, I strove to demonstrate the connection between the data and findings systematically throughout the manuscripts reporting the findings. Consequently, the reader should be able to assess the validity of my assertions and interpretations (Kyngäs et al., 2020; Lune & Berg, 2017).

To conclude, it is important to reflect on the advantages as well as the nature of limitations of content analysis, viz., how the data can be used and what can be inferred from it. Qualitative research provides a means of accessing unquantifiable and unreduced knowledge about actual individuals, presented by their personal traces, e.g., in the present studies, group (study II) and interview behavior (studies I and III). Qualitative research seeks patterns among cases but does not reduce these cases to their averages. Content analysis can be used to describe what is present but does not provide answers to why it is present. Causality may nevertheless be suspected or suggested by the patterns of association among the phenomena that are being assessed, but other means must be used to test such ideas (Lune & Berg, 2017) since content analysis lacks the tools required for the connection of concepts. Thus, rather than yielding explanatory findings, content analysis can provide meaningful descriptions of individuals' experiences and perspectives in the context of their personal life settings (Kyngäs, 2020b). Indeed, I noticed instances where I almost, for example, overgeneralized, inferred causality, or drew stronger than only tentative connections between diverse concepts. These instances were particularly related to my immersion into the data and the participants' provision of rich and detailed descriptions of their problems or development. All in all, the findings of this thesis should be understood as descriptions of meaning patterns, but I am happy if they can generate hypotheses for future research.

5.2 DISCUSSION OF FINDINGS

A few major findings emerged. According to all three studies, the harsh, self-invalidating, and punitive internalizations were ubiquitous and constituted a central source of distress for participants. Change in these internalizations was experienced as very meaningful by participants, since it seemed to break the vicious cycle of constant invalidation and punitiveness being repeated in the present as a self-generated phenomenon. Conversely, a lack of change in the harsh, self-invalidating, and punitive attitude towards the self was regarded as a key reason for stagnation, or absence of change. These findings are in line with Donald et al. (2019) who also found a strong positive correlation between self-compassion and recovery from BPD as well as a strong negative correlation between self-criticism and recovery. In an international multicenter design, Tan et al. (2018) explored the subjective experiences of individuals with BPD after attending a two-year-long ST treatment and found that 42% reported diminished harshness towards themselves as a gain of therapy. In concert with findings from the present studies, this occurred particularly after gaining an understanding of where this harshness stemmed from (Tan et al., 2018).

A pernicious internal dialogue between different self-aspects (i.e., schema modes) was observed. In this dialogue, a harsh, punitive mode attacked other modes that reacted either with fear, concealment of authentic reactions, and outward compliance (the compliant surrender mode), or with anger and rebellious behavior. That is, the original trauma, now in the form of internalized mental representations was constantly replayed in the mind of the patients in the present; malignant external forces (the punitive authority/parent mode) exerted major influence on the patients who, still deficient in so-called healthy adult resources, were unable to escape the victim role (the child mode). It is possible that these findings may be over-represented in our data because patients had been familiarized with ST concepts in their treatment. The risk of tautology is therefore relevant. However, most participants genuinely seemed to have benefited from a new self-understanding that had personal, felt meaning for them. I had the impression that they were by no means merely parroting newly learned concepts in a pseudomentalizing way. Moreover, findings from all three studies in this thesis show a striking number of similarities with those of Jack (1991), who reported that women with depression and interpersonal traumas also suffered from devastating internal dialogue between these self-aspects.

Findings from all three studies pertaining to this thesis converged in highlighting how the harsh, punitive internalizations governed BPD patients’ mental worlds and guided their behavior, causing pernicious consequences on various domains. One example of these consequences was habitually choosing avoidance over an approach orientation. Agency was indeed one salient area on which these harsh internalizations exerted harmful influence. More specifically, due to the self-invalidating, punitive internalizations, the focus of participants was on avoiding potential mistakes instead of approaching things they might be interested in, thereby obstructing authentic, goal-directed behavior, and inducing inertia. Overall, the internalized harshness broadly affected patients’ self-care. Before change took place, self-care could be considered irrelevant by participants. Due to the punitive attitude towards the self, it could even be considered forbidden. These findings are consistent with previous research suggesting that individuals with BPD (or features of BPD) often have agency processing problems (Adler et al., 2012; Agnew et al., 2016) and that agency seems to be a key in meaningful change (Morken et al., 2019a). With respect to the connection between self-criticism and agency in individuals with BPD, Donald et al. (2019) discuss how harsh self-criticism and a punitive self-concept may impede the recovery process by preventing individuals from acting. Accordingly, Shahar et al. (2006) and Shulman et al. (2009) found that self-criticism adversely affected young adults’ goal construal, predicting low levels of autonomous motivation and positive life-events. The present findings also provide evidence for the connection reported by these researchers between self-criticism and avoidance, i.e., how self-critical individuals shy away from doing things they really want to do, and experimenting (Shahar, 2015). On a positive note, participants in the present studies often associated their increased sense of agency with a decrease in the self-invalidating and punitive attitude towards the self.

In terms of development and change, the first study found that the enhanced ability to observe and perceive mental events with increased clarity was regarded as extremely helpful. Importantly, this self-observation now occurred from a new, more compassionate and normalizing position. Enhanced ability to observe and perceive mental events seemed to be associated with improved ability to maintain effective behavior even in the presence of emotions. This outcome seems important since the inability to function when experiencing strong emotions is often a cardinal problem in BPD (e.g., Linehan, 1993). Among other benefits, this enhanced mentalization, or improved metacognitive awareness of mental states, aided in healthy processing of the punitive internalizations and understanding these as mental events, as opposed to truths. Participants became skilled in recognizing the harsh, critical inner voice and in doing so, were able to achieve a healthy distance from it. This was associated with a host of positive effects, including self-validation, better self-care, and agentic action. These findings support previous research; improvement in self-understanding is a widely stated benefit from psychotherapy and a consistent finding in psychotherapy literature (Connolly Gibbons et al., 2007). Even if the scope is reduced to cover only the first-person perspective of BPD sufferers, the concordance with previous findings remains. More specifically, a meta-synthesis of 14 studies addressing the recovery processes in BPD found that a therapy that facilitated making sense and furthering understanding of own experiences was regarded as helpful (Katsakou & Pistrang, 2018). Later studies support this finding. Using a study design similar to the first study in this thesis, Morken et al. (2019a) explored personal experiences of psychological change in 13 female patients with BPD features and comorbid substance use disorder after attending MBT. With so-called ‘thick’ descriptions (Geertz, 1973) of improved mentalization, their findings share a number of similarities with findings from the first study. Accordingly, in the Tan et al. (2018) study, the most frequently cited subjective benefit from the treatment was an increase in insight: 86% of participants described how they felt that ST had facilitated their understanding of the self and their internal processes.

Participants in the present studies also reported increased ability to stay connected to their emotions without having to cut them off as a major positive change. They described deliberate attempts to implement change in their habitual ways of protecting themselves through avoidance strategies. These findings on new, healthy ways of processing emotions show striking similarity with previous research. More specifically, Morken et al. (2019b) found that from the patients' perspective, one of their central change processes after attending MBT involved new ways of perceiving and *feeling* emotions. Similarly, Tan et al. (2018) reported that after two years of ST, half of the patients described having a better connection with their emotions. That is, they were able to get in touch, or reconnect, with emotions previously warded off. These changes were generally described as a shift from intellectualizing to experiencing, and from avoiding to facing (Tan et al., 2018). In contrast, the Katsakou & Pistrang (2018) meta-synthesis described *controlling for* difficult emotions (Katsakou & Pistrang, 2018), a process that is different from the ability to face, stay connected, and feel.

Unsurprisingly, complex inter-relationships between meaningful changes were observed in the present studies. Our findings on the complex mutual interaction of change processes closely resemble the findings of Morken et al. (2019a) who explored personal experiences of change processes in individuals with BPD after attending MBT. The finding that gains in one area engender gains in another also builds hope: many intertwining roads may lead to Rome.

For the role of treatment factors in development and change, the first study found that the acquisition of helpful concepts through psychoeducation (e.g., names for modes, interpersonal cycles, and skills) seemed to facilitate self-observation and organizing of individual - at times bewildering and elusive - perceptions. Patients also found that psychoeducation helped them gain new understanding of their developmental histories and their imprints. Acquisition of information on the development of BPD seemed to facilitate compassionate self-understanding. It is of note that the Tan et al. (2018) findings on the perceived role of psychoeducation are almost identical to the findings from the first study. Specifically, these researchers reported that therapy was indicated as helpful in providing concepts and explanations on the BPD condition and in making sense of various events/situations (Tan et al., 2018). Our findings and findings from Tan et al. (2018) indicate that patients highly value psychoeducation and suggest that psychoeducation, sometimes rejected as a superficial approach, may provide impetus for ‘deep’ and meaningful change involving also emotions and early memories.

It can be hypothesized that it is possibly not only the provision of psychoeducation per se, but also *how* it is provided that may be crucial. As for the content of psychoeducation, in ST, symptoms and other problems are framed as attempts to deal with unmet or toxic frustration of a child’s needs (Young et al., 2003). By conceptualizing symptoms of BPD as an attempt to maintain some sense of personal integrity in response to trauma, this approach promotes self-understanding and a sense of continuity from childhood (Tan et al., 2018). Regarding the cultivation of self-compassion, Krawitz (2012), as cited in Donald et al. (2019), highlighted how interventions that explicitly request BPD patients to cultivate greater self-compassion often provoke adverse reactions, since they may be perceived as invalidating. Hence, Donald et al. (2019) suggest that the trauma therapy approach, where the “wise adult self” empathizes with the “child part” and has compassion towards the child’s suffering, has the advantage of being specific to the patients rather than generic. The ST model shares this same advantage. It enables an individualized conceptualization of a patient´s problems and history, possibly enhancing acceptability of the education provided.

For the role of treatment factors in development and change, participants also reported that peer experiences normalized their reactions and even their whole self, counteracting their prior sense of the self as a failure and the related, severe shame. Participants stated that group discussions on the psychoeducational material presented furthered their self-understanding and self-compassion. Learning from and with peers, a unique asset of treatment delivered in a group context, was perceived as extremely meaningful. Participants benefited from being able to hear how others, too, struggled and dealt with their problems. Together, the group analyzed problem situations and often came up with solutions in collaboration. At best, they learned how to persist even in the face of strong emotions – a skill extremely relevant for BPD sufferers. Our findings on normalization support Morken et al. (2019b), who investigated how patients with BPD features and substance use experienced MBT, as well as

Farrell et al. (2009), who published the first RCT on ST groups. Morken et al. (2019b) found that by identifying with others with similar problems, patients who had suffered from severe shame and a sense of being bad achieved a sense of self-worth. After listening to co-patients, they felt normalized and less alone (Morken et al., 2019b). In a similar vein, 89% of subjects in the Tan et al. (2018) study discussed the sense of connection among group members, and 67% believed that being in the company of similar people allowed them to bond and develop an understanding that they were not alone in experiencing such difficulties. According to observations reported by Farrell et al. (2009) and Tan et al. (2018), groups uniquely possess important curative factors stemming from supported peer-to-peer-interactions, such as universality, sense of belonging, vicarious learning, and opportunities for in vivo practice. Farrell et al. (2009) also stated that patients interpret peer responses as more genuine than those of professionals, who they may believe "have to respond positively". The qualitative part of this study by Farrell et al. (2009) also identified a decrease in the sense of defectiveness and an increase in belongingness, interestingly captured in the same words used by one of the participants in the current study: "*I'm not alone; I'm not crazy*". Accordingly, Johnson et al. (2016), after attending MBT, described how being understood broke the cycle of self-hatred and social exclusion. To summarize, exposure to different modern psychotherapies for BPD seem to yield surprisingly similar effects.

Concerning treatment-related factors, aggression in the group was found to hamper the recovery process for some participants. During group discussions, participants could hit each other's vulnerable spots, often unintentionally. However, deliberate displays of aggression were also observed. In this study, the two participants who showed the strongest reaction to displays of aggression were also the only ones reporting no change in their BPD symptoms. Our findings on feeling vulnerable and even bullied in the group are consistent with findings from a recent study exploring patient experiences with different treatments for BPD, including DBT, MBT, and generalist treatment. More specifically, Katsakou et al. (2019) reported that individuals with BPD could feel exposed when sharing personal information and that they could experience peers as dismissive or bullying. In a similar vein, reporting from an international multicenter study exploring experiences with 2-year ST for BPD, Tan et al. (2018) showed that group safety was compromised following conflict. Patients in their study reported a fear of being at the receiving end of others' intense emotional responses. Findings from the Tan et al. (2018) study also indicated that a particular incident or conflict involving a few patients in the group left others feeling unsafe and wary to speak their minds, subsequently contributing less. These researchers discuss how tension can linger even if, on the surface, a conflict appears to be resolved (Tan et al., 2018). If participants' interpersonal schemas are extremely insecure and epistemic trust low (Fonagy & Allison, 2014), it is reasonable to expect that a single episode experienced as too painful may induce a response that is difficult or even impossible to repair. This indeed happened in the present study when one patient experienced the group interaction as resembling her former exposure to bullying at school. Hence, she decided to no longer open up. According to findings from the first study, the most obvious consequence of displays of aggression in the group was an intensified need for participants to protect themselves, meaning that they resorted to their former coping strategies, including avoidance, compliant surrendering, or aggressive attacking. Due to prevailing mistrust and the use of old coping strategies, true sharing was at least partly blocked, and thus the underlying, adaptive primary emotions remained unexpressed, thereby reducing the potential gains from the treatment. In summary, previous research aligns with our findings that single aggressive events in the group can be difficult to repair and can stifle personal growth.

While general group therapy literature proposes that conflict is essential to group development, since the ability to effectively deal with conflict contributes to individual maturation (Ormont, 2002; Yalom, 1985), literature on group psychotherapy for BPD (Farrell & Shaw, 2012), as well as literature on constructive relationship management in BPD (Fruzzetti, 2007), does not share this view. In other words, BPD-specific understanding of relationship aggression clearly diverges from general group therapy notions. This BPD-specific understanding of relationship aggression suggests that even small amounts of aggression are harmful in relationships, since the consequences of venting personal aggression may be difficult to counter later (Tan et al., 2018). Importantly, in BPD-specific approaches, it is proposed that instead of expressing aggression, the underlying primary emotions and other vulnerable components of the experience, including early maladaptive schemas, should be sought behind aggression. It is proposed that aggression is often a secondary emotion, or part of a coping strategy the expression of which is unyielding (Farrell & Shaw, 2012; Fruzzetti, 2007).

Lastly, the emergence of stigma and self-stigma from two different datasets points to the relevance of this finding. Most participants had a history of serious traumatic invalidation. Findings from the present studies suggest that if people already believe that they are bad or even evil or do not know who they are, they may be extra susceptible to absorbing negative labels and believing that they describe the self. Accordingly, one previous study found that subgroups vulnerable to higher self-stigma were those dependent on others for self-worth validation, those with previous experiences with social devaluation, and those with limited sources of identification (Moses, 2011). Catthoor et al. (2015) also suggest that those who lack a strong sense of self that is clearly delineated from others and whose identities depend on definitions offered by others may be particularly susceptible to self-stigma. These vulnerability factors indeed closely resemble self-concept and identity vulnerability in BPD. Quenneville et al. (2020) also propose that the interpersonal hypersensitivity (Gunderson & Lyons-Ruth, 2008) inherent to BPD might contribute to vulnerability to internalized stigma by inducing hypervigilance to signs of rejection or criticism.

Overall, findings from these studies suggest that being diagnosed with BPD was a mixed blessing. Patients recognized that the diagnosis was a prerequisite for the specialist treatment that they found helpful, but it nonetheless could engender self-stigma that decreased their sense of self-worth. Hence, findings from the studies in this thesis also support Link and Phelan (2009) who argue that in terms of stigma, diagnosis and labelling can be seen as a package deal. That is, there is evidence that receiving the label of a mental illness is stigmatizing but can also be beneficial because it facilitates treatment and, ultimately, enhances recovery (Link & Phelan, 2009).

6 CONCLUSIONS

6.1 CLINICAL IMPLICATIONS

Findings from the studies constituting this doctoral dissertation have some clinical implications. Importantly, meaningful and "deep" change involving self-observation and the processing of emotions, self-concept, and identity was experienced after attending the psychoeducational group intervention that formed part of the study. As for specific treatment targets, these studies suggest that facilitation of mentalization (or metacognitive monitoring) skills, a sense of agency, and contact with one's emotional experiences may be particularly relevant.

As previously mentioned, research has robustly demonstrated that despite symptom amelioration, sustained psychosocial, and particularly vocational, impairment is a difficult problem in BPD (Soloff, 2019). Findings from the present studies suggest that exploring the unique, individual inner processes underlying this impairment may be especially helpful. More specifically, the studies constituting this doctoral dissertation identified one reason for this functional impairment and inertia: the self-invalidating, harsh, and punitive internalizations that obstructed agentic action due to fears of making mistakes, failing, and severe shame. As attenuation in these internalizations may, in turn, reduce the intense fears of failure or punishment that lead to thwarted agency, targeting these pernicious internalizations in treatment may be particularly relevant when aiming to facilitate functional improvement. Explicit and active focusing on these self-invalidating internalizations and on building self-worth may be of utmost importance in the treatment of BPD.

Findings also suggest that therapists' enhanced alertness to implicit, silent manifestations of SI in patients' in-session and out-session behavior could be beneficial. In other words, clinicians need to be aware that patients may be engaging in SI or self-punishment even when not obvious.

Regarding treatment delivery, results of the present study indicate that a group format may have important advantages, including collaboration in learning, normalization of participants' experiences and the self, and an enhanced sense of connectedness. These advantages can counteract the abysmal feelings of loneliness, detachment, defectiveness, and abnormality that are prevalent in individuals with BPD. On the other hand, group treatment can also inflict harm, since conflicts can compromise group members' senses of safety (Tan et al., 2018). As Farrell et al. (2009) noted, a group, per se, can play an important curative role in the treatment of individuals with BPD if it is structured to avoid invalidating and schema-perpetuating experiences. To prevent serious obstacles to recovery, it is of paramount importance to understand how an optimal group process may be facilitated. For participant selection, according to Tan et al. (2018), group ST might be contraindicated for a subgroup of BPD patients, not because they suffer from anger problems, but because they have difficulties controlling aggression, angry verbalizations, and accepting therapists' attempts to limit these. These researchers discuss how patients with such problems pose a threat to the safety of the group as a whole (Tan et al., 2018). In other words, the psychological well-being of the whole group is allowed to take precedence. The great challenge, however, is to find valid means to detect individuals with a propensity to display disruptive anger before treatment commences. Individuals with comorbid antisocial (ASPD) and narcissistic personality disorders are often excluded from ST groups, but no indication exists that this exclusion would suffice in safeguarding against uncontrollable displays of aggression (Tan et al., 2018). To date, the lack of data precludes understanding of, for instance, how many antisocial or narcissistic features would increase the risk of destructive aggression. Moreover, further complicating the assessment, a wide array of mutually interacting variables probably contributes to the risk of group-destroying aggression. Interestingly, different opinions on inclusion and exclusion criteria also exist. More specifically, MBT is provided in a group setting for the treatment of individuals with ASPD, or BPD with comorbid ASPD (Bateman & Fonagy, 2019; Bateman et al., 2016), suggesting that non-mentalized aggression can be managed when enhancing mentalization is the primary goal of treatment.

In addition to patient selection, other potentially relevant issues are the structure, content, and aims of group sessions when endeavoring to reduce invalidating and schema-perpetuating experiences. Regarding structure, the present group was structured such that psychoeducational material was first presented, after which participants could discuss their own experiences on the introduced topic. To strike a balance between covering the educational content and attending to the group process is challenging, however. Paying close attention to group process, and to silent factors (e.g., disengagement) in particular, is essential, as displays of aggression may trigger withdrawal in others (Tan et al., 2018). In an educative group, there may not be enough time to address and respond to participants' experiences in a way that encourages further exploration. This is a distinctive difference compared to MBT groups where the primary goal is to learn mentalizing skills (Bateman & Fonagy, 2019).

Naturally, patients' readiness for change varies from one moment to another. Even though the structure and primary aim of the group (e.g., lack of different or competing agendas) allowed addressing the group process and patients' reactions to a greater extent, participants may be far from ready to admit and "own" their vulnerability or insecurities that contribute to how they experience each other. The owning of one's own primary emotional reactions would be needed to prevent patients from projecting something that is within the self onto their peers. Ideally, in group therapy, participants are aided in taking back their projections and owning their reactions (Frank, 2019). The ongoing task of therapy for BPD is to help patients be in contact with their primary emotions, to notice which schemas and modes are currently being activated, and what action urges these trigger (e.g., urges to resort to old coping strategies, including attacking) (Linehan et al., 1993; Young et al., 2003). One example of such an approach to one's own reactions is: "*What you just said activated my inferiority complex and I felt an urge to resort to attack as an attempt to counter this intolerable feeling of not being equal and good enough."* Optimal facilitation of group processes in the treatment of BPD is a great challenge that still awaits evidence-based solutions.

