VOLUME I

RESEARCH COMPONENT:

Borderline Personality Disorder: reviewing the experiences of providing therapy for BPD; and writing online blogs about living with BPD

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for the Degree of

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Overview

This thesis is submitted in partial fulfilment of the requirements for the degree of Doctorate of Clinical Psychology (Clin.Psy.D.) at the University of Birmingham. The thesis consists of two volumes.

Volume I

This volume comprises three chapters. The first chapter is a literature review exploring the impact of working with clients diagnosed with BPD on therapists. The second chapter is the empirical paper, exploring writing online, specifically relating to people who blog about their mental health. The third chapter is the public domain briefing.

Volume II

Five Clinical Practice Reports (CPRs) are presented in this volume. The first report focuses on ‘Psychological Models’, formulating the experiences of Rose from both a Cognitive Behavioural, and a Systemic, perspective.

The second report details a small scale service evaluation assessing how four Community Mental Health Teams (CMHTs) meet the needs of local black and ethnic minority (BME) populations.

The third report details the case study of Rita, a 78 year old client detained under section 3 of the Mental Health Act. The report focuses on the assessment,

formulation, and intervention regarding physical aggression (‘behaviour that challenges others’).

The fourth report outlines the case of Alexa and her son, Callum, attending a child and adolescent mental health service (CAMHS) for support with tics. The intervention is evaluated as a single case experimental design.

The fifth report is an abstract for a verbal case study presentation. The abstract introduces Anna, a 71 year old lady referred for psychoanalytic psychotherapy for support with past trauma.

All names and identifying features have been changed to maintain confidentiality.

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Contents of Volume I

Chapter One: Literature Review

Abstract……1

Introduction and Rationale……2

Aims and Objectives……4

Methodology……5

Definitions……5

Search Terms and Information Sources……..5

Study Selection……6

Study Characteristics……...8

Brief Overview of Findings……14

Synthesis of Findings……..15

Negative and Positive Attitudes……16

Synthesis……21

Exploring Experiences……21

Exploring Attitudes……27

Comparing Attitudes by Occupation……..29

Comparing Diagnoses……30

Exploring Responses and Behaviours……36

Discussion……38

Recommendations for Future Research……..44

Limitations……44

Summary and Conclusions……45

References.....46

Chapter Two: Empirical Paper

Abstract……50

Introduction……...51

Aims……...55

Methodology……55

Participants and Data Collection……...55

Ethical Considerations……57

Data Analysis……...58

Validity and Quality……59

Research as Process……..59

The Researchers…….60

Findings……60

Background Information……..60

Themes……..61

Writing Online as Emotional Regulation……63

The Blog as Communication……...64

The Blog as a Living Document……69

Online Empowerment……..73

Problems Associated With Blogging……..77

Discussion……81

Limitations……86

Clinical Implications and Suggestions for Future Research…….87

References……89

Chapter Three: Public Domain Briefing

Literature Review

Outline……..92

Introduction and Rationale……92

Aims and Objectives……..93

Methodology……93

Findings and Conclusions……94

Limitations……95

References……...96

Empirical Paper

Outline……97

Introduction and Rationale……..97

Aims and Objectives……..98

Methodology……98

Findings and Conclusions……99

Limitations……99

References……..100

List of Tables for Volume I

Chapter One

Table 1. Search Terms……..5

Table 2. Eligibility: Inclusion and Exclusion Criteria……8

Table 3. Country of Origin and Contributors……....9

Table 4. Study Characteristics……..10

Table 5. Quality of Study……....14

Table 6. Characterisations of ‘negative’ and ‘positive’ attitudes and who contributes……16