Finally, in clinical practice, work remains to be done to affect the detrimental health care provider stigma. On provider stigma reduction, Kverme et al. (2019) offer some practical suggestions. Specifically, they recommend training and educational efforts that would motivate mental health professionals to develop more humanistic approaches that increasingly recognize the traumas individuals with BPD have survived. Some interventions targeting provider attitudes towards individuals with BPD show preliminary promise (e.g., Clarke et al., 2014; Masland et al., 2018), although overall findings are mixed (Sheehan et al., 2016). Kverme et al. (2019) also suggest that we could be more attentive to how power issues can be present in the way we use language and describe and diagnose people. Other researchers have also emphasized the power of language and assumed that the way it is used may influence stigma construction (Aviram et al., 2006; Masland & Null, 2021). Kverme et al. (2019) cite Davidson et al. (2016), who argue that we need to stop asking patients (implicitly) the question: “What is wrong with you?” and instead start asking them explicitly: “What has happened to you?” and then “How can I be of most help?” (p. 47).

For self-stigma, the second study found that participants were quick to pick up on hints of stigmatizing expressions and apply these to themselves. These findings suggest that to reduce self-stigma, the wording used in psychoeducation is important. A concrete implication is that the language of the treatment manual used in the present studies may benefit from some revisions.

6.2 RESEARCH IMPLICATIONS

Findings from studies in my thesis suggest that individuals with BPD can experience meaningful change in various areas. The extent to which findings from these studies can be generalized to other populations of BPD sufferers remains to be explored in further studies. Hence, findings from these studies should primarily be understood as hypothesis-generating, thereby inspiring further research. Further psychotherapy process studies, both quantitative and qualitative, are needed to illuminate the complex “how” questions of psychotherapy, viz., how patients gain relevant new competencies, how these meaningful changes are facilitated in treatment, and how obstacles to recovery are prevented.

The poignancy of SI was a novel finding. Although the relevance of SI to the psychopathology of BPD is well-described in psychotherapy literature (Linehan, 1993; Young et al., 2003), research on SI is in its infancy. Questions for future research include: What exactly is SI? What are its boundaries with neighboring concepts, such as self-criticism, or internalized punitiveness? What is the role of biological factors, for instance, neuroticism in SI? Does SI constitute part of a larger, overarching self-concept pathology (see e.g., Shahar, 2015)? Do gender or cultural aspects in the upbringing of female children play a role in the development of SI (Jack, 1991)? How is SI best targeted in therapy? These questions should be explored using a diversity of methodologies. Experimental designs, focusing on implicit in addition to explicit information processing are needed to further our understanding of how individuals with BPD trust or doubt their perceptions. Self-report instruments tapping SI (Zielinski, 2013) and a closely related phenomenon, i.e., self-silencing in intimate relationships, already exist (Jack, 1991; Jack, 2017; Jack & Dill, 1992), and could be further developed to explore SI. Qualitative research could also explore SI using in-depth interviews.

Stigma and its reduction are complex phenomena. In the future, a more elaborate understanding of the specific factors influencing the stigma related to BPD may suggest new targets for intervention for both clinicians, the general public, and for BPD sufferers themselves. Research is needed to further our understanding of the particularly problematic health care provider stigma, and of the process where stigma is internalized into self-stigma. Furthermore, future studies should address the potential efficacy and *mechanisms* of interventions that aim to target provider attitudes. Natvik and Moltu (2016) suggest that research on lived experiences in the field of mental health can have the important function of enabling empathic engagement with the experiences of sufferers (Natvik & Moltu, 2016).

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APPENDICES

APPENDIX 1.

The Schema Mode Model as Used in the Intervention (Authors, 2021; modified from Arntz et al., 2005; Young et al., 2003).

Mode	Classification	Description of the mode	Goals in treatment
The Vulnerable / Abandoned child	Child mode	The suffering "inner child" who feels unloved, sad, inconsolable, lost, panicky or frantic. Emotions are unmodulated and pure. Feels utterly alone in the world and is convinced that nobody cares for him or her. Lacks object permanence and time frame: cannot summon a soothing mental image of the caretaker and lives in the eternal now and thus cannot comprehend that feelings also have an end. Feels helpless and demands immediate and constant reassurance. Sometimes incapable of being alone. Often obsessed with finding a parent figure.	The child mode is warmly welcomed, allowed, and encouraged. The therapist helps the patient identify, accept, and satisfy his or her core emotional needs. The therapist "reparents" this mode by attempting to respond to the specific needs of the patient within the boundaries of the therapeutic relationship.
The Angry child	Child mode	This child mode is predominant when the patient is enraged because his or her emotional needs are not being met. Feels impatient, angry, or enraged. Rebels against maltreatment. May make demands that suggest entitlement or that the patient is spoiled, which, unfortunately, often alienates others.	To understand the message underlying the anger, i.e., the unmet needs of the "child", and to coach the patient to meet his or her needs in more adaptive ways.

The Detached protector	Coping mode	A coping mode that functions to cut off the experience of emotions and needs and to disconnect from others. Hypothesized as a safety strategy that protects the child from overwhelming emotions and attachment, since attachment is often associated with fear or deception. The mode may become automatic and the patient unaware of its operation.	To help the patient experience emotions as they arise, without blocking them and to help him or her to connect with others and express his or her needs. To explore the history and functions of the mode and gradually bypass it.
The Angry protector 1)	Coping mode	A coping mode that also functions to protect the individual from the pain of experiencing mental contents. He or she can become angry or cynical in trying to keep others at distance.	To examine both the origins and functions of the mode in the here-and-now and gradually bypass it in order to allow contact with and the expression of more vulnerable emotions.
The Compliant surrender mode 1)	Coping mode	Safety behavior driven by fear. This mode serves to protect the individual from exposure to further invalidation, rejection, conflict, or abuse, as the individual has learned very sensitively to detect others' wishes and to surrender to them.	To encourage connection with and validation of one's emotions and needs.
The Punitive authority (previously called the Punitive parent mode)	Dysfunctional authority mode	A severe self-punitive state during which the patient seems to condemn him- or herself as being bad and evil, doing wrong or deserving punishment. An internalization of rage, hatred, loathing, etc. of an authority figure. Besides preventing self-actualization, the punitive authority mode typically prevents patients from taking good care of themselves. The message is that the person does not deserve anything that is good for him or her or that self-care is simply not important.	To help the patient to reject the message of the punitive authority and build self-esteem.

The Healthy adult mode	Functional, healthy mode	Allows connection to emotions and needs in a compassionate way. Responds to the needs of the “inner child” and soothes him or her. Like the observer self, is able to observe inner experiences from a meta-perspective. Modifies old coping strategies into more flexible and adaptive ones. Takes responsibility for self and others in a balanced way, pursues pleasurable activities, and has healthy boundaries: autonomy and dependence are balanced.	Cultivated in treatment
The Happy child mode	Functional, healthy mode	Feels at peace because core emotional needs are currently being met. Is playful, optimistic, and spontaneous.	Cultivated and encouraged in treatment

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1) The Angry protector and Compliant surrender modes are not included in the BPD original mode model but are encountered in individual patients. We have included them here because they are referred to in the Results section.

ORIGINAL PUBLICATIONS (I – III)

I

“If you don’t have a word for something, you may doubt whether it’s even real” – how individuals with borderline personality disorder experience change.

Koivisto, M., Melartin, T., & Lindeman, S. (2021).

Psychotherapy Research

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"If you don't have a word for something, you may doubt whether it's even real" – how individuals with borderline personality disorder experience change

Maaria Koivisto, Tarja Melartin & Sari Lindeman

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EMPIRICAL PAPER

"If you don't have a word for something, you may doubt whether it's even real" – how individuals with borderline personality disorder experience change

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Abstract
Objective: This study explored how psychological change was experienced and what treatment-related factors or events were perceived as supporting or hindering their process by individuals with borderline personality disorder.
Methods: Eight BPD sufferers attended a 40-session psychoeducational group intervention at a community mental health care center. At intervention end, personal experience of meaningful change was explored in an in-depth interview and data were content-analyzed. Change in BPD symptoms was assessed by the Borderline Personality Disorder Severity Index IV interview.
Results: The qualitative content analysis on subjectively perceived meaningful change yielded three core categories: (1) improved ability to observe and understand mental events, (2) decreased disconnection from emotions, emergence of new or adaptive emotional reactions and decrease in maladaptive ones, and (3) a new, more adaptive experience of self and agency. Accordingly, (1) learning and (2) normalizing emerged as the main categories of helpful treatment factors. In turn, treatment-related factors perceived as obstacles were: (1) aggression in the group, and (2) inflexibility. With respect to symptom change, four participants were considered clinically as remitted, and two showed a reliable change.
Conclusions: Long-term psychoeducational group therapy seems to enhance mentalization / metacognitive functioning and promote self (or personality) integration in BPD patients.

Keywords: cognitive behavior therapy; group psychotherapy; integrative treatment models; personality disorders; qualitative research methods; process research

Clinical or methodological significance of this article: Acquisition of conceptual knowledge seems to facilitate self-observation in BPD sufferers. It was found that learning about BPD can aid in making sense of and organizing of experiences. Psychoeducation might provide the initial impetus that activates deep cognitive-emotional processing. Groups can have unique benefits such as providing opportunities for collaboration in learning and normalizing participants' sense of self.

Introduction

The last 30 years has seen enormous progress in the treatment of borderline personality disorder (hereafter BPD). Research has shown that symptoms of BPD are treatable, primarily by psychological, psychosocial, and relational approaches (Choi-Kain et al., 2017). Highly specialized treatment programs have been developed and tested in randomized controlled trials (Cristea et al., 2017). Today, dialectical-behavior therapy (DBT), mentalization-based therapy (MBT), schema therapy (ST) and

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transference-focused psychotherapy (TFP) are the established "big four" evidence-based treatments for BPD.

In addition to treatment trials, data from two well-designed naturalistic prospective longitudinal studies indicate a high symptom remission rate (Gunderson et al., 2011; Zanarini, Temes, et al., 2018). However, a disparity exists between symptomatic and functional improvement in BPD. Soloff (2019) hypothesizes that one reason for the significantly lower rates of psychosocial recovery compared to the high rates of diagnostic remission may be that the standardized quantitative reports of diagnostic remissions do not fully capture the clinical reality of BPD. Gunderson et al. (2018) compared four different theories underlying therapies for BPD: emotional dysregulation (DBT), mentalization failure (MBT), excessive aggression (TFP), and interpersonal hypersensitivity (good psychiatric management; Gunderson & Links, 2014). Karterud and Kongerslev (2020) added insecure attachment to this list, and also postulated that these features are dynamically intertwined (Karterud & Kongerslev, 2020). Although schema therapy was not included in the comparison by Gunderson et al. (2018), it has been suggested that insecure attachment and deprivation regarding the child's emotional needs also underlie BPD (Young et al., 2003). Thus, viewed from the perspective of personality development and integration, the relative slowness of functional improvement is not surprising.

Moreover, the **first-person** perspective of clients themselves may usefully expand the existing framework by furthering our understanding of the therapy process and illuminating processes of which therapists may be unaware. A recent major advance in this domain was the publication of a meta-synthesis of 14 qualitative studies exploring clients' experiences of their treatment for BPD and their recovery perceptions (Katsakou & Pistrang, 2018), which concluded that clients make changes in four main areas: developing self-acceptance and self-confidence; controlling difficult thoughts and emotions; practicing new ways of relating to others; and implementing practical changes and developing hope. Clients experienced change as an open-ended journey, a dynamic and gradual process that consisted of small steps, including setbacks as well as achievements.

However, little is known about *how* improvement is achieved. The processes and specific mechanisms through which treatment characteristics facilitate or promote change remain poorly understood (Katsakou & Pistrang, 2018; Silberschatz, 2017). To understand what works for whom, and how and under what circumstances is only possible at the level of the individual patient. The identification of critical processes of change is likely to be clinically relevant, since it can help therapists recognize and foster unique opportunities for patient change as these occur during psychotherapy (Elliott, 1983). The examination of such events provides a direct window into what can, in the eyes of the therapy participants, facilitate or interfere with change; this in turn may lead to a better understanding and, ultimately, improvement in psychotherapy (Castonguay et al., 2010).

Katsakou and Pistrang (2018) also conclude that although the studies included in their meta-synthesis identified areas where people with a diagnosis of BPD made progress, they provided little information about how those improvements were reached. They suggest that more detailed accounts of change processes are needed in order to provide rich and nuanced descriptions of how therapeutic change occurs. The present study responded this call by conducting in-depth interviews with BPD sufferers who had attended a 40-session cognitive therapy group intervention.

Study Aims

The aim of this study was to explore participants' subjective experience of meaningful development and change and how they experienced the present intervention and events in therapy. A secondary aim was to investigate change in BPD symptoms. The research questions were: How do participants with BPD perceive meaningful change in themselves after attending a long-term psychoeducational group intervention? If they experience change in themselves, what processes do they highlight? Alternatively, how do they describe the lack of change? How do patients experience the intervention as a group intervention? What elements of the intervention or events during the intervention do they find helpful or unhelpful?

Method

Study Design

This process-outcome study was conducted in community mental health care services in the City of Jyväskylä, Central Finland. Applying a mixed methods research design, the qualitative component of the study aimed, through interviews, to trace and describe patients' first-person experiences of meaningful development and change and how they experienced the effect of different treatment factors on their change process. The quantitative component assessed change in BPD symptom scores at the end of the 40-session psychoeducational group intervention.

Qualitative content analysis was the method chosen to explore subjective experiences owing to its data sensitivity, i.e., it allows the relevant themes to emerge from the data and is thus suitable for the study of idiographic experiences (Kyngäs et al., 2020). Change in BPD symptom severity was measured by the BPDSI-IV (Borderline Personality Disorder Severity Index-IV) interview. The assessments were conducted between June 2017 and October 2018 at the community mental health care center in Jyväskylä.

Recruitment and Setting

Participants were recruited from the community mental health care outpatient services of the City of Jyväskylä, which despite its name, forms part of the municipality's secondary, specialized psychiatric services. Professionals working in community mental health care outpatient services were approached, informed about the study, and asked to refer patients aged 18–65 years with BPD symptoms for potential recruitment. The study design was naturalistic. Professionals, as part of their routine work, informed patients with BPD diagnosis about the possibility to participate in the present study. The intervention that was part of the study was one that is routinely offered for BPD patients being treated at the community mental health care center and was not controlled for in the study. Hence, patients were simultaneously recruited for the study and the group treatment. Potential participants were assessed in order of referral. Since, owing to financial constraints, only one treatment group could be studied, recruitment ceased when the number of eligible patients reached eight.

The inclusion criterion was the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM–5) diagnosis of BPD. Exclusion criteria were a DSM–5 diagnosis of a psychotic disorder or a substance abuse disorder necessitating detoxification prior to treatment. Exclusion criteria were assessed only clinically; no other structured evaluations were performed. The referred patients were assessed for eligibility using the Finnish version of the Borderline Personality Disorder Severity Index IV interview (BPDSI-IV). No other diagnostic evaluations were performed. Based on the eligibility interview, one patient with a primary diagnosis other than BPD (post-traumatic stress disorder) was excluded. All the eligibility assessments were performed by the first author (MK), except one (performed by SL).

Treatment

Group Intervention

The intervention, which consisted of 40 weekly 2-hour psychoeducational group sessions conducted from August 2017 to June 2018, was originally developed in Northern Finland to meet the needs of public mental health services (Oulu BPD model; Leppänen et al., 2016). The group was led by two experienced psychiatric nurses who delivered the treatment as part of their routine work at the community outpatient mental health care center. The framework integrates elements drawn from cognitive and behavioral treatment models designed to treat BPD. One of the main components of the intervention is patient education in schema therapy using the concept of schema modes (Online Supplement 1). A table delineating the content of the sessions is presented in Online supplement 3.

Adjuvant Treatment

In addition to group treatment, all patients continued their pre-existing treatment as usual (e.g., weekly individual sessions with their psychologists or psychiatric nurses as well as medication) at the community mental health care center. This treatment would, if needed, also continue after intervention end. Adjuvant treatment was not controlled for in the present study, and hence it was not integrated or coordinated with the group intervention. While some of the individual therapists were familiar with BPD treatment or with the Oulu BPD model, others were not.

Participants

Seven of the eight patients included in the study were female. Patients were aged 23–42 (mean 30, median 26) at study start. At baseline, the participants' average BPDSI-IV (Borderline Personality Disorder Severity Index IV) score was 31.1 indicating moderate to severe symptoms. On average, the participants suffered from marked functional impairment, as reflected in the fact that only two were working or studying at entry into the study. One patient was attending a work try-out as occupational rehabilitation and five were receiving disability payments. No structural assessment of functioning was performed.

Researchers

All the present authors are psychiatrists and cognitive-integrative psychotherapists specialized in the treatment of BPD. TM has a PhD and is also a psychodynamic psychotherapist. SL is a professor in psychiatry and one of the developers of the intervention, while MK and TM had nothing to do with the development of the intervention or the organization that delivered the treatment. MK conducted all the interviews except for one eligibility interview, which was conducted by SL. MK and TM analyzed the data and had no communication with the treatment providers.

Data Collection Method

All the interviews were carried out at the community mental health care center. The in-depth interviews exploring participants' first-person experiences and the BPDSI-IV interviews measuring symptom change were conducted soon after intervention end. These interviews were executed in close succession, the BPDSI-IV immediately after the in-depth interview. As the same interviewer conducted all the interviews, there could be no blinding during the data collection. All eight participants (100%) were interviewed, and all the in-depth interviews were videotaped.

The BPDSI-IV interviews were conducted twice: pre- and post-intervention. All the BPDSI-IV interviews conducted to ensure eligibility were audiotaped except for one, which was due to technical error. The post-intervention BPDSI-IV interviews were videotaped.

In-depth Interview

The major part of the data consists of responses to a semi-structured in-depth interview in which patients were asked to reflect on their experience of personal development or meaningful change (or lack of it) over the past year during the group intervention. The questions used in the in-depth interview are presented in Online supplement 2. In this study, we were interested in responses to questions 1-4, i.e., to the questions that asked participants to reflect on their experience of personal development or meaningful change over the past year during the group intervention and the contribution of treatment-related factors or events to their change process.

BPDSI-IV Interview

The BPDSI-IV (Borderline Personality Disorder Severity Index-IV) interview scores comprise the quantitative data. The BPDSI-IV is a clinical interview assessing the frequency and severity of BPD symptoms during the previous three months. The purpose is to provide a quantitative index of current symptom severity. The BPDSI-IV is based on the DSM criteria for BPD and consists of 70 items organized into nine subscales: (1) abandonment, (2) unstable relationships, (3) identity disturbance, (4) impulsivity, (5) parasuicidality, suicide plans and attempts, (6) affective instability, (7) emptiness, (8) outbursts of anger, and (9) paranoid ideation and dissociative symptoms. The frequency of occurrence of each item over the previous three months is rated on an 11-point scale from 0 (never) to daily (10). Answers are then scored from never (0 point) to daily (10 points) or rated on a 5-point Likert scale (Giesen-Bloo et al., 2010; Leppänen et al., 2013). Previous research has found a cut-off score of 15 between patients with BPD and controls, with a specificity of 0.97 and a sensitivity of 1.00 (Giesen-Bloo et al., 2010). Recovery is defined as achieving a BPDSI-IV score of less than 15. Reliable change, which reflects individual clinically significant improvement, is achieved when the improvement is at least 11.7 points (Nadort et al., 2009). No systematic measurements other than the BPDSI-IV interviews were performed.

Data Analysis

Qualitative content analysis was applied to the in-depth interview data. This methodological approach was chosen because it allows both inductive and deductive classification and interpretation of data (Kyngäs et al., 2020). The preliminary approach to the data was inductive. MK immersed herself in the videotaped interview data and transcribed the interviews verbatim. The parts of the text that covered responses to questions 1–4 were extracted and compiled into a single text. This text, which forms the unit of analysis, was then divided into meaning units, e.g., words, sentences or paragraphs that describe a single idea. The meaning units were then condensed, and the condensed meaning units were abstracted and coded. All the text fragments from subsequent interviews sharing the same meaning were then assigned the same code. Units were then clustered based on their shared meaning, to form larger categories.

MK frequently went back over the transcribed in-depth interview data. MK and TM reviewed 80% of the videotaped in-depth interview data together and discussed and revised the preliminary codes and clustering decisions made by the first author. SL read the transcribed data and negotiated the clustering.

The BPDSI-IV was scored soon after the interview. As they were not blinded, the researchers were aware of the participants' remission status when analyzing the qualitative data.

Reflexivity

In qualitative research, researchers are interpreters of basically ambiguous human experience (Binder et al., 2012). In trying to understand research participants' experiences, some reconstruction of meaning is necessary and unavoidable (Morken et al., 2019a). Researchers' pre-assumptions inevitably have some influence on the findings in qualitative research meaning that the results of phenomenological exploration are co-created.

The exploration phase in qualitative research is often carried out in an interview context where experiences are recalled and relived in an interpersonal situation. The interview is thus much more than a data-gathering method, reflection on the interview relationship being an essential part of the research process, as the quality of this relationship determines what parts of the participant's experience become accessible and what parts remain unarticulated (Binder et al., 2012). For example, in the exploration phase of the current study, the interviewer noticed how subtle signals on her part influenced the interviewees. If, for example, her response was delayed due to a focus on note taking, some interviewees might start second-guessing their experience or even shut down. She also noticed that to be able to reflect upon their experiences and deepen their descriptions, some participants needed a lot of validation. She was concerned that, by so doing, she might be in danger of facilitating talk about what interested her personally and thereby disproportionately intrude her own mindset on the interview. She therefore sought to adopt the stance of a benevolent follower who would, nevertheless, structure the interview.

In the data abstraction phase, we noticed a major tension between our desire to remain close to the participants' lived experience while in part interpreting this by applying the theory and language of psychotherapy. We provide excerpts from the data both to increase transparency and help the reader follow and evaluate our reasoning.

Ethics

This study was approved by the ethics committee of the Central Finland Health Care District on 9th May 2017. All participants provided a written informed consent after receiving a full description of the study procedure.

Results

In this study, the quantitative part focused on change in BPD symptoms while the qualitative part explored participants' subjective experience of meaningful change and their views on how different treatment factors and events were related to their individual processes.

I. BPD symptoms

Four patients (50%) were considered remitted based on their BPDSI-IV interview, conducted soon after the intervention had ended. Two patients (25%) were considered to have experienced a reliable change and two (25%) to have remained unchanged.

II. Subjective experience of meaningful change

Based on the in-depth interviews, a total of 22 areas of change were initially coded. These codes were grouped into larger categories based on their shared characteristics. Three main areas of change were identified: (1) improved ability to observe and understand mental events in oneself and others, (2) decreased disconnection from emotions, and emergence of new, adaptive emotional reactions and decrease in maladaptive ones, and (3) a new, more adaptive experience of self and agency.

1. **Improved Ability to Observe and Understand Mental Events in Oneself and Others.** All eight participants, regardless of their remission status, reported having experienced changes in their ability to perceive their experiences with increased accuracy in the present moment and to make sense of them. Most participants perceived this emerging ability to obtain a meta-perspective, i.e., being able to "mentalize" what happens in the moment at hand, either in their own mind or in relation to others, as a major and very meaningful change. Importantly, this improved ability was often informed by a kind and compassionate tone:

> Íve become kind of very mindful of what I'm feeling and why is it that I'm feeling that way … I learned like to relate to myself in a way … like I would relate to a little child or baby, like why are you feeling bad like are you hungry? Or do you feel some discomfort or are you hurting and so on? Are you tired and so on? … Like you become mindful of this kind of stuff … That was like really, really, like really helpful. (becomes moved).

When able to understand mental events as representations as opposed to absolute truths, participants became less incapacitated by them and better able to engage in functional behavior:

> What was crucial for me in the group, was to get a grasp of 'I am not a valid person' which has affected every aspect of my life. Previously, I wasn't able to set any goals because it was a fact for me back then when the group began … During the course of the group, I got a steadily growing sense that this might not be a truth or that it might be a distorted view.

One patient felt that learning to deliberately focus her awareness on the present moment had been curative for her. This ability had ended her longstanding suicidal ideation and urges that had resulted in a serious suicide attempt a few months before the group started. For her, the improved ability to be present also seemed to serve as a basis for better understanding herself and others.

Four participants described how their relationships with partners and friends had improved. For example, improved mentalizing helped patients to understand that each person has his or her own thoughts and feelings, and thus they became more capable of allowing others to freely experience their own thoughts and feelings. They were able in more nuanced ways to interpret situations where they sensed some disagreement. This, in turn, diminished their formerly strong sense of threat and desperation.

> … realization that erm every person has those (schemas, modes, and coping strategies), like everything that works for me can be applied to others, too. My relationships with others have improved, that might be one (of the most meaningful changes).

For this patient, this kind of new understanding translated into more functional relationships. For example, if he realized that a friend of his was angry, he could choose to pause, postpone his own reaction and reflect on how it would be wise to respond in contrast to unmodulated knee-jerk responses that typically made things worse.

Half of the patients reported having gained new understanding of themselves in terms of their past. Being able to mentalize how their ways of experiencing, coping strategies, or symptoms had evolved helped them question their previous learning, which was no longer viewed as the only truth but understood as an imprint of their life experiences. Understanding how the past had affected oneself was associated with increased self-compassion, sense of agency and hope. For example, *if the schema 'I'm not a valid person' is learned, it can also be unlearned.*

The capacity to regulate emotions was associated with improved ability to observe and understand mental events. All eight patients described how they had become more able to modulate their own behavior to match the requirements of the situations they encountered in their daily lives. Many patients described how their developing ability to stop and take a step back and to adopt an observer perspective towards one's mental states resulted in a better ability to regulate distress. As a result of this kind of intentional awareness, emotions did not last as long as they previously did. Patients also reported improved capacity to resist acting on emotional urges and that they did not lose their ability to function even when emotional.

> You don't feel the need to do something when you are anxious nearly as often as earlier. You can just stop and analyze it a bit and then it doesn't last that long any more … And I feel that it might not be that crippling as it used to be. I can do things even if I'm anxious, like my whole life doesn't fall apart anymore.

2. **Decreased Disconnection from Emotions, and Emergence of new, Adaptive Emotional Reactions and Decrease in Maladaptive Ones.** The content analysis yielded a second core category, the theme of which was the processing of emotions. Seven out of eight participants, i.e., all but one who remained unchanged according to the BPDSI-IV, described an increased ability to stay connected to their emotions without having to cut them off. In addition, participants reported new, adaptive emotions and a decrease in less adaptive emotions.

a) Decreased disconnection from emotions

Five patients described how experiential avoidance had been one of their main regulatory strategies for as long as they could remember. They also reported that their awareness of the various strategies they used to disconnect from their mental contents had increased. Now that they were willing to attempt to establish more contact with their emotional experiences, they were working to implement change in the conscious parts of their avoidance strategies. The resulting emerging ability to feel more and feel oneself to be authentic was welcomed, although some participants also described feeling acutely sensitive and aggrieved when trying to allow themselves to experience what was in their minds. One patient also described how she had lost her previous level of functioning when trying to stay in contact with her experiences, as she did not yet have the skills to deal with overwhelming emotions.

Besides detaching from emotions, another strategy that had buffered participants against painful emotions was angry protection:

> I feel this is new in me: I can apologize for doing something and I dare to make an apology and I now dare to really admit 'I was wrong'.

This patient offered examples of how the ability to allow oneself to be more vulnerable in relationships and a decreased need to defend oneself had exerted a positive influence on her relationships.

b) Emergence of new, adaptive emotions and decrease in maladaptive emotions

Learning about the development of BPD and further elaborating on the theme during group discussions triggered memories and emotions.

> What I've noticed is that previously I kind of had very few memories of my childhood but now that I've recalled the bad stuff, I also have recollection of some nice memories … Yesterday, when I was at my boyfriend's place, he asked if he could have a closer look at my teddy bear … and then I remembered somehow very vividly the moment when I was buying that teddy bear when I was ten … It was interesting, 'cos somehow, previously I haven't been able to recall almost anything at all (of childhood) … It's nice to notice how my whole childhood kind of erm opened up my memory to more … at first, bad things and then good memories, too.

Participants described sorrow over what had been missing in their lives and what was still missing, and adaptive anger towards those who had exploited them or failed to meet their needs. They also described decrease in self-hatred, guilt, and shame:

> The most crucial thing was that this is not my fault, that it makes sense I have this (BPD), there's a logical reason for this. I've done what I've done, my behavior has been what it's been, it makes sense. 'Cos I've always wondered why I behave like this. Why do I fuck everything up, why do I do reckless things … I kind of compensated for what I had to endure myself back then (in childhood) … Now that my awareness has increased, now that I know why I behaved like I did, it also means I can forgive myself.

Self-compassion and pride were mentioned as new emotions. Sometimes waning of the internalized punitive self-concept enabled emergence of these new emotions. However, self-compassion increased even in those who had not, at least explicitly, suffered from harsh self-criticism.

Hopelessness is a very prevalent secondary emotion in BPD. Three patients explicitly mentioned the emergence of a new counteracting feeling, hope. While others did not explicitly name hope as a discrete emotion, a decrease in hopelessness or an increase in hope was indirectly evident in their accounts, e.g., in how they expressed their new willingness to live, in the cessation of their previously unrelenting suicidal ideation, in their increased trust in their own competence to deal with daily hassles or in their ability to plan for the future.

3. **A new, More Adaptive Experience of Self and Agency.** The content analysis yielded a third core category that reflected change in the experience of self. Importantly, only patients who were classified as either remitted or having achieved reliable change described experiences in this category.

a) Attenuation in internalized harshness and emergence of one's own voice

Three patients described attenuation in the harsh way of relating to oneself. One of them reported this to be among the most important experiences in her change process. As one example, she described a recent moment in a fitting room when she noticed that her previous self-berating attitude was no longer coloring her self-observation:

> I didn't have thoughts like "ugh, how ugly you are, you're no use to anybody, your belly is ugly, ugh" … instead … I felt sorrow … Maybe for the first time in my life, I saw myself in the mirror as I really am or I think I saw myself as I really am … And somehow, I have a growing sense of … like I have to take better care of myself. For example, I smoke and I genuinely now have a constantly growing sense that, for example, I have to quit smoking, that it's bad for me … I've always known that it's bad for me but now there is a sense that it's no good to me and I can decide whether I do this for myself.

In addition to enabling more realistic self-observation, change in the harsh self-concept resulted in feelings of sorrow, self-compassion and need for self-care. Throughout the interview, this patient's narrative suggested that the waning of internalized punitiveness had played an essential role in enabling her self-actualization:

> I'm not drifting any more … Previously, I didn't feel I was able to choose, I didn't have the possibility to choose, to make decisions concerning me … Gee, I suddenly realized … for example, I can start studying. I can become something if I work towards that. I can do that because I'm adequate, I'm valid … 'cos I'm worth it. And one thing: I can do it even if it all went wrong … I don't need to succeed … It's ok to fail. 'Cos previously, failing at something was like < makes a gesture of cutting her throat >.

Some descriptions revealed how the change in internalized harshness was related to positive change in the other-oriented, self-forgetful, or submissive coping strategy:

> Previously, in my life, I didn't actually do anything I myself kind of wanted to do … I always kind of tried to understand what the other person like wants to do and for example <laughter> I made food only if someone else was also going to eat it and then I did it in just the way the other person wanted it done and then I might even make something I didn't even like but it was the right thing to do 'cos the other person preferred it … I'd like learn to relate to people in a completely new way … like somehow genuinely and … I feel I've begun to hear my own voice that I somehow I haven't heard earlier what I'd like and so on kind of erm I feel this (the group) gave me a good start for something like kind of being able to build the kind of life I would like to have.

b) Self as continuous and existent

One patient described how the ability to identify her own opinions, interests and preferences was related to her becoming more consistent and stable across different situations. Previously, she had experienced a weak sense of self that even made it difficult for her to be alone. She described how her previous need to accede to other people's wants and opinions changed as she grew stronger:

> I'm able to stick to my own … or I'm able to identify what is like my own opinion and … I'm not like a chameleon any more, at all, that has almost completely ceased … There was a time, when I didn't know at all what I like and because of that, I was unable to be alone 'cos if I was alone, there was no mirror. There was no possibility to mirror what I might be interested in or what I should do at the moment … That was quite bad earlier … In a way, I feel like I exist or I am able to see the future, too. There's not only this moment that's going on right now … that's quite a major insight.

For her, the ability to identify and validate her own perceptions seemed pertinent to the process where the self became more stable and continuous.

III. Treatment factors and events perceived as helpful or hindering

We also asked participants to describe what treatment-related factors they had experienced as either facilitating or hindering their process. The qualitative content analysis yielded two main categories of helpful factors: (1) learning and (2) normalizing. Accordingly, two main categories that were perceived as hindrances were found: (1) aggression in the group and (2) inflexibility of the treatment. In some instances, participants also described *how* different factors or events had affected them. Thus, when the data allowed, we sketched links between treatment-related factors and areas of change.

Treatment Factors or Events Perceived as Helpful

1. **Learning.** Acquiring information, especially about the development of BPD and mental states, the so-called schema modes typically encountered in BPD, but also about interpersonal cycles and various skills was regarded as helpful. The concepts facilitated self-observation, expressed in utterances such as "This is the voice of the Punitive authority mode", "Now I'm acting from the Compliant surrender mode", "I want to activate my observer self" or "Are there factors that increase my vulnerability to emotions right now?" Conceptual knowledge aided in making sense of and organizing experiences that were elusive: "*If you don't have a word for something, you may doubt whether it's even real*". It helped patients when they aimed to take a healthy distance from their mental states and regulate them.

> In my opinion, it's indeed information that is the curative thing here … because it helps me to get a clearer sense of my experiences. Organizing is the correct word for how the group affected me. I can organize things in my mind, that's the point … When I realized that there are different self-states, I realized that the voice of the Punitive parent isn't my own. It's her voice. I realized I don't need to listen to it anymore. It was awareness of that self-state that enabled me to expel it … to literally push it at arm's length (demonstrates with a gesture) … It's this distance that enables me to feel that it's outside of me, it isn't part of me anymore. I can disagree with it, but what's even better, I can engage in a dialogue with it … But in order to change, in order to be able to put it at arm's length, you first need to do a lot of ground work, realize many things (gestures towards the group workbook).

Obtaining information on BPD and various skills also resulted in understanding that BPD is a treatable condition and that one can be an active agent in the change process. This seemed to be associated with an increased sense of self-efficacy and hope: "*I can learn, I can practice, I can recover*". Learning about the development of BPD triggered early memories and various emotional reactions described under the rubric Emergence of new, adaptive emotions and decrease in maladaptive emotions. Thus, learning was not merely a cognitive or a passive process where the patient was simply receiving information. Rather, it seemed that psychoeducation provided the initial impetus that activated cognitive-emotional processing, and that patients were active in processing new information. They were also very eager to learn from and with peers. For example, participants highly valued the detailed analyses of problem situations conducted in the group and collaboration in learning how challenging situations or emotions could best be approached, handled, and endured:

> … if somebody had had some hassles, we figured out what had triggered the situation and what the factors underlying it were and then we kind of dissected the situation and figured out how it could be approached normally.

2. **Normalizing.** It seemed that the conceptualizations offered in the group were experienced as normalizing and kind. This seemed to set the tone for more compassionate self-observation. Besides information acquisition, peer experiences were commonly mentioned among the treatment factors or events perceived as helpful. Participants learned that others also experience difficult emotions, are sensitive or hypervigilant in interpersonal contexts, may distort information when emotional, etc. Being able to share, connect with and be understood by others seemed crucial:

> It's such a strong feeling when you realize that first, you're not alone and then, that someone else has also been through that … I'm not defective like I used to believe, I'm not too weak … If these folks have experienced the same thing, my experience gets … validated and it becomes true … It's not that I've just imagined it, it's not that Íve just aggrandized everything in my mind … Ím not completely crazy as I used to believe.

This patient identified the above-described event, where she had shared her experience of annihilation of the self in the group and found that two peers were able to relate to it, as one of the most powerful episodes in her change process. Finding out that others were like oneself was healing:

> Others' experiences (had a major influence) … We had many similarities … very many and … for example, when someone told us that she had got a job or something like that, I started to feel like "I may be able to start working as well" … I've been receiving disability payments for about five years or at least four and a half years now … I started to think that I might also be able to do that (start working) … You start to feel like normal, you don't feel yoúre like … kind of, some kind of problem case, in any way … You feel that it's normal to have feelings like that from time to time … The group actually had a major role in that I've now been able … This fall, I'll begin a work try-out and next fall, I'm determined to start studying.

Peer experiences seemed to help participants to validate and normalize not only their emotions, but their whole self. This could translate into agency. As one's self-concept became increasingly positive and patients no longer perceived themselves as fatally flawed, they were able to act in a new way.

Treatment-related Factors or Events Perceived as Hindering Change

1. **Aggression in the Group.** Besides being beneficial, peer experiences were also experienced as the most important hindrance to development and change, inducing hurt or even harm. Half of the patients reported being troubled by aggression expressed in the group. Two patients who described experiencing a particularly strong reaction to their peers' behavior, reflected on how aggression reminded them of their own former aggressive behavior. In addition, for some participants, displays of aggression in the group triggered early traumatic memories, hypervigilant scanning for potential aggression in others, and strong avoidance reactions:

> I suppose one instance was enough for me … It cut too deep inside and made me recall my time at junior high school … Exactly the same feelings surged, directly from the time at junior high … so I felt I won't take this anymore, this issue is concluded now … I felt insecure, and that made me retreat into my shell, like into that Protector mode … like "I dońt really have anything to say" … If I'm in that Protector mode, I feel "ok, this was enough, I can leave right away" … I feel I can't get anything out of this (group treatment) anymore … In fact, if there was some argument, I kind of avoided it because reopening my wounds doesn't aid me in healing myself, but rather drags or actually dragged me down again.

Importantly, the participants who reported being most disturbed by aggression in the group also reported no benefit from the treatment in the BPDSI-IV interview.

One member's behavior was sometimes experienced as aggressive by some but not all group members. This participant differed from the others in that she was emotionally more constrained and more prone to rely both on rational processing and on overcompensation strategies. She pondered whether, due to these qualities, she might have appeared to others as having no problems. In return, the group pressured her to express more vulnerability and to open up more than was possible for her at the time. However, she recognized that her holding back was at least partly fear-based:

> For me, it (change) means that I analyze my thoughts and, and like cognitively process them … I'm not sure whether I'd ever been ready to go there (to sharing emotions at the expressional level

> in the group) … Be it any situation, if I broke down there in the group, if I couldn't cope with talking about something or the like, that wouldn't bring me any further, rather backfire … One thing I very often brought up there (in the group) was that I don't want to lose control because I'm not able to tell whether I am the person who cries gracefully or whether I'm someone who shrieks and goes red in the face. I can't tell, and I somehow don't want to know.

This patient, too, was left with the feeling of not being understood and not able to connect with others. Consequently, she resorted to an even stronger intellectualization and distancing of emotions in the group context.

To conclude, the participants in this group remained insufficiently encouraged to engage in the further exploration and management of aggression. This outcome seemed to strengthen their reliance on their old coping strategies. The feeling that they had to protect themselves or overcompensate for their vulnerabilities seemed to block their sharing of their underlying adaptive emotions or needs.

2. **Inflexibility of the Treatment.** Some participants experienced the wordings of the mindfulness exercises practiced at the beginning and end of each session as aversive. They had previously attended another group where the exercises varied from session to session and also wanted to discuss this possibility in the present group. However, the original wordings were retained, which left some group members with the feeling that genuine negotiation was not possible. For one participant, the most difficult aspect of this situation was her feeling that the other participants' wishes were valued more highly than hers. She felt that the group leaders sided with those in the group who wanted to limit the amount of time spent on discussing potential revisions of wording. For her, this episode resulted in a rupture in the therapeutic alliance that was never fully repaired. She described the strengthening of her old coping strategy, namely, acting compliant while hiding her true feelings such as disappointment and anger:

> At first, my approach was, that I'll try to be myself in the group (but then) I noticed that some stuff (in the group) was allowed here while some was not … I was able to present an edited version of myself in good time so that I was accepted (compares herself to the above-mentioned group member) … I made use of the same coping strategy I had used at home … I'm able to behave in a way that I can survive … It has always been easiest not to be myself, but to behave as others want me to behave.

Discussion

In this study, we explored (1) what factors BPD sufferers themselves considered meaningful in their process of personal development and change and (2) what treatment-related factors or events contributed to or hindered this process. We contrasted these narratives with their medical recovery status as assessed by the BPDSI-IV.

The main area in which participants perceived themselves to have made progress, was in their improved ability to monitor and understand mental events in oneself and others. Second, participants reported increased ability to be in contact with their own emotions as a major positive change. We also noticed a decrease in maladaptive emotions such as unjustified guilt, shame and hopelessness and the emergence of new, adaptive emotions such as hope, pride and self-compassion. Third, only patients who had experienced change in their BPD symptoms (either reliable change or remission) described changes that could be understood as reflecting a more adaptive self-experience. Most importantly, the waning of harsh or punitive internalizations and the ability to identify and validate one's opinions and preferences seemed a meaningful part of their more adaptive self-experience. Fourth, we observed complex inter-relationships between meaningful changes.

To illustrate the inter-relatedness of meaningful change, participants had first, for example, to adopt a meta-perspective towards, or to be able to mentalize the internal voice that tells "you are not a valid person", since in the state of psychic equivalence (Bateman & Fonagy, 2012) "you are not a valid person" is reality and no alternative perspectives are possible. In other words, participants had to be able to distinguish between truths and mental representations. Importantly, this improved metacognitive awareness of mental states or the ability to explicitly mentalize was associated with a more compassionate attitude towards oneself. It also seemed that enhanced mentalization in combination with kindness towards oneself enabled an approach orientation instead of the previous avoidance behavior that had functioned as an attempt to feel safe. Acting - and possibly failing - became possible because they were no longer so closely coupled with punishment. In fact, it was found that some processes seemed to cut across nearly all domains, most importantly, self-validation, self-compassion, and agency.

Our findings on the relationship between internalized harshness and agency resemble those of Donald et al. (2019), who found that harsh self-criticism and punitive self-concept may impede the recovery process by preventing individuals from acting. They found a strong positive correlation between self-compassion and recovery from BPD and a strong negative correlation between self-criticism and recovery. Likewise, Katsakou et al. (2019) found that moving from shame to self-acceptance and compassion is central to the recovery process. Previous findings on self-compassion group interventions for BPD suggest that such interventions have some utility (Feliu-Soler et al., 2017; Lucre & Corten, 2013). Donald et al. (2019) postulate that these findings may reflect what Krawitz (2012) highlighted: interventions that explicitly ask BPD patients to cultivate greater self-compassion often provoke negative reactions, as they may be perceived as invalidating. Donald et al. (2019) suggest that the trauma therapy approach, where the "Wise adult self" empathizes with the "Child part", showing compassion towards the child's suffering, has the advantage of being client-specific rather than generic. The schema therapy model of BPD, on which the present intervention was primarily based, shares this same advantage, and enables an individualized conceptualization of patients' problems and history. Schema therapy also adds the Punitive authority (or Critic) mode to the conceptualization (Online Supplement 1). The present participants became skilled in recognizing this harsh, critical voice and in doing so, achieved a healthy distance from it. This seemed to associate with a host of positive effects, such as self-validation, better self-care, and agentic action.