Table 7. ‘Positive’ and ‘Negative’ Attitude Definitions……18

Chapter Two

Table 8. Participant Characteristics…….61

Table 9. Superordinate Themes……...62

List of Figures for Volume I

Chapter One

Figure 1. Flow Diagram of Search Process…….7

Appendices Volume I

Appendix A: Quality Criteria Framework……...101

Appendix B: Study Characteristics Table……..106

Appendix C: Participant Information Sheet and Consent Form…….127

Appendix D: Interview Schedule……130

Appendix E. Research Ethics Committee Approval Letter……..131

Appendix F. Instructions for Authors for Nominated Journal……..133

Appendix G. Example of email response to interview questions……...136

Contents of Volume II

Clinical Practice Report 1: Psychological Models

Abstract……1

The Client and Current difficulties……2

Personal history and circumstances……2

Assessment ……3

Formulation from a Cognitive-Behavioural (CBT) perspective……..10

Formulation from a Systemic perspective……14

Reflections……..26

References……28

Clinical Practice Report 2: Small Scale Service Evaluation

Abstract……..31

Introduction……32

Relevant Legislation, Research, and Literature (local and national)……33

Statement of Aims……...39

Methodology……..39

Process……..39

Recruitment and Participants……....40

Develpment of Interview Schedule and Semi-Structured Interviews……41

Analysis……..42

Ethical Considerations……43

Results……44

Ethnicity Information…….....44

Interview Data……45

Discussion and Recommendations…….51

Findings discussed in the context of initial aims, and linked to recommendations……...51

Factors that may inhibit or enable recommendations……...57

Strengths and Limitations……..58

References……...59

Clinical Practice Report 3: Case Study

Abstract……61

The Client and Current Difficulties……...62

Background Information……63

Assessment……68

Formulation……..76

Reflections……...83

References……..84

Clinical Practice Report 4: Single-Case Experimental Design

Abstract……86

Case Summary……87

Presenting Difficulties……87

Background and Assessment……..88

Formulation……93

Intervention……97

Methodology……99

Design……..99

Data Collection……..100

Results……101

Graph and Visual Inspection……101

SPSS Autocorrelation; and Trend Line……..103

Paired Samples T-Test……105

Discussion and Reflections……..106

References……..109

Clinical Practice Report 5: Oral Presentation of Case Study

Abstract……111

References……..112

List of Tables for Volume II

Table 1.The Building Blocks of the DRE Action Plan……..34

Table 2. A Breakdown of Ethnicity Across the Four CMHT's……..44

Table 3. A Breakdown of Ethnicity……...54

Table 4. Outcome Table for Autocorrelation for Lag 1……103

Table 5. Summary of t-test Results……105

List of Figures for Volume II

Figure 1. Beckian-Style Longitudinal Formulation Model……12

Figure 2. A Schema Formulation……..13

Figure 3. Coordinated Management of Meaning……17

Figure 4. A Genogram of Rose's family……...20

Figure 5. Maintenance Cycle……25

Figure 6. Maintenance Cycle……25

Figure 7. Thematic Analysis Map of Themes – Main Needs Identified……..48

Figure 8. Thematic Analysis Map of Themes – What CMHT's could do differently……51

Figure 9. A Functional Analysis……82

Figure 10. A Family Genogram……89

Figure 11. A Developmental Formulation……94

Figure 12. Combined Intensity and Frequency of Tics: "Tic Distress Level", Over Baseline and Intervention Phases……. ……..101

Appendices Volume II

Appendix A: Participant Information and Consent Sheet……113

Appendix B: Interview Schedule……117

Appendix C: Ethical Considerations……118

Appendix D: Recommendations……..120

Appendix E:Challenging Behaviour Scale……121

Appendix F:Behaviour Monitoring Chart……..122

Appendix G:Diary for Feeling Scared and Having Habits……..124

Chapter One: Literature Review

What is it like to engage in therapy with clients diagnosed with Borderline Personality Disorder? A review of the experiences and attitudes of clinicians.

Abstract

Introduction: In 2003, the guidance 'Personality Disorder: No Longer a Diagnosis of Exclusion' was published by the National Institute for Mental Health in England, recommending improved service delivery for this client group. Borderline Personality Disorder (BPD) is well represented within clinical services, with research documenting that many clients still experience BPD as a diagnosis of exclusion. In order to understand why this is still happening, it is important to explore clinicians' experiences of working with this client group.

Objectives: Depth is chosen over breadth for the current review, and so the specific focus is on clinicians engaging in psychological therapy with this client group. The main question posed is: what does the literature suggest it is like to work with clients diagnosed with BPD?

Methodology: Three databases were searched for keywords, including Psychinfo, Web of Science, and Embase. The search yielded 20 eligible studies for the current review.