Our results accord with those of previous studies. In the areas of change, we identified the same themes as found in a recent meta-synthesis of qualitative studies that explored BPD sufferers' perceptions of recovery (Katsakou & Pistrang, 2018), although we categorized them somewhat differently. For example, our first core category "improved ability to observe and understand mental events in oneself and others" encompassed themes from three of the four main categories identified by Katsakou and Pistrang, namely "developing self-acceptance and self-confidence", "controlling difficult thoughts and emotions" and "practising new ways of relating to others". Our patients reported on mindfulness experiences and gave rich accounts of their enhanced ability to observe mental events in a new, more compassionate way, to reflect on them, to understand others' minds and to regulate their emotions and impulses without losing their ability to function. This divergence in the categorization of the same themes may reflect different researcher backgrounds and theory-guided analysis despite the initial use of an inductive approach. Using study design similar to ours, Morken et al. (2019a) explored personal experiences of psychological change processes in 13 female patients with BPD features and comorbid substance use disorder after attending mentalization-based treatment. From the patients' perspective, their central change processes involved new ways of perceiving and feeling emotions, new ways of thinking about mind-states, new ways of self-reflecting in interpersonal encounters and new ways of exploring others' intentions in interpersonal encounters. The findings of Morken et al. (2019a) not only resembled those of the present study but the change processes also seemed to demonstrate complex mutual interaction.

With respect to helpful and unhelpful treatment factors or events, the first main finding was that learning about BPD was helpful. Second, normalization emerged as a beneficial factor. Furthermore, two unhelpful treatment factors or events were found: aggression expressed in the group, and inflexibility of the treatment.

Starting with learning, participants described how learning about BPD helped them to relate to themselves in a more normalizing and compassionate way and gave them hope. They learned concepts that aided self-observation and helped them to organize their experiences. Their accounts often revealed a multi-faceted learning process that involved the retrieval of memories, activation of deep emotional processing, and the ability to make use of their recently acquired psychoeducation in new situations. Thus, we assume that psychoeducation provided the initial impetus for this learning. At best, learning was collaboration, as patients were especially eager to learn from and with peers how difficult situations and emotions could be approached, dealt with, and endured. Some narratives revealed innovative moments of collaborative learning that were perceived as very meaningful.

Our findings on the benefits of acquiring information on BPD support those of previously published studies showing that psychoeducation can reduce BPD symptoms (Ridolphi et al., 2019; Zanarini, Conkey, et al., 2018). According to Zanarini, Conkey, et al. (2018), non-disclosure of a diagnosis of BPD in clinical practice often leaves patients thinking that they are "bad" people or the only one suffering from these symptoms. The present qualitative findings support and extend findings from quantitative studies. Specifically, we found that the feeling of inner badness and the associated guilt or self-hate decreased as patients learned about their disorder.

With respect to helpful treatment-related factors and events, our second main finding was that normalization was experienced as healing. Although it was clearly evident that the educational material contributed to normalization, participants often referred to peer experiences when discussing this phenomenon. Specifically, listening to others who had experienced something similar provided comfort and relief by normalizing and validating one's experiences and even the whole self. Patients described how this normalization was related to a decrease in the sense of aloneness and an increase in feeling connected with others. Normalization also promoted agency. We found that when self-concept becomes more positive and patients no longer identify themselves as flawed, they become able to act in a new way, to take constructive steps towards building a life worth living. In sum, patients started to perceive themselves as more normal, more like others and capable of enduring ordinary disappointments and failings as part of life and to proceed working towards their goals when simultaneously experiencing emotions. This is a significant change, as people with BPD have a propensity to seriously lose their capacity to function when strong emotions are activated.

Previous qualitative research on BPD patients' subjective experience of recovery has identified connectedness as a relevant dimension in the change process. For example, reporting on a thematic analysis of interviews with five women diagnosed with BPD, Agnew et al. (2016) described how the participants understood their suffering as having relational origins and therefore, relational solutions. Consequently, finding ways of connecting constructively with others was regarded as important in recovery. In a similar vein, Kverme et al. (2019) who interviewed 12 female BPD patients about their experiences with recovery and treatment, identified "moving toward connectedness" as a key dimension in the recovery process. They described how, across their participants, "connectedness implied feeling 'I am like others and others are like me', feeling human amongst other humans and part of a community, part of a whole", in contrast with the feeling of separateness they experienced in the outside world. A subcategory in the Kverme et al. (2019) study was "learning to hold one's own", by which they referred to being an agent in the process of change. Agency implied being able to believe that change could come about through action, by changing old patterns and habits. This, too, accords with our observations: hearing others' experiences normalized the group members' experiences and, even more fundamentally, the self, and this change facilitated agency.

Our findings on normalization also support Morken et al. (2019b), who explored how patients with BPD features and substance use experienced mentalization-based treatment, and Farrell et al. (2009), who published the first randomized controlled trial on schema therapy groups. Morken et al. (2019b) found that by identifying with others with similar problems, patients who had suffered from shame and a sense of being bad achieved a sense of self-worth. After listening to co-patients, they felt normalized and less alone and bad. According to observations reported by Farrell et al. (2009), groups uniquely possess important curative factors stemming from supported peer-to-peer-interactions such as universality, sense of belonging, vicarious learning and opportunities for in vivo practice. Farrell et al. (2009) also stated that patients accept peer responses as more genuine than those of professionals, who they may believe "have to respond positively". The qualitative part of the study by Farrell et al. (2009) also identified decrease in the sense of defectiveness, captured in the same words as used by one of the present participants: "I'm not alone, I'm not crazy". Interestingly, participation in a schema-oriented intervention yields almost the same experiences as participation in mentalization-based therapy.

However, serious obstacles to a helpful therapeutic process, such as problems in the processing of aggression, also emerged. An important finding was that the two participants who showed the strongest reaction to aggression expressed in the group were also the only ones reporting no change in their BPD symptoms. Our findings concerning feeling exquisitely vulnerable in the group and even bullied are consistent with findings from a recent study exploring recovery processes in BPD. Katsakou et al. (2019) also reported that individuals with BPD could feel exposed when sharing personal information and that they could experience peers as dismissive or bullying. If participants' interpersonal schemas are very insecure and epistemic trust low (Fonagy & Allison, 2014), a single episode experienced as too painful may induce a response that is difficult or even impossible to repair, as happened when one patient experienced another patient as resembling her former school bully and decided to not open up anymore. Failure to process aggression must be regarded a limitation of the intervention investigated in the current study. The group was structured such that psychoeducational material was first presented, after which the participants could discuss their own experiences on this theoretically introduced topic. It is not, however, an easy task for group leaders to strike a balance between covering the educative content and attending to the group process. In an educative group, there may not be enough time to respond to participants' experiences in a way that encourages further exploration. In addition, patients may be far from ready to admit their more primary woundedness and the insecurities that contribute to how they experience each other, a process needed to help prevent them from projecting onto peers something that is within the self. As

Farrell et al. (2009) put it, a group per se can play an important curative role in the treatment of people with BPD if it is structured to avoid invalidating and schema-perpetuating experiences. Feedback needs to be solicited and constantly actively processed to avoid an escalating group process. The intervention was also limited in that individual therapy was not an integrated component of the treatment model. We do not know if the fate of the non-responders who experienced a strong negative reaction to aggression would have been different had the group facilitators and individual therapists had structured opportunities for collaboration, as is the case in DBT and MBT treatments.

With respect to helpful and unhelpful treatment factors and events, our last finding was that inflexibility of the treatment hindered the patient's ability to benefit from it. Most importantly, inflexibility triggered a feeling of not being heard and a feeling that the facilitators are not on "my side". Our findings accord with the meta-synthesis findings reported by Katsakou and Pistrang (2018). They found that feeling that one was not an equal partner was mentioned as an unhelpful treatment-related factor in 9 of the 14 studies included in their meta-synthesis of qualitative studies investigating BPD clients' experiences of treatment and recovery. Consistent with our findings, they noted that therapy that was too rigid and inflexible induced feelings of powerlessness and anger. Recently, Katsakou et al. (2019) also found that individuals with BPD felt coerced and disrespected when they experienced therapists as rigid in following therapeutic agendas. According to Linehan (1993), many battles in psychotherapy have to do with the maldistribution of power and patients' attempts to rectify it. She explains how borderline patients are quick to detect power differences and are intolerant of arbitrariness in the therapeutic relationship, perhaps because they have suffered in the past from an unequal distribution of interpersonal power. It is not surprising that most psychotherapies for BPD nowadays underscore the need for flexibility as opposed to rigid rules (e.g., Bateman & Fonagy, 2012; Linehan, 1993).

Study Strengths

Perspective triangulation, i.e., the combination of different frameworks may be considered a strength of this study. Combining the medical framework (change in BPD symptoms) and patients' subjective experience of meaningful change and treatment enabled us to compare narratives between those who achieved remission and those who achieved reliable change with those who did not change in medical terms.

The credibility of the results is increased by investigator triangulation, i.e., the involvement of multiple observers and interpreters. In addition, the trustworthiness of the study is supported by the provision of representative excerpts from the data.

Limitations

This study has its limitations. It was predetermined that only eight patients could be studied. We were, therefore, unable to take saturation into account in the sampling protocol.

Regarding the trustworthiness of this study, SL is one of the developers of the intervention while both MK, who interviewed the patients, and TM, who interpreted the data with MK, had nothing to do with the development of the intervention or the organization that delivered the treatment.

A major limitation concerns the transferability of the results, as some of these results may apply only to group treatment. For example, while it may be quite easy to deliver psychoeducation in the group context, an educative approach in the individual therapy setting is a more complex issue and may meet with a very different response.

In sum, psychoeducation, sometimes rejected as a superficial approach, seems capable of providing impetus for very meaningful change. Groups can have unique benefits such as providing opportunities for collaboration in learning and normalizing participants' sense of self, as participants can feel understood and feel that they are like others and others are like them. However, to prevent serious obstacles to recovery, it is of paramount importance to understand how an optimal group process may be facilitated.

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Supplemental Data

Supplemental data for this article can be accessed https://10.1080/10503307.2021.1883763

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APPENDIX 1.

The Schema Mode Model as Used in the Intervention (Authors, 2021; modified from Arntz et al., 2005; Young et al., 2003).

Mode	Classification	Description of the mode	Goals in treatment
The Vulnerable / Abandoned child	Child mode	The suffering “inner child” who feels unloved, sad, inconsolable, lost, panicky or frantic. Emotions are unmodulated and pure. Feels utterly alone in the world and is convinced that nobody cares for him or her. Lacks object permanence and time frame: cannot summon a soothing mental image of the caretaker and lives in the eternal now and thus cannot comprehend that feelings also have an end. Feels helpless and demands immediate and constant reassurance. Sometimes incapable of being alone. Often obsessed with finding a parent figure.	The child mode is warmly welcomed, allowed, and encouraged. The therapist helps the patient identify, accept, and satisfy his or her core emotional needs. The therapist “reparents” this mode by attempting to respond to the specific needs of the patient within the boundaries of the therapeutic relationship.
The Angry child	Child mode	This child mode is predominant when the patient is enraged because his or her emotional needs are not being met. Feels impatient, angry, or enraged. Rebels against maltreatment. May make demands that suggest entitlement or that the patient is spoiled, which, unfortunately, often alienates others.	To understand the message underlying the anger, i.e., the unmet needs of the “child”, and to coach the patient to meet his or her needs in more adaptive ways.
The Detached protector	Coping mode	A coping mode that functions to cut off the experience of emotions and needs and to disconnect from others. Hypothesized as a safety strategy that protects the child from overwhelming emotions and attachment, since	To help the patient experience emotions as they arise, without blocking them and to help him or her to connect with others

		attachment is often associated with fear or deception. The mode may become automatic and the patient unaware of its operation.	and express his or her needs. To explore the history and functions of the mode and gradually bypass it.
The Angry protector 1)	Coping mode	A coping mode that also functions to protect the individual from the pain of experiencing mental contents. He or she can become angry or cynical in trying to keep others at distance.	To examine both the origins and functions of the mode in the here-and-now and gradually bypass it in order to allow contact with and the expression of more vulnerable emotions.
The Compliant surrender mode 1)	Coping mode	Safety behavior driven by fear. This mode serves to protect the individual from exposure to further invalidation, rejection, conflict, or abuse, as the individual has learned very sensitively to detect others' wishes and to surrender to them.	To encourage connection with and validation of one's emotions and needs.
The Punitive authority (previously called the Punitive parent mode)	Dysfunctional authority mode	A severe self-punitive state during which the patient seems to condemn him- or herself as being bad and evil, doing wrong or deserving punishment. An internalization of rage, hatred, loathing, etc. of an authority figure. Besides preventing self-actualization, the punitive authority mode typically prevents patients from taking good care of themselves. The message is that the person does not deserve anything that is good for him or her or that self-care is simply not important.	To help the patient to reject the message of the punitive authority and build self-esteem.
The Healthy adult mode	Functional, healthy mode	Allows connection to emotions and needs in a compassionate way. Responds to the needs of the "inner child" and soothes him or her. Like the observer self, is able to observe inner experiences from a meta-	Cultivated in treatment

		perspective. Modifies old coping strategies into more flexible and adaptive ones. Takes responsibility for self and others in a balanced way, pursues pleasurable activities, and has healthy boundaries: autonomy and dependence are balanced.	
The Happy child mode	Functional, healthy mode	Feels at peace because core emotional needs are currently being met. Is playful, optimistic, and spontaneous.	Cultivated and encouraged in treatment

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1) The Angry protector and Compliant surrender modes are not included in the BPD original mode model but are encountered in individual patients. We have included them here because they are referred to in the Results section.

II

Self-invalidation in borderline personality disorder: A content analysis of patients’ verbalizations.

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Self-invalidation in borderline personality disorder: A content analysis of patients' verbalizations

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EMPIRICAL PAPER

Self-invalidation in borderline personality disorder: A content analysis of patients' verbalizations

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ABSTRACT

Objective The ability to trust one's own perceptions is crucial for psychological well-being and growth. The relevance of its opposite, self-invalidation (SI), to the psychopathology of borderline personality disorder (BPD) is emphasized in many contemporary theories of evidence-based treatments for BPD. Empirical research on this topic remains scarce, however. This study aimed to describe manifestations of SI in individuals with BPD during a 40-session psychoeducational intervention based mainly on schema therapy.
Method Transcripts of videotaped group sessions were analyzed inductively using qualitative content analysis.
Results SI emerged as a recurrent, ubiquitous phenomenon. The content analysis yielded three core categories of SI: (1) a self-critical and harsh attitude towards the self (subcategories reflected punitive internalizations that could engender fear-based inertia, self-erasing, submissive coping behavior, and temporal fluctuation in SI), (2) a deficient sense of normalcy, and self-doubt, and (3) self-stigma. We also found an association of SI with various dimensions of BPD, including difficulty in the identification of emotions, secondary emotional reactions such as guilt, shame, anger, and resentment, self-related and interpersonal problems, and suicidal urges.
Conclusions SI is a detrimental cognitive-emotional process relevant to BPD that merits treatment. Efforts to reduce self-stigma, a pernicious aspect of SI, are imperative.

KEYWORDS: Borderline personality disorder; self-invalidation; self-stigma; qualitative research; content analysis

Clinical and methodological significance of this article: Despite the hypothesized centrality of self-invalidation for borderline personality disorder in many contemporary psychotherapies, research on this topic is scarce. Applying inductive content analysis to a large data set consisting of 80 hours of videotaped group sessions, this study found that individuals with borderline personality disorder strongly experienced self-invalidation. Self-invalidation adversely affected the processing of emotions and self, and interpersonal interaction.

Introduction

Although individuals with borderline personality disorder (BPD) may be well-known for being convinced of their ideas, they are also prone to self-invalidation (SI). SI refers to doubting or questioning the authenticity of one's feelings, ideas, or experiences (Livesley, 2017).

It can be hypothesized that SI encompasses different dimensions, such as implicit and explicit facets, along with temporal fluctuation. With respect to temporal fluctuation, Linehan (1993) describes how individuals with BPD may initially observe themselves accurately but thereafter discount their perceptions owing to self-mistrust. Thus, Linehan refers to the ability to maintain trust in what was observed

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(and apparently at least tentatively validated) a moment ago. However, due to the absence of empirical research, the dimensions of SI, including its temporal fluctuation, deliberateness, or the level of awareness individuals have over their SI, remain poorly understood.

SI can manifest itself in the form of overt judgmental thoughts, such as "I am a bad person," or "I don't deserve to feel better" (Manning, 2019). Other manifestations include trivializing one's distress (Livesley, 2017) and oversimplifying the ease of problem solving, expressed by denying one's problems or blaming oneself for them (Miller et al., 2017). The individual's internal representations of the self may be polarized and distorted (i.e., "all-bad") (Kernberg, 1975). S/he may turn against the self with self-blame and self-hatred (Koerner, 2012), or in the belief that s/he deserves to die, even want to commit suicide as self-punishment (Miller et al., 2017). SI may also allow individuals to avoid dealing with their emotions, thereby functioning as a regulatory mechanism (Linehan et al., 2002).

Dialectical behavior therapy (DBT; Linehan, 1993) posits that SI stems from an invalidating environment that fails to teach individuals when to trust their own emotional and cognitive responses as reflections of valid interpretations of individual or situational events. Individuals then adopt the characteristics of the invalidating environment. Mistrusting their own internal states, they rely instead on the environment for clues on how to respond (Linehan, 1993).

Schema therapy (ST; Young et al., 2003) describes a severe self-punitive state, the so-called punitive parent mode (Online Supplement 1), in which individuals condemn themselves as bad and evil or as deserving of punishment (Arntz et al., 2005). This mode is hypothesized to gestalt an internalization of one or both parents' rage, hatred, loathing, abuse, or subjugation of the individual as a child (Young et al., 2003). The punitive parent mode affects information processing in different phases. As Valkonen (2018) states, in this mode, it seems as if self-observation is executed mainly from an extremely critical observer position, or from an observer position that is *occupied by* an internalized other, that is, a punitive parental introject. Being performed by an abusing other, self-observation manifests an extremely negative or harshly critical tone that renders it highly problematic (Valkonen, 2018). Besides affecting self-observation, the punitive parent mode is characterized by specific patterns of thought that typically concern the invalidity of one's own opinions/wishes/emotions along with beliefs that one has no right to express these (Arntz et al., 2005). ST also identifies the so-called mode of compliant surrender. According to ST theory, this submissive mode, hypothesized to be driven by fear, attempts to protect the individual from further exposure to invalidation, rejection, conflict, or abuse, thereby functioning as safety behavior (Arntz et al., 2005; Young et al., 2003).

In a similar vein, mentalization-based treatment (MBT; Bateman & Fonagy, 2004) assumes that due to traumatic experiences in the attachment relationship, individuals with BPD feel that they are evil or hateful because they have internalized evil into part of the self (the "alien self"). More specifically, persecution from the maltreating person is experienced from within; part of the self-structure feels a desire to destroy the rest of the self (Bateman & Fonagy, 2004). This can be understood as an extreme manifestation of SI.

SI is not without consequences. It is proposed that the ability to evaluate one's behavior nondefensively and to trust one's own self-evaluations is crucial to growth (Linehan, 1993). Conversely, it is hypothesized that insidious doubt concerning one's own perceptions (Livesley, 2003), responding to one's emotional states with negative secondary emotions such as shame, disgust, and anger (Miller et al., 2017), and a tendency to look for external sources of validation all hinder the development of an adaptive self-system (Safer et al., 2009). Moreover, this self-invalidating cognitive style may hinder self-understanding (Livesley, 2017) and the establishment of personal goals and the development of a sense of agency (Livesley, 2003).

To the best of our knowledge, empirical research on SI is scarce. However, overlapping concepts, such as self-criticism (Shahar, 2015; Werner et al., 2019) and self-silencing (Jack, 1991), have been investigated. Self-criticism refers to the tendency to set oneself unrealistically high standards and to adopt a punitive stance towards oneself once these standards are not met (Shahar, 2015). Empirical evidence supports the conceptualization of self-criticism as an important vulnerability factor for psychopathological development (Werner et al., 2019) and the role of parental criticism (Muralidharan et al., 2015) and rejection (Campos et al., 2013; Sobrinho et al., 2016), attachment avoidance and anxiety (Dagnino et al., 2017; Martins et al., 2015), and childhood maltreatment (Falgares et al., 2018; Glassman et al., 2007; Sachs-Ericsson et al., 2006) in the development of self-criticism. In addition, psychotherapy research indicates that compared to their less self-critical counterparts, patients with high levels of self-criticism show a less favorable response to psychotherapy (e.g., Marshall et al., 2008). Compared to self-criticism, self-silencing has received less empirical attention. Using a phenomenological, descriptive approach and a longitudinal study design, Jack gave voice to 12 depressed women (Jack, 1991). These women described an inner dialogue between their authentic, first-person part and another, internalized voice that relentlessly judged them harshly. They often responded to the latter by self-sacrificing and self-negating behaviors. Overall, the condemning voice confused these women, obscuring what they knew by experience and creating inner division. A measure, the Silencing the Self Scale (TSSS; Jack, 1991, 2017) that assesses womens' beliefs about the self in intimate relationships, was also developed and validated in a larger, heterogeneous sample of women (Jack & Dill, 1992).

Study Aims

Despite the hypothesized centrality of SI for BPD in many contemporary psychotherapies, few researchers have addressed this phenomenon. The present study contributes to filling this gap. This qualitative study comprised individuals with BPD attending a predominantly ST-based psychoeducational intervention. As our approach to the data was inductive, meaning that we allowed relevant themes to emerge freely from the data, the only research question was: what emerges as the most pertinent phenomenon from this data set comprising 40 transcribed group sessions? Since this turned out to be SI, we explored its manifestation in group discussions.

Method

This study is part of a larger process-outcome study which is described in detail elsewhere (Koivisto et al., 2021). The study involved a community mental healthcare services center (henceforth the center) in the City of Jyväskylä, Central Finland.

Participants

Research Subjects. A total of eight outpatients were included in the study; seven of them were female. Patients were aged 23–42 (mean 30, median 26) at study start. At baseline, the participants' mean Borderline Personality Disorder Severity Index (BPDSI; Arntz et al., 2003) score was 31.1, indicating moderate to severe symptoms. On average, the participants suffered from a marked functional impairment, as shown by the fact that only two were working or studying at study entry. One patient was attending a work try-out as occupational rehabilitation and five were receiving disability payments. No structural assessment of functioning was performed.

Researchers. The present authors are psychiatrists and cognitive-integrative psychotherapists specialized in the treatment of BPD. TM has a PhD and is also a psychodynamic psychotherapist. SL, MD, and PhD is a professor in psychiatry and one of the developers of the intervention, while MK and TM, who analyzed the data, had no involvement in either the development of the intervention or the organization that delivered the treatment.

Instruments

BPDSI Interview. The Borderline Personality Disorder Severity Index interview (BPDSI; Arntz et al., 2003) was administered three times: before entry into the study, at treatment end, and at the 12-month follow-up. It is a clinical interview assessing the frequency and severity of BPD symptoms during the previous three months. The purpose is to provide a quantitative index of current symptom severity. The BPDSI is based on the DSM criteria for BPD and consists of 70 items organized into nine subscales: (1) abandonment, (2) unstable relationships, (3) identity disturbance, (4) impulsivity, (5) parasuicidality, suicide plans and attempts, (6) affective instability, (7) emptiness, (8) outbursts of anger, and (9) paranoid ideation and dissociative symptoms. The frequency of occurrence of each item over the previous three months is rated on an 11-point scale from 0 (never) to daily (10). Answers are then scored from never (0 points) to daily (10 points) or rated on a 5-point Likert scale (Giesen-Bloo et al., 2010). Previous research has found a cutoff score of 15 between patients with BPD and controls, with a specificity of 0.97 and a sensitivity of 1.00 (Giesen-Bloo et al., 2010). Recovery is defined as achieving a score of less than 15. Reliable change, which reflects individual clinically significant improvement, is achieved when the improvement is at least 11.7 points (Nadort et al., 2009). The present study used the translated Finnish version of the BPDSI (Leppänen et al., 2013).

Procedures

Setting and Recruitment. Participants were recruited from the center, whose services form part of Jyväskylä's municipal secondary, specialized psychiatric services. Professionals working at the center were approached, informed about the study, and asked to refer patients aged 18–65 years with BPD symptoms for potential recruitment. The professionals, as part of their routine work, then informed patients with BPD symptoms of the possibility to participate in the study. The intervention which formed part of the study is routinely offered to individuals with BPD being treated at the center and thus was not controlled for in the study. Hence, patients were recruited for both the study and the group treatment simultaneously. We assessed potential participants in order of referral. Owing to financial constraints, we could study only one treatment group. Therefore, when the number of eligible participants reached eight, recruitment ceased.

The inclusion criterion was a BPD diagnosis based on the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5; American Psychiatric Association, 2013). Exclusion criteria were a DSM-5 diagnosis of a psychotic disorder or a substance use disorder necessitating pretreatment detoxification. Exclusion criteria were assessed clinically only, with no other structured evaluations. The referred patients were assessed for eligibility based on the Finnish version of the BPDSI (Leppänen et al., 2013), with no other diagnostic evaluations. All the eligibility assessments except one (performed by SL) were performed by MK.

Treatment. *Group Intervention.* The intervention, comprising 40 weekly 2-hour psychoeducational group sessions and implemented between August 2017 and June 2018, was developed to meet the needs of public mental health services (Leppänen et al., 2016). The group was facilitated by two experienced psychiatric nurses who delivered the treatment as part of their routine work at the center. The framework integrates elements drawn from cognitive and behavioral treatment models designed to treat BPD. One of the main components of the intervention is patient education using the concept of schema modes (Online Supplement 1). The intervention also includes education in the development of BPD and DBT skills.

Adjuvant Treatment. In addition to group treatment, all patients continued their preexisting treatment as usual (TAU) at the center. TAU consisted of weekly individual sessions provided by psychologists or psychiatric nurses as well as medication. TAU was not linked to the group intervention, and therefore we did not control for it. While some of the individual therapists were familiar with BPD treatment or the treatment model studied, others were not.

Data Collection. The present data consist of 80 hours of videotaped group sessions (40 videotaped group sessions each lasting two hours). All group sessions were delivered at the center, conducted in Finnish, and videotaped with two cameras to ensure that all participants would be visible simultaneously.

Data Analysis. The data were analyzed using inductive content analysis. The data sensitivity of content analysis informed our choice of method, since we wished to remain close to the participants' lived experience by employing description but a relatively low level of interpretation (Sandelowski & Barroso, 2003). Moreover, inductive content analysis is suitable for the exploration of phenomena uncovered in existing research (Kyngäs, 2020).

MK and TM watched 80% of the videotaped data in each other's company. MK transcribed verbatim all the videotaped group sessions. Due to a lack of additional transcribers, parts consisting solely of psychoeducation were left untranscribed. This yielded a total of 374 pages of transcribed data.

Our approach to the data was inductive, meaning that we allowed relevant themes to emerge freely from the data. In analyzing the data, we followed the guidelines for inductive content analysis as described by Kyngäs (2020). Hence, the analysis was executed according to the following steps: data reduction, data grouping, and formation of concepts, i.e., data abstraction. Since SI emerged as a ubiquitous theme, this study set out to explore it. In the data reduction phase, MK extracted all the parts of the transcribed group session data pertaining to SI and compiled them into a single text. In the data grouping phase, all utterances expressing a single idea related to SI were assigned an open code. For instance,"if someone needs me, I never say 'no' but reschedule or cancel my own engagements, otherwise I feel really bad" was initially coded "self-erasure." In the data abstraction phase, the similarities and differences in the content of these open codes were compared to determine which codes could be grouped together to form larger sub-concepts, such as "self-erasing, compliant behavior." Based on similarities and differences in the content of the sub-concepts, the data abstraction phase continued until no (or not enough) shared meaning between the sub-concepts was found and the core categories could be constructed (Kyngäs, 2020).

MK and TM negotiated the clustering decisions made by MK. SL read the transcribed data and, in negotiation with MK and TM, supervised the clustering. No other validation strategies were applied. Finally, the data were quantified. MK counted the number of utterances related to each core and subcategory.

Reflexivity. In qualitative research, researchers are interpreters of basically ambiguous human experience and hence their preconceptions will inevitably affect the findings (Binder et al., 2012). More specifically, what is oriented towards and noticed as well as what is left out of awareness, is unlikely to be random but rather selected and affected by the researchers' preconceptions. Here, we attempted to deal with our biases using reflexivity (Morrow, 2005) as a tool and, perhaps most importantly, noticed that the relevance of SI to the psychopathology of BPD was indeed coloring our preunderstanding. Since we took care not to select themes in line with our own preunderstanding, we questioned the choice of studying SI in dialogical interchange. However, since SI was a recurring and apparently poignant phenomenon that manifested in 39 out of 40 sessions, we selected it as the theme for this study. Furthermore, our primary intention was to describe the data with minimal interpretation. In all instances, we back our interpretations with excerpts from the data in the hope that they will increase transparency and help the reader follow our reasoning.

Ethics. The study was approved by the ethics committee of the Central Finland Health Care District on 9 May 2017 (No. 10U/2017). All participants signed a written informed consent after receiving a full description of the study procedure.

Results

Descriptions of how invalidation had been adopted as the patient's stance towards emotions and the self were abundant in the data. Specifically, the content analysis yielded three core categories of SI: (1) a self-critical and harsh attitude towards self, (2) a deficient sense of normalcy, and self-doubt, and (3) self-stigma. Online Supplement 2 depicts these core categories and their relative proportions.

1. A Self-critical and Harsh Attitude Towards the Self

All eight participants exhibited critical, self-disparaging processing that made them feel vulnerable, insecure, blunted, dysfunctional, worthless, not deserving of good things, or suicidal. Of the total of 534 self-invalidating expressions found, 440 (82.4%) were in this core category. Four subcategories were identified: (a) self-critical and harsh self-observation and self-talk, (b) self-erasing, compliant behavior, (c) initial self-validation followed by subsequent self-erasure, and (d) deliberate display of counterfeit reactions as a coping strategy. The relative proportions of these subcategories are presented in Online Supplement 3.

A. Self-critical and Harsh Self-observation and Self-talk.

> Sarah: It is as if I had a voice in my head telling me … "you never do anything right". Somehow I feel this voice isn't even my own.

> Mary: Yeah, I feel like you. In these moments, I feel the urge to injure myself physically, to hit myself, for instance. And if I happen to look at myself at the mirror, I feel like breaking the mirror.

The self-disparaging attitude was ubiquitous, affecting different phases and areas of processing, from observation to overt thinking. All eight participants exhibited self-observation or self-talk of this kind. With a total of 287 expressions, this subcategory accounted for 65.2% of the core category "self-critical and harsh attitude towards the self."

After being acquainted with the concept of the "observer self," one patient kept asking whether this type of observation includes emotions. Further exploration of her question revealed that she habitually observed her experiences from an extremely critical perspective that communicated a disallowing of her own emotions and thoughts:

> It's interesting how easy it is … or at least how easy it is for me to confuse the punitive parent with the observer self. The punitive parent has become or pretends to be my observer self … It tells me I'm not allowed to experience my feelings and thoughts.

Another patient noticed how she experienced a critical, punitive internalization as well as her emotional reaction to this internalization at the level of a child:

> I've noticed that I still experience the punitive voices at the level of a child. They are exactly same voices I was taught when I was young. I haven't had the chance to outgrow them.

Participants experienced bewilderment at noticing how the harsh processing occurred at an automatic level, escaping meta-awareness and therefore being difficult to discern:

> Amanda: What is this … if I'm, say, in a cheerful mood … Like life is wonderful, and here I am happily driving my car and feeling fine. Then, all of a sudden … you just crash … There comes the experience "you failed in this" or "you said this or that to somebody". Those thoughts just pop up, hit

> me, and place a damper on my mood. Is it that I don't deserve to feel good? Or what is it? And why does it come like that?
>
> Pauline: That's exactly what I've been wondering. Is it that I don't deserve it?
>
> Amanda: This occurs particularly when I've just achieved something. When I'm feeling happy because of succeeding at something … Then, abruptly, like [makes a gesture that represents shooting self in the head] … Then I feel ashamed … like why did I undertake this task at all? … And I feel like crying and would like to drive under a truck even though I was happy smiling just two minutes ago.
>
> Sarah: Exactly. It's particularly after those happy moments that the punitive parent's voice drags you down.

According to the present data, typical triggers for the activation of the critical, self-disparaging type of processing were performance (including success), interpersonal interaction, and the activation of emotional reactions. As the above quotation indicates, downplaying of the self can blunt positive experiences without the individual necessarily being aware of the process. Focusing on or rejoicing in success triggered thoughts such as "don't think you amount to anything," and "it's bad to let your happiness show." This seriously hindered the reception of positive experiences: "the punitive voice wants me to stay stuck."

Overall, performance was an area in which the self-critical and harsh processing was particularly active. The participants anticipated harsh or arbitrary evaluation and believed that mastery should be achieved immediately and without practice. This left them with a constant fear of failure that often resulted in freezing, resignment, or inertia, thereby paralyzing the capacity for healthy action:

> I've always felt I can't affect my life. In fact, I haven't even tried to … I'm so afraid that it will turn out that I'm not capable of doing anything right.

Agentic pursuit of own goals was also hindered because participants felt they were not entitled to it:

> Pauline: It's interesting that these exercises almost always end up with a conclusion like "how would you like to think or act if you were able to act as you want?" 'Cos often, I'm not able to do this because I feel I don't deserve it. I'm not allowed to even think about what I would like …
>
> Sarah: Yeah, it's difficult to even know what you would want for yourself.
>
> Pauline: That [awareness of wants] is something that's not allowed to exist.
>
> Sarah: Exactly. Then you just freeze and feel like "I don't wanna do anything".

Interpersonal interaction was another common trigger for self-doubt and related feelings of uncertainty. Expressing one's opinions or revealing felt emotions induced fear of having expressed something bad. Occasionally, self-disparaging processing manifested itself in the form of explicit self-talk that the participants were aware of. At other moments, however, the participants only noticed the emotional consequences (e.g., panic) while remaining unaware of the cognition part of the experience:

> Such a wicked problem … Sometimes, I'm unable to notice any thoughts. Then it's impossible for me to pinpoint the problem. I only sense that the child [part] panics because she feels she did something wrong.

Not infrequently, the critical processing triggered by interpersonal interaction included a guilt-inducing tone: "because of you, others are now feeling bad." Participants expected that expressing themselves in their ordinary way would potentially hurt others and feared the loss of connection. When the interpersonal situation was over, they would scrutinize their actions. This post-event processing had the potential to induce emotions so overwhelming that they even wished to skip future group sessions.

> Sarah: … Even though I'd said something positive, and even though the reception was ok, and everything was supposed be all right, afterwards, I'd think anyway: … "Why didn't I think it through!", and "I shouldn't have said it." A kind of fear, or a strange panic …
>
> Pauline: If everything you did was always wrong, you just get used to it.

Finally, activation of one's own emotional reactions often triggered self-critical processing, encapsulated in thoughts such as "this shouldn't be a problem for anyone." During the check-in round, Suzanne recounted an incident that was emotion-laden to her. Shortly thereafter, she invalidated her experience: "this sounds so slight … Anyway, I shouldn't feel this way since nothing is wrong." The participants' narratives revealed the internalization of an oversimplifying attitude towards their inner reactions. This internalization communicated to them that it did not matter what they were experiencing, that negative emotions should not be expressed, and that they should behave well irrespective of their emotions. These participants anticipated that their reactions would be judged by others and were, therefore, prepared for guilt-inducing responses, punishment, and humiliation, and thus focused on self-protection instead of free exploration or sharing.

Processing of the hypothesized origins of the cruel attitude towards the self appeared helpful. All eight patients contributed to these discussions. Of the previously mentioned 287 expressions in the present subcategory, 87 (30.3%) were related to the developmental history of the harsh tone of self-observation and self-talk, as exemplified below:

> Pauline: … it didn't even matter what I did. If I blinked, it was a bad thing. If I left, it was bad. But if I stayed, that was bad, too … Well, I understand her [mother] because I know her background. But in any case, it's wrong … And I even feel that's the main reason for my being here in this group.

Several group members were able to relate to this and shared their own experiences.

> Pauline: The common thread here is that we didn't do anything wrong, but our treatment was demeaning, anyway. That's the point, isn't it?
>
> Facilitator: Yes, it was very unpredictable. As you said: you blink or don't blink but have no chance to predict the consequences of your actions.
>
> Amanda: Or: "Because of you, daddy and I had to stay home … "
>
> Facilitator: What emotion does that induce?
>
> Amanda: Guilt.
>
> Facilitator: Like "this is my fault. I should do better somehow."
>
> Sarah: That's exactly how I relate to myself nowadays, as an adult.
>
> Facilitator: And how about shame?
>
> Pauline: … You feel ashamed, too, because every imaginable thing is your fault. But you have no opportunity to compensate for it because it actually wasn't your fault … Then you're left with endless shame, since you can't make amends or treat guilt that isn't even real.

The harsh attitude towards the self was not without consequences. Participants recognized how it affected their processing of emotions. It engendered various secondary emotions, including guilt, shame, anxiety, anger, and resentment, as well as blocking of emotions:

> Pauline [to Suzanne]: What you mentioned during the check-in round, I feel you. Like "it's no big deal, so why can't you just stop dwelling on it?" You kind of push the emotion away, even though you know it isn't the right thing to do.

The critical, self-disparaging attitude towards the self affected the whole self. Participants even questioned their right to exist.

> *Pauline: As a child, I had to behave as if I was non-existent …*
>
> *Sarah: … I also feel I don't have the right to exist, to be visible or to affect other people in any way.*

This was followed by a discussion about how the protagonist in the Moomin tale "The Invisible Child," became visible again; that is, through experiencing and expressing the whole spectrum of emotions, including the "negative" ones.

B. **Self-erasing, Compliant Behavior.** This subcategory describes behavioral responses to the harsh attitude taken towards the self. Seven of the eight participants talked about self-erasure. This subcategory contained 111 expressions and was the second largest subcategory of the core category "a self-critical and harsh attitude towards the self" (Online Supplement 3).

> Earlier, I had a strong feeling or idea that I should kind of fade away … I shouldn't make a fuss, but just silently evaporate, like vanish in order not to burden anybody.

Such self-abandoning behaviors included subservience and inadequate self-care, that is, denying oneself pleasurable or beneficial activities. A central example of the latter was making detrimental health choices. Specifically, participants reported denying themselves meals or adequate rest or sleep, as these were perceived as undeserved:

> I find it hard to go to bed. As far as I understand it, it might have something to do with the fact that sleep is so important. It feels good, and I know I feel really bad if I don't get enough sleep. But then, I'm not allowed to go to bed because I don't deserve to feel good … My mind wants me to feel bad.

As opposed to deliberate, active self-erasing behavior, some participants' self-erasing behavior was primarily characterized by indifference and lack of orientation towards the self:

> It's not about holding to my needs, but more about noticing them. That might be the point there: do I even notice them.

Disconnected from their own needs, participants silently focused on others' needs:

> I was so anxious. I just couldn't decide. I wanted somebody else to tell me what to do. But then the healthy adult took the reins, and I messaged my friend "sorry, I won't be able to drop by". And I felt relieved right away. But at first, I felt I'd never be able to cancel it. Then a thought crossed my mind: "Perhaps I sometimes have the right to express that something is inconvenient for me."

Self-erasing, other-oriented behavior often seemed to originate in the internal dynamics of the individual's punitive-submissive counterparts, where the self was experienced as worthless and fear of the interpersonal consequences of noncompliance dominated the patient's mental world. Thus, compliant behavior could serve to appease the harsh and critical voice:

> When I'm not angry, I comply with everything 'cos I fear the consequences of not complying … I never say 'no'. That will only backfire … I go along, like "suits me fine" … Were I to negotiate with someone, like "you want it like that, and I want it like this", I would always give up … I was explicitly taught that I don't matter … I'm not allowed to think of myself or be assertive if there are other people around, to the point that I don't even know what I want.

As evident from the excerpt above, self-erasing behavior constituted part of a vicious cycle that had detrimental effects on the self. However, the present data also included numerous examples of change-talk:

> It just seems so silly that it's so important to me not to ever hurt anybody, or that nobody should ever get annoyed because of something I said. I mean, people will inevitably have emotional reactions all the time. They'll react to aspects I might not even be aware of.

Occasionally, self-sacrificing behavior was driven by the projection of one's own, deprived needs onto others. Since the participants attempted to avoid inducing similar, presumably intolerable experiences in others that they themselves had endured as children, they tended to give excessively to others without considering their own boundaries:

> It's difficult for me to deny somebody something because it activates my own childhood experiences … Because you … did not feel quite understood, or people just said "no" to you without explaining it … Then, as a grown-up … you are careful not to repeat the same mistake. So, you don't want to say just "no" but rather want to explain the reasons for that "no" so that the other person understands and won't feel so bad about it.

Participants also recognized how self-erasure could function as a reenactment of the victim position. They became aware of how, in their inner dynamics, they continued to repeat the traumatic invalidation they had been exposed to during their personal histories. Paradoxically, the bittersweet victim position could even be a source of pride:

> Like taking the victim role, even though at that moment, you don't regard yourself as a victim … Kind of a Jesus spirit. I don't mean in a religious sense, but anyway like: I surrender to be crucified for the sake of others, ha ha ha.

Compliant, self-erasing behavior was state-dependent as opposed to static. Subservient behavior might be followed by different mental states. In the subsequent angry, impulsive, and/or rebellious states, the compliant behavior temporarily subsided:

> You volunteer to do it all by yourself, but then complain: "Fuck it! Why do I always have to serve you!" Ha ha ha.

Their collaboration in processing these experiences facilitated the participants' awareness of their complex and often conflicting emotions. Further, they came to realize how they themselves contributed to the problem in the present, as opposed to their habitual enactment of the old victim role.

C. **Initial Self-validation Followed by Subsequent Self-erasure.** This subcategory refers to temporal fluctuation, that is, experiencing self-doubt and self-erasure following the initial validation one's emotions, thoughts, or actions. The behavior itself (self-erasure) is analogous to that in the previous subcategory. However, since this subcategory is characterized by temporal fluctuation in the experience, we consider it merits existence as a distinct entity. Of eight patients, five described initial self-validation followed by subsequent self-erasure. A total of 15 such expressions accounted for 3.4% of the core category "a self-critical and harsh attitude towards the self" (Online Supplement 3).

> Sometimes I'm in fact able to say "not now" but after a while, I feel so bad I go back on it. For instance, if I'd negotiated with my boyfriend about who was

> going to do the shopping … If we'd managed to settle it so that he'd be doing it, and he'd been ok with that and not even annoyed, I'd still get the feeling that it's no big deal for me, like what's the problem here for me, why can't I just do it … Very often, I end up eating my words.

Self-validation followed by self-erasure was also found in group interaction. Neutral responses, perhaps experienced as lack of validation, sufficed to induce this, and the participants recanted, apologized, readjusted, or critically reflected on their personal contribution: "Am I being too talkative?" or "I'm talking way too much." We observed numerous retreats from interaction with the group, as manifested in expressions such as "never mind" and in speech turns that commenced but soon after were aborted. Withdrawals into long silences also occurred. These sequences could be indications of initial self-validation followed by self-erasure. However, these data preclude the drawing of conclusions on the motives of silent behaviors, as alternative explanations also exist (e.g., angry retreats due to feeling misunderstood). Ambiguous utterances or behaviors of this kind were not included when the data were quantified.

D. **Deliberate Display of Counterfeit Reactions as a Coping Strategy.**

> Everything I say, I say with such uncertainty that it's easy for me to recant anytime … It's often not that I even wanted to agree in the first place. It's more that I've learned that my opinion is automatically seen as irrelevant, or perfectly stupid, like: "You idiot, how can you think like that" … I've noticed I hardly ever act according to how I feel but rather opposite to my emotions … I try to appear as calm, composed and brave as I can … I can act sociable … I may appear happy … but that doesn't feel good to me … I'm super good at faking positive emotions … When I'm angry, I might smile even more … But then, without anybody being able to anticipate it, I suddenly fall apart as I'm no longer able to act composed. I wonder how I could allow myself to show some [emotional reactions].

In this subcategory, as in the previous one, trust is initially experienced in one's own reactions. However, unlike in the previous subcategory, this self-validation is maintained, with the individual deliberately displaying other, feigned reactions including inauthentic positive emotions, counterfeit opinions, or feigned self-invalidation. Three of the eight patients described behaviors in this subcategory. The 27 expressions in this subcategory accounted for 6.1% of the core category "a self-critical and harsh attitude towards the self" (Online Supplement 3).

Clearly, displaying inauthentic reactions while concealing true ones was a survival strategy. Pretended self-invalidation, for example, functioned to protect patients from the pain of social invalidation and related feelings of disappointment, shame, or humiliation. More specifically, since they had learned that others could be unresponsive to their feelings, ridicule their dreams and fail to share their joy or pride in their accomplishments, or even turn aggressive or destructive, they hid these experiences while presenting a self-downplaying façade supposedly acceptable to the invalidating other. Thus, besides protection of the self, the purpose of this strategy was to maintain contact with others.

> I was taught to @be positive! Think positively!@ And so on. So, my attitude towards my own experiences has been like … if someone, say, sawed my leg off, I'd think about it like @fortunately I still have the other one left.@
>
> Text inside @-marks is uttered in a phony voice.

Importantly, patients also applied this interpersonal strategy in their treatment:

> Previously, I only talked to my therapist about issues I assumed she wanted to hear. For instance, I told her that everything is fine and that I'm busy studying … But then I noticed it didn't help me, and somehow, nowadays, I'm able to voice all the thoughts that go through my mind.

Participants recognized the harmful consequences of this coping strategy; displaying counterfeit behavior entailed consequences for both oneself and one's relationships. It led to a vicious circle where one was misperceived – and thereby invalidated – by others:

> Sarah: I've noticed that my actions have no correlation with who I really am. I mean, I feel my behavior reflects a completely different person. One can't infer anything from my behavior because I play a role without ever revealing my true self. No wonder people are unable to know me; no wonder I'm given gifts I don't even like … Gee, I realized how I was taught to deal with emotions when I was a child. It's as if they inserted a script in my brain with a message telling me "don't pay attention to how you feel, but just behave".
>
> Pauline: And those gifts, they are for the self you present outwardly.

Hidden underlying needs were unnoticed by others and therefore not responded to:

> Sarah: I get a lot of positive feedback but it's not the kind of feedback I'd need. It feels too superficial.

> Facilitator: The underlying need is not met.
>
> Sarah: No, it's not.
>
> Pauline: The feedback is not authentic because others are unable see the real me.

This discordance between felt, inner states, and those presented to others had an alienating effect on participants' relationships.

2. A Deficient Sense of Normalcy, and Self-doubt

> Don't make a scene about this, since it might just be your BPD kicking in.

Content analysis yielded a second core category of SI that was characterized by doubting one's perceptions. Participants experienced global uncertainty about "what is normal." Being diagnosed with BPD added another layer to self-mistrust, since one's perceptions could potentially reflect personality pathology. Six out of eight patients described experiences related to this core category. The 79 expressions observed in this core category accounted for 14.8% of the total of 534 self-invalidating expressions (Online Supplement 2).

Participants experienced confusion in attempting to figure out to what extent they could trust their reactions: "I constantly monitor my emotions and thoughts, but I'm uncertain whether I can trust them or not. How can I tell a misinterpretation due to BPD from a valid reaction? How do I know what is justified?" Adjustment of one's emotions and emotional needs and how to express them were issues the participants were particularly eager to work on:

> Amanda: How can you tell what are realistic limits? I mean, for instance, in relationship with a partner. I've been reflecting on whether these are just my own issues, or this BPD again. Like am I asking too much from him. Like do I dare to mention my needs out loud or does he think "you're just crazy".
>
> Sarah: That's exactly what I fear, too. Always.
>
> Amanda: Then you give up expressing your needs.
>
> Suzanne: I get so hurt so easily that I feel it just can't be normal.
>
> Sarah: The problem is that you're unable to discriminate between when it's ok to get hurt, like when not to take offense is too much to expect from you, and when it's not ok.
>
> Pauline: It's annoying to always have to distinguish between what is due to BPD and what is normal, I mean doubting whether my emotions are based on reality.
>
> Sarah: I could easily attribute everything to BPD. I refrain from expressing nearly any hurt feelings since my automatic appraisal is that "this probably isn't a real issue". Then I analyze the situation in my mind and might consult my best friend … But I have the tendency to say to myself "you're just exaggerating". Then I feel like "you shouldn't feel hurt because of that".

Pauline recognized the devastating effects of SI on the processing of emotions and noticed that by self-invalidating, she continued to repeat the previous traumatic invalidation in the present:

> Earlier, I did that a lot, too, and still do … But I feel it's very dangerous to always bypass your experience, judging your reactions as wrong … and not fitting the situation. Then you say to yourself … "how foolish" … or "that's irrelevant". Doing that, I'm not open to my emotions, I avoid facing them … As you said [to the facilitator, referring to what had been read out loud a moment earlier]: "had no permission to express his or her emotions", I continue to repeat it myself.

"Normalcy" was an intriguing but elusive concept for the participants. In addition to a wish to learn to adjust their reactions, one motivation behind the frequently posed question "What is normal?" was participants' limited sense of normalcy. Looking back on their developmental histories, participants felt they had been left without templates for normative reactions and thus deprived of the opportunity to learn to gauge their reactions and how these affected other people. Moreover, participants' childhood experiences that had disrupted the development of an understanding of "what is normal" included deprivation of validation and congruent feedback:

> Facilitator: … of course you felt bad.
>
> Pauline: … You said "it was an app-rop-riate reaction". That's exactly what's missing in my script. That doesn't even exist in my world. I don't have such a word. The point is: since my feelings were never validated … I'm unable to tell whether it's ok to feel something.

Participants were prone to experience themselves as highly abnormal and deviant. Reflecting the stark contrast they perceived between themselves and others, they frequently spoke about "'normal persons," or "integrated persons" when referring to others. This seemed to drive a wedge between themselves and others and fuel additional judgmental labeling of their own reactions.

3. Self-stigma

> From an outsider perspective, my life looks like a soap opera … I'm a drama queen … I'm so ashamed of being this kind of a person.

The third core category concerns the stigma and self-stigma associated with being diagnosed with BPD. All eight patients talked about it. The 15 expressions on this theme accounted for 2.8% of the total of 534 expressions of SI in this data set (Online Supplement 2). The present participants were painfully aware of the negative stereotypes and prejudices attached to BPD. They could apply these labels to themselves, thereby inducing additional feelings of worthlessness and shame: "What's the logic behind this I-am-good-enough talk? After all, diagnostically, we are mentally ill. Try and think 'I'm adequate just as I am,' then."

During one group session, Emma recounted an occasion when she had expected that disclosing her BPD diagnosis in a medical encounter would have ameliorated its psychological-interactional impact. To her disappointment, her disclosure failed to achieve this objective. Her fellow patients who had experienced stigma in medical encounters had no illusions about the consequences of disclosure:

> Judy: I usually avoid mentioning I have BPD … I prefer to keep my cards close to my chest because it easily gets misconstrued. I'm borderline means … I'm an ugly person - I mean, psychologically.
>
> Sarah: Yeah, I don't like to disclose it either.
>
> Judy: Really, I mean [if I disclose it], the interaction always turns like I̲ am the source of all problems. From then on, they interact with me with kind of a psycho attitude, you know, in a way you interact with a nutcase … The diagnosis is more like a burden … you're branded on your forehead, and you're treated accordingly. And the mental diagnosis will then be emphasized in all sorts of irrelevant contexts.
>
> Sarah: Persons with BPD have a bad reputation … I've noticed that if they know, then the treatment turns extra lousy.
>
> Judy: … and when the staff report, they say "that one's borderline; no wonder she might be a bit spiky" … That way, I'm denied the opportunity to evaluate my treatment anymore: I'm spiky because I'm borderline.

Occasions were observed where participants were extremely quick to latch on to expressions which they then attached to themselves. For instance, when the topic of mindful observing was presented in the group, the facilitator acquainted the participants with the idea of *observing the drama of your life*. The word "drama," unfortunately, has a strong pejorative connotation in Finnish. This direct translation from English to Finnish may inadvertently have led one participant, who was speaking just before the facilitator took the floor, to call herself a "drama queen." Moreover, although the present data preclude causal conclusions, we suspect that some of the wording (e.g., "borderline patients often are … ") in the psychoeducational material might have invoked self-stigma talk.

Discussion

In this study, patients with BPD strongly experienced SI, as manifested by a self-critical and harsh stance towards the self, a deficient sense of normalcy and self-doubt, and self-stigma. A pernicious dialogue between different self-aspects (modes) was observed. In this dialogue, a harsh, punitive mode attacked other modes that reacted either with fear, concealment of authentic reactions, and outward compliance, or with anger, resentment, and rebellious behavior. Our findings show a striking number of similarities with those of Jack (1991), who reported that women with depression also shifted between these modes.

Sometimes the harsh, critical mode spoke to the patients using the words of their significant others. Hence, patients could experience this voice as ego-alien ("I feel the voice isn't even my own"), possibly reflecting an introject not truly processed, but rather "swallowed whole" (Perls et al., 1994). Consistent with our findings, Zinker (1994) notes how such introjects are often force-fed by a significant other. This phenomenon, reflecting introjecting with minimal effort (Zinker, 1994), may resemble the MBT concept of the development of an "alien self" (Bateman & Fonagy, 2004).

In the psychotherapy literature, SI often refers to doubting one's own perceptions (Linehan, 1993; Livesley, 2017). As proposed by Linehan (1993), individuals with BPD may also have very little sense of what is normal. Evidence from the present study supports these clinical observations. Moreover, we found empirical support for Linehan's observations on the fluctuating nature of self-validation and SI (Linehan, 1993), that is, how individuals with BPD may initially observe themselves accurately but soon after discount their perceptions owing to self-mistrust.

The present participants described how SI obstructed their agentic behavior. These observations accord with those reported by Shahar et al. (2006) and Shulman et al. (2009), who found that a partly overlapping phenomenon, self-criticism, adversely affected young adults' goal construal, predicting low levels of autonomous motivation and positive life-events. The present findings also provide evidence for the connection reported by these researchers between self-criticism and avoidance, that is, how self-critical individuals shy away from doing things they really want to do, and experimenting (Shahar, 2015).

Our findings on stigma and self-stigma support existing findings indicating that BPD is highly stigmatized (Grambal et al., 2016; Quenneville et al., 2020; Rüsch et al., 2006; Sheehan et al., 2016). Our findings suggest that to reduce self-stigma, the wording used in psychoeducation may be important. Other researchers have also emphasized the power of language and assumed that the way it is used may influence stigma construction (Aviram et al., 2006; Masland & Null, 2021).

SI is an important treatment target in many contemporary psychotherapies for BPD. Treatment for SI includes increasing patients' awareness of the numerous ways in which they engage in SI (Livesley, 2017), both during sessions and in their lives outside therapy, for example, by asking them, "Do you notice how you said/felt X but then took it back? What happened?" Moreover, therapy strives to convey the idea that the harsh, punitive mode is merely one mode within the patient (Arntz & van Genderen, 2021; Shahar, 2015). Learning to observe mental events mindfully may aid in putting this mode in its place. Targeting SI also requires that the therapist constantly searches for the contrary, that is, the valid in patients' responses and communicates this to them (Fruzzetti & Ruork, 2019; Linehan, 1993). Heightening awareness of the early causes of SI is also a necessary component of therapy. In ST, traumas contributing to the development of SI are treated using experiential techniques, including imagery rescripting (Arntz & van Genderen, 2021).

A strength of the present study is its large data size. The use of investigator triangulation, that is, the involvement of multiple observers and interpreters, may increase the credibility of the results. A limitation is that the content analysis of group session data can only describe SI as it manifests in explicit verbal expressions or overt behaviors, and thus neglects more subtle, less conscious, or unverbalized aspects of SI. Caution must be exercised in interpreting the results of the quantified data; the participant who talks least may be the one who suffers the most seriously from SI. Because the present patients were acquainted with the concept of the so-called mode of the punitive parent (Online Supplement 1) during the group intervention, it is possible that expressions related to self-criticism and harshness may be over-represented in our data at the cost of other aspects of SI. However, the patients had not been familiarized with the concept of SI in their treatment context.

Questions for future research include: What exactly is SI? What are its boundaries with neighboring concepts, such as self-criticism and self-silencing? What is the role of biological factors, for example, neuroticism, in SI? Do gender or cultural aspects in the upbringing of female children play a role in the development of SI? Does SI constitute part of a larger, overarching self-concept pathology (see for example, Shahar, 2015)? These questions should be explored using a diversity of methodologies. Experimental designs focusing on implicit in addition to explicit information processing are needed to further our understanding of how individuals with BPD trust or doubt their perceptions. Self-report instruments tapping a closely related phenomenon, that is, self-silencing in intimate relationships, already exist (Jack, 1991, 2017, 1992), and could be developed to explore SI. Qualitative research could also explore SI using in-depth interviews.

To conclude, SI may be a devastating vulnerability relevant to BPD. It may engender serious consequences, including difficulty in the observing of emotions, thwarted exploratory behavior, poor self-care, and suicidal urges. It is imperative that efforts are made to reduce self-stigma, one pernicious aspect of SI.

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III

Processing of self-concept and identity in individuals with borderline personality disorder: findings from a content-analytic follow-up study.

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Processing of Self-concept and Identity in Individuals with Borderline Personality Disorder: Findings from a Content-Analytic Follow-up Study

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Abstract: We explored how five individuals with borderline personality disorder (BPD) perceived their self-concept over the 12 months after attending a psychoeducational intervention at a community mental health care centre. In this mixed-methods process–outcome study, subjective experiences of meaningful development gathered via an in-depth interview were explored using content analysis. Symptom change was assessed by the Borderline Personality Disorder Severity Index interview. A total of 221 utterances related to the processing of self-concept and identity were identified. Content analysis yielded five core categories pertaining to self-concept and identity: 1) from extremely negative and fluctuating self-concept to improved self-worth and stability; 2) self as actor: sense of agency; 3) decreased disconnection from and integration into self of emotions and emotional needs; 4) the importance of understanding the origins of the negative self-concept; and 5) challenges to the processing of self-concept and identity. Identity development was hampered by insufficient self-compassion and perception of the diagnosis as an additional stigma. The data highlight the importance in treatment of achieving change in punitive internalizations and judgmental self-talk. The findings also suggest the value of facilitating a sense of agency and contact with emotional experiences.

Keywords: Borderline personality disorder; identity; self-concept; self-stigma; psychoeducation; mixed methods

Borderline personality disorder (henceforth BPD) is a serious mental disorder that causes intense suffering. A feature of BPD is impairment in self-functioning and identity; identity disturbance is a BPD criterion in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013).

According to Jørgensen (2009), identity can be conceptualized as (1) an inner psychological structure, (2) the specific content of the self and psyche, and (3) an ongoing process. The self-schema “I am a failure” is an example of the specific content of identity. Structure refers to the level of integration in the content, i.e., in the concept of self, and process to how information about the self, others, and one’s own past, present, and future is continuously being processed (Jørgensen, 2009). The boundary between identity and two closely related yet dissimilar concepts, “self-concept” and “self-esteem”, requires definition. Baumeister (1999) defines identity as who you are, self-concept as your ideas about yourself, and self-esteem as how you evaluate yourself and how you feel about yourself.

The importance for BPD of a disturbance in self-concept is reflected in various clinical models in which alteration in self-concept is regarded as the core component of the disorder (Evans et al., 2015). Early psychodynamic theories viewed identity in BPD as diffuse, referring to lack of integration in the concept of self and significant others (Kernberg, 1975; Yeomans & Delaney, 2008). Transference-focused therapy posits that this failure of integration results from the predominance of internalized aggressive object relations over idealized ones and the excessive use of primitive defence mechanisms, such as projection, splitting, or dissociation (Yeomans & Delaney, 2008). The individual is thus left with unidimensional, contradictory, or fragmented internalized representations of self and others, and difficulty in discerning more subtle variations (Kernberg, 1975). Schema therapy (Young et al., 2003) theory addresses variation in the content as well as structure of the self-concept. The theory posits that BPD is characterized by early maladaptive schemas and schema modes. The former refers to *trait*-like cognitive structures whereas the latter refers to fluctuating facets of personality that can be understood as cognitive-emotional-behavioural *states*. An individual's schema modes may be integrated into a cohesive whole or dissociated; the degree of integration varies (Young et al., 2003). Similarly, the theory of cognitive analytic therapy (Ryle, 1997) assumes that partial dissociation provoked by childhood trauma or deprivation results in the persistence of separate self-states, and hence BPD is characterized by fragmented self-states. Examples of these self-states are abuser rage, victim rage, and zombie (Ryle, 1997). The cognitive analytic therapy concept of self-states shares many similarities with the schema therapy concept of schema modes. Despite individual differences, the transference-focused therapy, schema therapy, and cognitive analytic therapy models share the view that self-concept is fragmented and unstable in BPD (Evans et al., 2015).

Two other evidence-based BPD treatments, namely dialectical-behaviour therapy (Linehan, 1993) and mentalization-based therapy (Bateman & Fonagy, 2004), seem to place no marked emphasis on the centrality of identity disturbance. They nevertheless describe the negative content of self-experience. Moreover, both dialectical-behaviour therapy and mentalization-based therapy aim at facilitating integration. In dialectical-behaviour therapy, difficulties within the self and identity are hypothesized as stemming from invalidating environments in which children fail to learn how to trust and validate their own observations and emotions as valid reflections of reality. Without validation of their own experiences, children learn to look to others in an attempt to find out what to think or feel, thereby leaving identity fragile. According to Linehan (1993), attempts to inhibit mental contents and the related inability to experience, process, and integrate traumatic events may also contribute to the absence of a strong sense of identity. Mentalization-based therapy assumes that intensive negative self-representations encountered in BPD are due to trauma, neglect, and failed parental mirroring of the child (Löf et al., 2018). Due to this incongruent mirroring of the child's mental states, the child may internalize the caregiver's mental state as an "alien self", engendering discontinuity within the self (Bateman & Fonagy, 2004). With respect to self or identity as a process, indications of the failure of self-organization become apparent at moments of impaired mentalization (Fonagy et al., 2012). Individuals may attempt to alleviate the incoherence within the self through externalization. In other words, they may project the alien part (for instance, "badness" or "abuser") of the self onto another person who then becomes the carrier of these unacceptable or intolerable aspects. They may also attempt to alleviate the incoherence by suicidal acts (Bateman & Fonagy, 2004; Fonagy et al., 2012).

Studies have consistently revealed that individuals with BPD have a negative explicit self-concept (Gad et al., 2019), and low self-esteem (Korn et al., 2016). They tend to experience shame (Karan et al., 2014; Rüsch et al., 2007), and a high degree of self-blame and self-neglect combined with reduced self-love (Klein et al., 2001). Recently, Spitzer et al. (2021) found that women with BPD displayed significantly more shame- and guilt-prone implicit self-concepts compared to healthy controls. With respect to identity as content, beliefs encompassing the themes of loneliness, unlovability, rejection, and abandonment, as well as experiencing the self as bad and deserving punishment have been found to be highly BPD discriminative (Arntz et al., 1999; Arntz et al., 2004).

Individuals with BPD also tend to experience self-stigma (Grambal et al., 2016; Quenneville et al., 2020; Rüsch et al., 2006). Self-stigma is the introjection of negative public perception, reflecting a maladaptive process where individuals accept societal prejudices and integrate this evaluation into their own self-concept (Livingston & Boyd, 2010). As Goffman stated, those who are stigmatized are diminished "from a whole and usual person to a tainted, discounted one", a process that leads to a "spoiled" identity (Goffman, 1963). Individual vulnerability to self-stigma may vary. Literature on vulnerability and resilience factors is still scarce, however. Among adolescents briefly hospitalized for psychiatric reasons, Moses (2011) reported that subgroups vulnerable to higher stigma were females, those with prior exposure to social devaluation, those dependent on others for self-worth validation, and those with limited sources of identification (Moses, 2011).

Importantly, studies are now beginning to address how self-referential information is processed. Findings from this stream of research suggest negative processing biases in BPD. Auerbach et al. (2016) showed that, compared to healthy youth, patients with BPD endorsed, recalled, and recognized more negative and fewer positive self-relevant words. Using a controlled real-life social interaction design, Korn et al. (2016) investigated the impact of social feedback on self-evaluations. They found that individuals with BPD, when receiving feedback on their character traits, integrated undesirable feedback for themselves to a greater degree than healthy controls did.

On the temporal stability of self-esteem, Santangelo et al. (2017) found that the estimated odds of acute changes in self-esteem were eight times higher in patients with BPD compared to healthy controls. Findings from the same study also suggested a pattern characterized by sudden dramatic worsening and slow recovery of self-esteem in patients with BPD.

Qualitative studies addressing self-concept and identity from the BPD sufferer's subjective perspective have been fewer. Using narrative analysis, Adler et al. (2012) compared the narrative identities of twenty mid-life individuals with features of BPD to the narrative identities of a comparison group of twenty individuals with no such features. They found that, compared to controls, the narrative identities of the individuals with features of BPD were significantly lower in the themes of agency, communion fulfilment (but not communion), and overall coherence. More specifically, to quote the authors, "the life stories of individuals with features of BPD portrayed a protagonist who was batted around at the whims of his or her circumstances, unable to influence life's direction", indicating low agency (2012, p. 9). This disempowered protagonist has trouble fulfilling his or her deep wishes for connection and constructing a coherent personal narrative (Adler et al., 2012).

Using thematic analysis of interviews, Agnew et al. (2016) explored identity in five women with symptoms of BPD. All five spoke about feeling lost, unreal, or conflicted. They also felt broken, destructive, and helpless. This study captured some aspects that can be hypothesized to reflect the consequences of trauma and dissociation to self and identity, for instance blocking, disconnection, and a glazing over of traumatic events in their lives and lack of perceived control. The participants also described self-conflict with respect to such issues as morality and wickedness, goodness and badness, or childishness and adultness. All of them spoke about their attempts to conceal their physical and psychological self from others for fear of being judged negatively or being hurt or abused. As in Adler et al. (2012), narratives about change following insight were largely lacking (Agnew et al., 2016).

Finally, a relevant research question is whether treatment can affect the content, structure, or processing of the self-concept. A randomized controlled trial comparing BPD patients assigned to dialectical-behaviour therapy or to so-called community treatment by experts revealed that the participants in both conditions started therapy with overall hostile, critical, and punishing introjects. However, over the course of the treatment and 1-year follow-up, the patients assigned to dialectical-behaviour therapy reported significantly greater self-affirmation, self-love, self-protection, as well as less self-attack (Bedics et al., 2012). Roepke et al. (2011) compared a 10-week inpatient dialectical-behaviour therapy to wait-list. They found that, compared to wait-list controls, patients in the treatment group showed significant enhancement in self-concept clarity and in some facets of self-esteem. Moreover, a naturalistic study revealed that BPD patients who had a very negative self-image at study start showed improved self-image on all aspects of the SASB (Structural Analysis of Social Behavior; Benjamin, 1974) after 18 months of mentalization-based therapy (Löf et al., 2018). However, we know little about how change in identity and self-concept occurs in treatment and how competencies in this area could be brought out in therapy. If we aim to explore treatment-related change in identity and self-concept, the first-person perspective of patients can illuminate important aspects that researchers and therapists may be unaware of. Qualitative research into the phenomenology of identity and self-concept may help further the development of useful treatment strategies that target these central problems.

Study Aims

In this study of individuals with BPD attending a mainly schema therapy-based psychoeducational intervention, we were enabled to explore how development and change in self-concept and identity was maintained after treatment end, i.e., over a 12-month follow-up period. As our approach was inductive, meaning that we allowed relevant themes to emerge freely from the data, the initial research question was: what are the most pertinent phenomena that emerge from this in-depth interview data focusing on participants' first-person perspectives on their development? Since these turned out to be self-concept and identity, we set out to investigate 1) how patients perceived their self-concept or identity 12 months post treatment, and 2) whether, and if so how, self-concept or identity altered and was processed over the follow-up compared to the situation at treatment end.

Method

This mixed-methods process–outcome study involved a community mental healthcare services centre (hereafter, the centre) in Jyväskylä city, Central Finland (Koivisto et al., 2021). The process component of the study aimed, through in-depth interviews, to trace and describe patients' first-person experiences of meaningful development. The outcome component assessed change in BPD symptom scores.

Recruitment and Setting

Participants were recruited from the centre, whose services form part of Jyväskylä municipality's secondary, specialized psychiatric services. Professionals working at the centre were approached, informed about the study, and asked to refer patients aged 18-65 years with BPD symptoms for potential recruitment. The study design was naturalistic. The professionals, as part of their routine work, informed individuals with BPD symptoms of the possibility to participate in the study. The intervention that formed part of the study is routinely offered to individuals with BPD being treated at the centre and thus was not controlled for in the study. Hence, participants were recruited for the study and the group treatment simultaneously.

We assessed potential participants in order of referral. Owing to financial constraints, we could study only one treatment group. Therefore, when the number of eligible participants reached eight, recruitment ceased.

The inclusion criterion was a BPD diagnosis based on the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5; American Psychiatric Association, 2013). Exclusion criteria were a DSM-5 diagnosis of a psychotic disorder or a substance abuse disorder necessitating pre-treatment detoxification. Exclusion criteria were assessed clinically only, with no other structured evaluations. The referred patients were assessed for eligibility based on the Finnish version (Leppänen et al., 2013) of the Borderline Personality Disorder Severity Index interview (BPDSI; Arntz et al., 2003), with no other diagnostic evaluations.

Treatment

Group Intervention

The intervention consisted of 40 weekly two-hour psychoeducational group sessions implemented between August 2017 and June 2018. It was originally developed to meet the needs of public mental health services (Leppänen et al., 2016). The group was facilitated by two experienced psychiatric nurses who delivered the treatment as part of their routine work at the centre. The framework integrates elements drawn from cognitive and behavioural treatment models designed to treat BPD. One of the main components of the intervention is patient education using the concept of schema modes (see Appendix). Moreover, the intervention includes education in the development of BPD and dialectical-behaviour therapy skills.

Treatment as Usual

In addition to group treatment, all patients continued their pre-existing treatment at the centre. This treatment consisted of weekly individual sessions provided by psychologists or psychiatric nurses as well as medication. It would, if needed, also continue post intervention, often with reduced frequency. It was not linked to the group intervention, and therefore we did not control for it.

Participants

Seven of the eight outpatients included in the study were female. Patients were aged 23-42 (mean 30, median 26) at study start. At baseline, the participants' mean BPDSI score was 31.1 indicating moderate to severe symptoms. On average, the participants suffered from substantial functional impairment, as shown by the fact that only two were working or studying at entry into the study. One patient was attending a work try-out as occupational rehabilitation and five were receiving disability payments. No structural assessment of functioning was performed.

Researchers

The present authors are psychiatrists and cognitive-integrative psychotherapists specialized in the treatment of BPD. TM is also a psychodynamic psychotherapist. SL is a professor in psychiatry and one of the developers of the intervention, while MK and TM, who analysed the data, had no involvement in either the development of the intervention or the organization that delivered the treatment.

Measures

In-Depth Interview

The qualitative data of the present study consist of responses to a semi-structured in-depth interview in which participants were asked to reflect on their experience of personal development over the 12-month post-treatment follow-up period. Mean interview duration was 79 minutes. The interview questions included:

1. How would you describe your personal development or sustained growth (or lack thereof) during the past year?
2. Is there anything that was previously hard for you that you are nowadays able to deal with in a new way?
3. Is there anything that you are still struggling with? What kinds of things or moments or situations are you still finding it hard to deal with?

4. During the past year, how you have been using what you learned in the group?
5. What about life outside the treatment context? Does that play a role in your development and, if so, how great a role?

Borderline Personality Disorder Severity Index Interview

The Borderline Personality Disorder Severity Index (BPDSI; Arntz et al., 2003) is a clinical interview assessing the frequency and severity of BPD symptoms during the previous three months. The purpose is to provide a quantitative index of current symptom severity. The interview is based on the DSM criteria for BPD (Arntz et al., 2003).

Data Collection

All the interviews were conducted at the centre. The in-depth and the BPDSI interviews were conducted at treatment end (Koivisto et al., 2021) and 12 months thereafter. The present study draws on the 12-month follow-up data. Both interviews were implemented in close succession, the BPDSI immediately after the in-depth interview. MK conducted all the interviews which were filmed.

Data Analysis

We applied content analysis to the in-depth interview data (Kyngäs et al., 2020).

Choice of Method

Following our desire to predominantly give a voice to the patients and thus describe the data while applying a relatively low level of interpretation (data-sensitivity; Kyngäs et al., 2020), content analysis emerged as the method of choice as it enables an approach to the data that favors description over interpretation (Sandelowski & Barroso, 2003). We also wished to compare participants' subjective experiences with change in symptom scores, that is, to apply a mixed methods approach. Content analysis allows this kind of methodological integration (Kyngäs et al., 2020), as well as both qualitative analysis and quantification (Gbrich, 2007). Lastly, local influences may have affected our selection of approach. Since content analysis has become firmly embedded in Finnish nursing research in recent decades (Kyngäs et al., 2020), it was a natural choice.

The Analytic Process

At first, MK reviewed all the filmed in-depth interview data. After that, MK and TM reviewed 80% of the data in each other's company. MK transcribed these interviews verbatim. The transcribed data amounted to 110 pages, which MK reread several times. When relevant, she also returned to the filmed raw data to obtain an understanding of nuances (including non-verbal signs indicating the relevance of a topic for the participant) that were not fully captured in the transcriptions.

Our approach to the data was inductive, meaning that we let relevant themes emerge from the data. Since the processing of self-concept and identity emerged as a ubiquitous theme, it was chosen as the topic of this study. In analysing the data, we followed the guidelines for inductive content analysis described by Kyngäs et al. (2020). The analysis was conducted according to the following steps: data reduction, data grouping, and data abstraction, i.e., formation of concepts.

In the data reduction phase, MK extracted the parts of the transcribed interviews that covered data pertaining to the processing of self-concept and identity, compiled them into a single text, and selected the level of a unit of analysis. The unit of analysis refers to the portion of content that will be the basis for decisions made during the later development of codes (Roller & Lavrakas, 2015). In this study, the unit of analysis refers to a meaning describing a single, relatively circumscribed, coherent idea. Most typically, it comprises one or a few sentences. The following segment is one example of a unit of analysis:

> The punitiveness in me was massive … It governed me … I guess more than 50% of my BPD was due to it … It was like the engine, or gearbox … Then you remove a huge piece, and the whole dynamics change … I'm still processing all this … The worst part is: Who am I, then? But it's not a panicky "Who am I?" but it's more like "Let's see who I might be.

(Please note that the dots denote filler words that were preserved in the original data but, for the sake of convenience, removed for this presentation.)

In the data grouping phase, MK read through the data sentence by sentence and marked instances of open codes. The similarities and differences in the content of these codes were compared to determine which codes could be grouped together to form larger sub-concepts. Based on the similarities and differences in the content of the sub-concepts, the data abstraction phase continued until not enough shared meaning between sub-concepts remained, and core categories could be constructed (Kyngäs et al., 2020).

MK and TM negotiated the clustering decisions made by MK in dialogical interchange. SL read the transcribed data and supervised all data analysis phases. No other validation strategies were applied. Finally, the data were quantified.

Reflexivity

The ideal of openness in qualitative research can only be met in an approximate way (Meinefeld, 2004). A fundamental restriction is that every observation takes on meaning from the researcher's own meaning schemas: what is oriented towards, and hence noticed, as well as what is left out of awareness is unlikely to be random but rather selected and affected by a researcher's prior knowledge and preconceptions. To reduce the distorting effects of the personal biases of researchers, qualitative research literature recommends reflexivity as a tool (Morrow, 2005). However, prior knowledge and preconceptions can only partially be made explicit. Moreover, reflexivity *per se* does not guarantee openness to the content, since, even applying this tool, aspects of prior knowledge and prejudices will remain implicit and unrecognized, thereby leading to selective observation and interpretation (Meinefeld, 2004).

In this study, data was gathered in an interview context. During an interview, experiences are recalled and relived in an interpersonal situation between the interviewee and the interviewer. Hence, in qualitative research, an interview is much more than a data-gathering method. Reflection on the interview relationship is an essential part of the research process, since the quality of this relationship determines which parts of the participant's experience become accessible and which remain unarticulated (Binder et al., 2012). During the interviews, some participants described their development using the language of schema therapy. Since MK was also versed in schema therapy, there was common ground. This was probably a mixed blessing in the sense that shared language may have facilitated the exploration of some experiences while, on the other hand, it may have influenced the findings to the benefit of experiences reflecting schema therapy goals at the cost of something else.

MK also noticed how subtle signals on her part influenced the interviewees. If, for example, her response was delayed due to focusing on note taking, some interviewees might start second-guessing their experience or even shut down. She also noticed that to be able to reflect upon their experiences and deepen their descriptions, some participants needed a lot of validation or normalization. As utterances are never validated to an equal extent, she was concerned that, by validation or abstinence, she might disproportionately intrude her own mindset into the interview and thus steer the interview towards her own personal interests or biases. She therefore sought to adopt the stance of a benevolent follower who would, nevertheless, structure the interview (Koivisto et al., 2021).

In the data abstraction phase, we noticed a major tension between our desire to remain close to the participants' lived experience while interpreting this by applying the theory and language of psychotherapy. Due to our familiarity with some topics at the cost of others, the study faced the risk of unintendedly becoming more deductive in nature, as prior knowledge probably shaped both the data collection and analytic processes to some extent.

We provide excerpts from the data both to increase trustworthiness through transparency and help the reader follow and evaluate our reasoning.

Ethics

This study was approved by the ethics committee of the Central Finland Health Care District on 9 May 2017 (No. 10U/2017). Potential participants were informed that participation was voluntary and that they would be offered the same treatment regardless of their participation in the study. They were informed that discontinuation without providing any explanation was possible at any time and would not affect their future treatment at the centre. All participants signed a written informed consent after receiving a full description of the study procedure which ensured details would remain anonymous.

Findings

Of the original sample of eight, we were able to reach five for the 12-month follow-up interviews.

Overall, the participants' BPDSI scores showed a continuous decrease over the 12-month follow-up period. Compared to scores at treatment end (Koivisto et al., 2021), the mean decrease was 1.4 points. Over the follow-up, four participants showed a slight amelioration in their BPD symptoms, while one participant's score increased by 3 points.

These participants described their longstanding struggles with feeling worthless, incompetent, and fundamentally bad, and feeling that they are wrong and to blame. From an early age, they had endured serious psychological traumas from their relationships with their significant others but had, during treatment, obtained an enhanced understanding of how the imprints of these experiences were related to their difficulties in experiencing the self.

Four participants showed continuous, albeit fluctuating, development in their identity over the follow-up period. The fifth participant, who showed no change at treatment end, also described no gain at follow-up. In other words, if a change process regarding identity was initiated during treatment, change was evident already at treatment end.

We found a total of 221 expressions related to the processing of self-concept and identity. Five core categories were identified: 1) from extremely negative and fluctuating self-concept to improved self-worth and stability, 2) self as actor: sense of agency, 3) decreased disconnection from and integration into self of emotions and emotional needs, 4) the importance of understanding the origins of the negative self-concept, and 5) challenges to the processing of self-concept and identity (See Table 1 – NB. Number of participants reflects the number of participants contributing to utterances in the specific category.).

Categories	Number of utterances Total = 221	Number of participants Total = 5
1. From extremely negative and fluctuating self-concept to improved self-worth and stability	67	5
2. Self as actor: sense of agency	55	5
3. Decreased disconnection from and integration into self of emotions and emotional needs	22	3
4. The importance of understanding the origins of the negative self-concept	25	5
5. Challenges to the processing of self-concept and identity	52	5
a) Oscillating between old and new ways of experiencing and behaving	22	5
b) Feeling lost when the dominating self-script was questioned	7	2
c) Feeling exquisitely exposed and vulnerable when less disconnected	7	3
d) The detrimental effects of improved self-understanding without self-compassion	12	1
e) Diagnosis as an additional stigma	4	1

Table 1: Processing of Self-Concept and Identity: Core and Subcategories

Processing of Self-Concept and Identity

From Extremely Negative and Fluctuating Self-Concept to Improved Self-Worth and Stability

All five participants described their previous identities as characterized by a sense of being bad or fundamentally flawed. This self-experience was coloured by shame. On the processing of self-concept, the participants' narratives showed how, compared to the present, in which they were more capable of observing their mental events from a meta-perspective, they had previously taken their negative self-concept at face-value without questioning it: "[Earlier on], I defined myself only through intuition … like 'You can't do anything' and 'You are bad at this and that'."

In addition to being extremely negative, the baseline self was insecure. Specifically, the participants' narratives showed an experience of self that constantly fluctuated according to interpersonal experiences:

> Previously, I felt I *am* what others think about me or project on me … They can validate or judge me … I assumed others are constantly judging me … There, the demandingness and the punitiveness and all that faulty learning was evident.

Change in the hitherto harsh, judgmental attitude towards the self was an integral part of positive change. This finding was evident in both those who showed development in identity processing and those who experienced no development. More specifically, one patient whose BPDSI scores indicated no change largely attributed this outcome to the persistence of a harsh attitude towards the self:

> If I feel like it, I should be able to allow myself a chance to take a break without doing anything … I should have the right to stay on the sofa … But I'm constantly busy doing my chores there in the house with my mother's voice ringing in my ears telling me "You've never been any fucking good." … Everything must be tip-top. She doesn't allow me any rest; I expect she'll continue yelling at me even beyond the grave … There is no therapy or group or anything, nothing helps me to get rid of it … I still have great respect for her (starts weeping).

While criticizing themselves, participants often used the second-person pronoun "you" instead of the first person "I", possibly reflecting the introjective nature of this harshness. They started to realize how these internal dynamics, in which the critical part of the self, downplays the recipient of this critique, prevent the development of the self:

> You, I … In fact, you shouldn't say "you" as it's my life … I've noticed a change here: Nowadays, I can talk about myself … I don't need to externalize but can say "I" … In this way, I can feel that what I am saying is true, and I become visible.

As patients' own self grew stronger, their other-directedness and dependence on external validation decreased. The former need to excessively comply and defer to others' wishes seemed to decrease:

> Nowadays, I prefer to search for valid information and, based on that, form my own opinion. I no longer adopt views just because somebody says "it's like this" … but can reflect on issues, gather information, and experience things on my own. I can make up my own views without necessarily having to agree with the other person … My need for validation has decreased.

Two participants described how being able to validate oneself and "own" one's mental states had a positive effect on their relationships. As they became more individualized and less dependent, their ability to more clearly communicate their thoughts and feelings improved. These new interpersonal experiences, in turn, positively affected their self-concept, resulting in positive cycles where gains in one area engender gains in another.

Self as Actor: Sense of Agency

All five subjects referred to sense of agency. Participants often ascribed their previous (or persistent, as in the following excerpt) inability to work towards their goals or sustain jobs to their negative self-concept, a global sense that one is incompetent. The participants' narratives revealed an inner voice that invalidated their self-esteem, thereby blocking healthy agency:

> I'm disappointed with my whole life … I've started many studies (offers a list of them) but haven't been able to complete any of them … I think I'm no good at this so I can't do this work … This may be because the voice of Joanna Smith (mother; pseudonym) is still there, telling me "You' re not capable of anything".

Change in one's agency often seemed related to a decrease in the self-berating inner voice. This decrease in the harsh way of relating to oneself enabled participants to become aware of their needs and goals, and to validate these:

> I never got an opportunity to learn what I'd be capable of … I could never concentrate on studying … The ... punitiveness was so intense that it paralyzed me and blocked me from setting any goals … I can't be anything; I can't go for anything … I guess I was an underachiever because of that … Now that I'm starting to experience myself as equal to others, I can go after things … Now that I can invest time and money in *myself* … now that I constantly don't need to be of help to others, I try to search for what I'd be interested in … But I still need to work on what I was told and what I learned: that you're bad at this and that.

Three participants frequently referred to their emergent ability to set their own goals and use their skills: "For the first time in my life, I've set goals regarding my drinking", or "every single day, I use the skills I learned in the group". Feeling able to affect their emotions and work towards their goals, these individuals experienced a sense of mastery. They also elaborated on their long-term plans:

> Back then, … I believed I'd never be able to work … I was unable to visualize the future ... It was difficult for me to think even of the next week or month … to think in terms of years was impossible, and the future appeared just gloomy … This is a huge change: I can make long-term plans [elaborates on future study plans in a detailed manner].

This development translated into behaviour change as after receiving disability payments for five years, this participant had been able to start working and at the time of the follow-up interview had been working steadily for a year.

Decreased Disconnection from and Integration into Self of Emotions and Emotional Needs

Participants described deliberate attempts to implement change in their habitual ways of protecting themselves. They made a conscious effort to decrease their avoidance of emotions and relationships, as disconnection and concealing the self from others had served as one of their main coping strategies. The ensuing feeling of connectedness with one's emotions and others was experienced as very rewarding:

> More than anything, I long for connection … It is something I've never had … I've always felt somehow detached … There are still instances when I'm about to slide into those (disconnected) states but nowadays, but I'm able to notice it and stop … And somehow, I'm able to stay there without withdrawing from the relationship … A barrier that existed between me and the world has started to fade … I actually created an image of how I somehow remove the barrier between me and others.

The Importance of Understanding the Origins of the Negative Self-Concept

All five participants described how understanding the developmental origins of their negative self-experience had been important to them. Four participants showed understanding of the history of their identity disturbance in referring to their parents' untreated mental and substance use disorders. Moreover, the participants' narratives revealed distorted mirroring, and parental reactions primarily based on parents' mental states with little validation or mentalization of the child's mental states or needs:

> I think about the good-bad themes quite intensively. For instance, am I bad? If yes, how bad am I actually? ... I feel that, in fact, I'm not really that bad … My family of origin has affected me even though I'd like to deny its effect … My mother kept saying I'm possessed by the devil, even quite recently.

Participants described how their previous behaviour was mainly guided by fear, with invisibility serving as a coping strategy. This left no opportunity for the development of one's own identity. Understanding the imprint of the experienced maltreatment was felt to be essential:

> My childhood environment was so confusing that I never had an opportunity to become an integrated person … I had to be … something that was imposed on me … invisible, without character, 'cos the reactions in my environment were completely random … with no correlation to my behaviour. If I … did something that was regarded as a good thing one day, I managed to attract their attention, but then, the next day the same behaviour was the worst thing in the world, and I was punished for it.

Challenges to the Processing of Self-Concept and Identity

Questioning of one's former identity often initiated a deep process characterized by joy over one's personal development but also brought challenges. All participants described having experienced challenges in the processing of their self-concept and identity. Five subcategories were identified: a) oscillating between old and new ways of experiencing and behaving, b) feeling lost when the dominating self-script was questioned, c) feeling exquisitely exposed and vulnerable when less disconnected, d) the detrimental effects of enhanced self-understanding without self-compassion, and e) diagnosis as an additional self-stigma.

a) *Oscillating Between Old and New Ways of Experiencing and Behaving* - All five participants described oscillation between their old and new ways of experiencing and behaving. When attempting to apply their new learning, participants might question the legitimacy of their self-validation and related new, more agentic behaviour and therefore experience the recurrence of their previous behaviour patterns. If, for instance, they validated their emotions or needs, the resurgent harsh inner voice might criticize them for "wrong-doing", thereby inducing internal struggle. In the short term, patients could avoid this struggle by slipping back into their old behavioural patterns:

> Previously, I didn't know at all what I myself like. I then tried to observe it and actually, I realized I'd prefer quite a different lifestyle. But it's so hard for me to ask for something …. Issues like expressing my opinion, asking for something, or negotiating … I express these like "either way, I'm perfectly ok with that", or "if you want it like that, I'm fine with it". Last autumn, I tried to listen inwards and practice expressing my needs to my boyfriend, but then we had tiffs … So I gave up but now I'm angry all the time.

The "owning" of emotional *needs* seemed the most difficult step in the process of connecting. Four participants referred to this challenge. More specifically, longing for closeness, touch, or attention often induced embarrassment, shame, disgust, or fear of being exposed or weak. These experiences seemed related to keeping emotional needs outside of awareness, thereby preventing their integration into the self, or expression. The participants also described how expressing their emotional needs had felt so difficult for them that they had only expressed them when in an altered state, such as intoxicated.

b) *Feeling Lost When the Dominating Self-Script was Questioned* **-** As the participants had, for decades, viewed their self-schemas as truths without questioning their validity, they experienced puzzlement about their new, more healthy identity: "Who am I, eventually?", "What is included in me?" The most robust example of this perplexity was their previous habitual deferral to the self-invalidating, judgmental inner voice that told them they are bad or even toxic. As this had constituted a major part of their identity, they could feel lost without it:

> The punitiveness in me was massive … It governed me … I guess more than 50% of my BPD was due to it … It was like the engine, or gearbox … Then you remove a huge piece, and the whole dynamics change … I'm still processing all this … The worst part is: Who am I, then? But it's not a panicky "Who am I?" but it's more like "Let's see who I might be".

c) *Feeling Exquisitely Exposed and Vulnerable When Less Disconnected* - I've really tried to work on my habitual detachment … It feels very light, but the other side of the coin is that I've never felt this vulnerable.

Reducing protective avoidant coping strategies and thus allowing oneself to feel more could elicit episodes of exquisite vulnerability:

> Of course, when you, for the first time, approach situations where emotions can be triggered … it stirs up fears … It is a very holistic state, kind of massive fear of being exposed … of being somehow embarrassed … But without facing these

> problems, I won't change … For years, I just stayed at home and got drunk at weekends … That way, I was able to keep those issues at bay, hidden … the shame and the related fear of failure.

d) *The Detrimental Effects of Improved Self-Understanding Without Self-Compassion* **-** Reflecting with insufficient self-acceptance on one's former behaviour only led to feeling worse rather than better:

> I've always felt I'm a bad person and that there is something fundamentally wrong with me … But now that I've become so painfully aware of the behaviour patterns I repeated for years, it's even more extreme … It's been so hard to face all those bad attributes in yourself since I previously just escaped and avoided that stuff all together … Such nasty patterns … I made so many mistakes when I was dysregulated … Like "Look at me and see how I'm suffering!" … Nowadays, I understand that there would've been other options available to me … that I could have acted differently, and that increases my bad feelings about myself.

Looking back at her previous behaviour retriggered intense shame. Although participants understood that some behaviours had served as attempts to meet one's emotional needs, perceiving clearly but without self-compassion was unhelpful. This participant also scored higher on the BPDSI at follow-up as compared to treatment end, indicating an increase in BPD symptoms and hence relapse.

e) *Diagnosis as an Additional Stigma* **-** The one participant in this subcategory produced several utterances about how being diagnosed with BPD had affected her identity in an unhelpful way, entailing additional feelings of being tainted:

> The diagnosis induces massive shame in me … As if it was written on my forehead … Hearing the word "personality disorder" feels crushing, overwhelming (starts to cry) … Of course, it helped me to get the right treatment, but after that, I feel it has caused problems rather than been of help to me.

This was the same participant whose BPDSI score increased over the follow-up. We have the impression that self-stigma combined with perceiving one's problems with increased clarity but insufficient self-compassion influenced this deterioration. However, the data preclude strong causal conclusions.

Discussion

This study explored the subjective experience of self-concept and identity as a process in five individuals with BPD 12 months after their participation in a psychoeducational group intervention at a community mental health care centre. Five main findings emerged. First, change in the harsh, judgmental attitude towards the self was experienced as an integral part of positive change by participants. Conversely, a lack of change in this attitude was regarded as a key reason for stagnation, or absence of development. Second, change in this harsh way of relating to the self also seemed crucial to enabling healthy action. Third, participants described a decrease in the habitual ways of protecting oneself, namely, disconnection from emotions, attachment needs, and other people that contributed to a healthier self. Fourth, gaining understanding of the origins of one's low self-view was deemed helpful by the participants. Fifth, development was nonlinear and fraught with challenges.

Returning to Literature

Our findings echo previous research on negative self-concept (e.g., Gad et al., 2019; Klein et al., 2001) and shame (e.g., Karan et al., 2014; Rüsch et al., 2007; Spitzer et al., 2021) experienced by individuals with BPD. On identity as content, the present findings also support Arntz et al. (1999) and Arntz et al. (2004) who found that experiencing the self as bad and deserving of punishment was associated with BPD.

The present study found that, even post treatment, former patients continuously processed their identity. This finding is in line with Jørgensen (2009) who proposed that, in addition to content and structure, identity is an ongoing process. As for various psychotherapy theories, improved mentalization skills were deemed beneficial by participants as these diminished the constant fluctuation in self-concept, thereby increasing stability: what was previously taken as face value (e.g., I'm bad) could now be reflected upon. Moreover, participants became more capable of discerning more subtle nuances in their self-concept. Hence, over the follow-up, the self was only seldom experienced unidimensionally, for instance, as entirely bad. Our finding that participants emphasized change in the internalized punitiveness as pivotal to healthy development also resembles findings of Donald et al. (2019) who found a strong positive correlation between self-compassion and recovery from BPD and a strong negative correlation between self-criticism and recovery.

In the present study, participants often associated their increased sense of agency with a waning of their self-invalidating or punitive attitude towards the self. Conversely, they ascribed their previous inability to set goals and work towards these in a sustained manner to an inner voice that invalidated their dreams, self-esteem, and sense of self-competence, thereby blocking healthy agency. This voice obstructed agency by inducing a serious fear of making mistakes; failing at something engendered intolerable shame. Consequently, as participants felt unable to bear emotions associated with this predicted course of events, inertia appeared as a secure solution. With respect to the connection between self-criticism and agency in individuals with BPD, Donald et al. (2019) also found that harsh self-criticism and punitive self-concept may impede the recovery process by preventing individuals from acting. Accordingly, in their report on the findings of the McLean Study of Adult Development, Gad et al. (2019) highlighted the clear impact identity disturbance has on behaviour. They discuss how identity disturbance is associated with less effective functioning in school, work, and interpersonal relationships, denoting that if people feel worthless, they may not be motivated to look for a job or pursue an educational goal. Previous qualitative research has also shown that a low sense of agency tends to inform the narratives of individuals with features of BPD (Adler et al., 2012; Agnew et al., 2016), and Agnew et al. (2016) discuss whether this may be linked to perceived lack of control. Sources for an improved sense of agency other than attenuation in the former harsh self-criticism and judgmental attitude towards the self also emerged from the present study. Specifically, participants' narratives suggest that the emergent ability to use one's skills across various new situations also contribute to a sense of mastery and an increased sense of agency. When able to affect their emotions and mental states, relationships, and life, the participants no longer felt disempowered and at the whim of circumstance.

We also found that a decrease in the habitual ways of protecting oneself, viz. a decrease in disconnection from emotions, attachment needs, and other people, contributed to a healthier self. Participants actively strived to reduce their disconnection, concealment, and other avoidance behaviours. This finding may be significant since according to Linehan (1993), attempts to inhibit mental contents and the related inability to experience, process, and integrate (traumatic) events may contribute to the absence of a strong sense of identity. Our findings also correspond with Agnew et al. (2016), who found that while individuals with features of BPD experienced blocking, disconnection, and glazing over traumatic experiences, they were also able to establish different levels of connection both to themselves and others.

With respect to our last main finding, namely, challenges encountered in the processing of identity, the single most poignant observation to emerge was that the most difficult part of this process of reconnecting was the validation of one's emotional needs and their integration into the self. The "owning" of emotional needs indeed appeared to be a complex process connected to previous traumatic experiences and shame. If the aim is to target difficulties pertaining to attachment-related traumas and needs, the psychoeducational group treatment that formed part of this study may inevitably be limited. Our impression was that to facilitate connection with emotional experiences associated with trauma and the related emotions of fear, disgust or severe shame and that had to be blocked already at a young age, some participants would have benefitted from longer treatment.

Our data showed another relevant challenge: perceiving one's problems with increased clarity but with too little acceptance was harmful. This one case of deterioration was, at least partially, related to reflecting on one's former behaviour patterns with insufficient self-compassion and acceptance towards the self. Livesley (2003) proposed that enhanced self-understanding with too little self-acceptance can lead to further self-criticism, and our data support this hypothesis. Reflecting on their experiences at treatment end, that is, 12 months earlier, our participants described having found helpful the compassionate conceptualizations of their difficulties offered in the psychoeducational group context. Back then, they also reported that feeling understood by peers increased their self-compassion (Koivisto et al., 2021). For some participants, this new, tentative compassionate attitude towards the self nevertheless failed to last over the follow-up.

For one patient, the diagnosis of personality disorder was a "double hit": an individual, who had already experienced traumatic invalidation, was now defined by an authority figure through a label that was experienced as crushing and that induced further shame. Our findings on self-stigma in BPD accord with previous research. Self-stigma is common in BPD. Recently, Quenneville et al. (2020) found that, compared to subjects with ADHD and bipolar disorder, subjects with BPD experienced a higher level of self-stigma. Similarly, Grambal et al. (2016) found that patients with BPD suffered from a higher level of self-stigma than patients with anxiety disorders. An earlier study also showed that females with BPD displayed higher self-stigma than females with social phobia, and that self-stigma was inversely related to quality of life, self-efficacy, and self-esteem (Rüsch et al., 2006). According to Lam et al. (2016), diagnostic labels can have a devastating effect on an individual's sense of self through a process of internalized stigma. If people already believe that they are bad or if they do not know who they are, they may be especially susceptible to absorbing negative labels and believing that they describe the self. Having often been exposed to social devaluation and being dependant on external validation (Moses, 2011), individuals with BPD may be particularly vulnerable to self-stigma.

Limitations and Strengths

This study has its limitations, the most serious of which concern data saturation and high attrition. First, we were unable to take saturation into account during sampling, since due to financial constraints, it was predetermined that only one group of eight could be studied. Thereafter, three participants were lost at the 12-month follow-up. In the absence of purposive sampling of critical and extreme cases, maximum possible variation probably failed to be achieved. In terms of high attrition, it is impossible to know whether those we were unable to reach might have given us a different picture of identity development.

We are conscious that two of our subheadings under "Challenges to the processing of self-concept and identity" refer to the views of just one participant. We have included the findings here as in our previous research patients highlighted self-compassion as an important element in their recovery process (Koivisto et al. 2021). In addition, all eight participants described having experienced, and suffered from, stigma (Koivisto et al., 2022). That only one participant explicitly highlighted these themes in this sub-study is something of an anomaly but the sentiments expressed seemed so significant for this one person (linked to her relapse), we thought her poignant utterances were worth including.

We are aware that our findings may reflect the content of the psychoeducational intervention that formed part of the study; the fact that the intervention was mainly based on schema therapy may have influenced the findings. More specifically, participants were acquainted with the concept of schema modes and taught to observe and work on them. They seemed to work especially hard on the so-called "punitive parent" and "detached protector" modes (see Appendix). Hence, participants' narratives about their development probably mirrored the content of the treatment.

This study also has its strengths. The participants we were able to reach for the follow-up interviews, seemed sincere and honest in their self-exploration, and they provided rich, poignant and detailed information that was appropriate in terms of the research question. In addition, method triangulation (process and outcome) may be considered a strength. Combining the exploration of patients' lived experiences within a medical framework enabled us to contrast subjective narratives with symptom change. Given our post-positivist epistemological position, we believe that our investigator triangulation - the involvement of multiple observers and interpreters - increases the credibility of the results.

Clinical Implications

Our findings highlight the importance in treatment of achieving change in punitive internalizations and judgmental self-talk. Targeting self-invalidating and self-critical inner voices directly and focusing on building self-worth may be useful if the treatment aims to break the cycle of self-hatred and shame, alleviate functional impairment, and promote agency.

Participants also highlighted the importance of understanding how they developed their negative self-view; it was not simply that they were "bad". They valued the role of psychoeducation in the process. As for the content of psychoeducation, in schema therapy, BPD symptoms are conceptualized as attempts to deal with unmet or toxic frustration of a child's needs (Young et al., 2003) and to maintain some sense of personal integrity in response to trauma (Tan et al., 2018). This approach seemed to facilitate compassionate self-understanding. Moreover, psychoeducation provided participants with graspable concepts that seemed to facilitate self-observation (Koivisto et al., 2021).

We suppose that setbacks are to be expected in the processing of negative identity. Driven for years by fear and shame, with alternating attempts to make oneself either invisible or visible as a coping strategy, the individual may just fail to recruit resilience when faced with new challenges. Even in the absence of new challenges, they may feel confused as the very basis of their self, despite its fundamental negativity, is under transition. Consequently, relatively long-term work on "who I really am" may be required. We assume that the challenges in the processing of self-concept and identity that we identified could have been navigated had the patients been able to continue some form of specialist treatment.

The stigmatizing effects of being diagnosed with BPD warrant further elaboration. On stigma reduction, Kverme et al. (2019) offer some practical suggestions. Specifically, they recommend training and educational efforts that would motivate mental health professionals to develop more humanistic approaches that increasingly recognize the traumas individuals with BPD have survived. Importantly, they also suggest that we could be more attentive to how power issues can be present in the way we use language and describe and diagnose people. They cite Davidson et al. (2016), who argue that we need to stop asking patients (implicitly) the question: "What is wrong with you?" and instead start asking them explicitly: "What has happened to you?" and then "How can I be of most help?" (2016, p. 47).

Implications for Further Research

Individuals in this study highlighted change in the harsh, judgmental attitude towards the self as the most relevant single aspect contributing to their development or lack thereof. Future studies could investigate whether change in this harshness predicts outcome in the treatment of BPD. If so, process and process–outcome studies could explore how individuals in therapy experience and respond to interventions targeting this harshness. This may expand our understanding of how this phenomenon is best addressed and help further the development of useful treatment strategies.

Reflexivity

We were touched by these findings. They improved our understanding and evoked empathy towards patients and their struggles. Although content analysis precludes causal conclusions, self-concept and identity difficulties appeared as logical consequences or attempts to survive relational trauma. The participants' intent to heal was palpable.

In addition, we were surprised by the amount of meaningful and "deep" change involving the self-concept and identity experienced by participants after attending the psychoeducational intervention that formed part of the study. We are under the impression that, despite meaningful development being pushed forward, the treatment was apparently too brief for some participants.

Conclusions

Although the extant research on different aspects of self-concept and identity and the processing of these is relatively rich, further work is nonetheless needed to illuminate *how* change in self-concept and identity occurs in therapy and how these changes could best be facilitated. Results of the present study contribute to this knowledge base by highlighting the importance of achieving change in self-invalidation, judgmental attitude towards the self, and punitive self-talk in therapy. Moreover, it is imperative to try to reduce stigma.

Mixed methods research has been shown to be useful in examining both process and outcomes. We were touched that our research on patients' lived experiences enabled greater empathic engagement with the experiences of sufferers (Natvik & Moltu, 2016).

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Appendix

The Schema Mode Model as Used in the Intervention (Koivisto, Melartin, & Lindeman, 2021, modified from Arntz et al., 2005; Young et al., 2003)

Mode	Classification	Description of the mode	Goals in treatment
The Vulnerable / Abandoned child	Child mode	The suffering "inner child" who feels unloved, sad, inconsolable, lost, panicky or frantic. Emotions are unmodulated and pure. Feels utterly alone in the world and is convinced that nobody cares for him or her. Lacks object permanence and time frame: cannot summon a soothing mental image of the caretaker and lives in the eternal now and thus cannot comprehend that feelings also have an end. Feels helpless and demands immediate and constant reassurance. Sometimes incapable of being alone. Often obsessed with finding a parent figure.	The child mode is warmly welcomed, allowed, and encouraged. The therapist helps the patient identify, accept, and satisfy his or her core emotional needs. The therapist "reparents" this mode by attempting to respond to the specific needs of the patient within the boundaries of the therapeutic relationship.
The Angry child	Child mode	This child mode is predominant when the patient is enraged because his or her emotional needs are not being met. Feels impatient, angry, or enraged. Rebels against maltreatment. May make demands that suggest entitlement or that the patient is spoiled, which, unfortunately, often alienates others.	To understand the message underlying the anger, i.e., the unmet needs of the "child", and to coach the patient to meet his or her needs in more adaptive ways.
The Detached protector	Coping mode	A coping mode that functions to cut off the experience of emotions and needs and to disconnect from others. Hypothesized as a safety strategy that protects the child from overwhelming emotions and attachment, since attachment is often associated with fear or deception. The mode may become automatic and the patient unaware of its operation.	To help the patient experience emotions as they arise, without blocking them and to help him or her to connect with others and express his or her needs. To explore the history and functions of the mode and gradually bypass it.
The Angry protector *	Coping mode	A coping mode that also functions to protect the individual from the pain of experiencing mental contents. He or she can become angry or cynical in trying to keep others at distance.	To examine both the origins and functions of the mode in the here-and-now and gradually bypass it in order to allow contact with and the expression of more vulnerable emotions.
The Compliant surrender mode *	Coping mode	Safety behavior driven by fear. This mode serves to protect the individual from exposure to further invalidation, rejection, conflict, or abuse, as the individual has learned very sensitively to detect others' wishes and to surrender to them.	To encourage connection with and validation of one's emotions and needs.
The Punitive authority (previously called the Punitive parent mode)	Dysfunctional authority mode	A severe self-punitive state during which the patient seems to condemn him- or herself as being bad and evil, doing wrong or deserving punishment. An internalization of rage, hatred, loathing, etc. of an authority figure. Besides preventing self-actualization, the punitive authority mode typically prevents patients from taking good care of themselves. The message is that the person does not deserve anything that is good for him or her or that self-care is simply not important.	To help the patient to reject the message of the punitive authority and build self-esteem.

The Healthy adult mode	Functional, healthy mode	Allows connection to emotions and needs in a compassionate way. Responds to the needs of the "inner child" and soothes him or her. Like the observer self, is able to observe inner experiences from a meta-perspective. Modifies old coping strategies into more flexible and adaptive ones. Takes responsibility for self and others in a balanced way, pursues pleasurable activities, and has healthy boundaries: autonomy and dependence are balanced.	Cultivated in treatment
The Happy child mode	Functional, healthy mode	Feels at peace because core emotional needs are currently being met. Is playful, optimistic, and spontaneous.	Cultivated and encouraged in treatment

* NB The Angry protector and Compliant surrender modes are not included in the BPD original mode model but are encountered in individual patients. We have included them here because they are referred to in the Results section.

MAARIA KOIVISTO

Research into the first-person perspective of individuals attending mental health treatment can provide a detailed understanding of their lived experiences of psychological pain and treatment, thereby furthering our understanding of the therapy process. The present study contributes to this area of qualitative literature by exploring the personal experiences of distress, development and change in eight individuals with borderline personality disorder in the context of a psychoeducational group intervention delivered at a community mental health care center.

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