Findings and Conclusions: Overall, findings in the current review indicate that therapists find it stressful, challenging, and emotionally distressing to work with

clients diagnosed with BPD, more so than other diagnoses. The clinical context and supervision/ training are important in order to work with this level of complexity and emotional demand. Alongside this, many staff also find the work to be fun and inspiring at times. However, the literature is underdeveloped and has many quality and conceptual issues, meaning more research is required.

Introduction and Rationale

Personality Disorder (PD) is a diagnostic classification applied to people who experience persistent and longstanding difficulty in relation to the self and others. Within this, the category of Borderline Personality Disorder (BPD) is well-represented in clinical services, and incorporates problems in areas such as: affect (e.g. rapidly fluctuating emotional experiences); extreme feelings of anxiety and depression; and experiences of impulsivity or risk taking (Korzekwa, Dell, Links, Thabane, & Webb, 2008; defined by the Diagnostic and Statistical Manual of Mental Disorders 5th Edition; DSM-V).

Proponents of psychological understandings of mental distress often recognise the benefit some clients may gain from receiving a diagnosis (e.g., improved access to services); but remain mindful of the harm that can result from labelling (British Psychological Society, 2013). For example, Berger (2014) proposes that a personality disorder (PD) diagnosis positions a deficit within the individual as a fundamental feature of their identity, rather than a transient state. Foucault described how society can 'separate off' individuals who are different to the societal norm (1965, 1973) through the 'dividing practice' of ascribing what

Goffman (1961) called a ‘spoiled identity’, constructed in part by professional disciplines (e.g., classification systems labelling people as ‘disordered’). Problems become located inside the person, objectifying their identity. Within a wider picture therefore, diagnosis can be seen as a construct within psychiatric disciplines, rather than a truth about what is ‘wrong’ with an individual (Walker, 2006).

In view of what can be unhelpful about diagnostic categories in relation to ‘personality disorders’, alternative perspectives can be considered. Psychologically, a formulation-driven approach would attempt to understand an individual’s difficulties in relation to their life experiences (Johnstone & Dallos, 2013). Research demonstrates that people who meet diagnostic criteria for BPD have often been abused or neglected in childhood, and so responses such as difficulty in self-concept and relationships, and problems with affect and managing emotions, can be understood in light of early traumatic and chaotic experiences and attachments (Berger, 2014; Hatloy, 2012; Bowlby, 2005).

Considering the difficulty for this client group in managing relationships and emotions, it can be understood how mental health staff could become frustrated in their efforts to engage with their clients, feeling ‘stuck’ with what to do next. Research demonstrates that staff often do find this work difficult, complex, and challenging, more so than working with clients with other diagnoses (e.g., Bourke & Grenyer, 2013). Markham and Trower (2003) reported how when staff learn of a client’s diagnosis of PD, preconceived judgments, biases, and expectations about the difficulty of the work are prompted, before even meeting the individual.

In 2003, the guidance ‘Personality Disorder: No Longer a Diagnosis of Exclusion’ was published by the National Institute for Mental Health in England (NIMHE) to

encourage service development. The NIMHE guidance stated how people with a PD diagnosis are often supported at the margins: through A&E; inappropriate admissions to inpatient units; and left on caseloads of community based staff, who may be likely to prioritise other clients' needs due to lack of confidence in their own skill base for working with greater levels of complexity. The NIMHE suggested that this client group are becoming 'revolving door patients' with multiple admissions, inadequate care-planning, and infrequent follow up; and hypothesised that this may be because clinicians are unwilling to engage, feeling they do not have the skills, training, or resources to provide an adequate service; or find interactions so challenging that they are reluctant to become involved.

Unfortunately, research shows that many clients still experience BPD as a diagnosis of exclusion (e.g., Rogers & Dunne, 2011). In order to understand why this is still happening, it is important to explore clinicians' experiences of working with this client group – what it is like, how they feel about it, how it impacts on them, and how it is managed.

Aims and Objectives

A previous brief review was conducted by Sansone and Sansone (2013) which focused broadly on the 'responses' of all mental health staff to working with a BPD client group. In contrast, the current review intends to choose depth over breadth; and so the focus will be specifically upon the full experience of staff providing therapy only, who have clinically engaged with clients diagnosed with BPD.

The main research question posed in the current review is: what does the literature suggest it is like to work therapeutically with clients diagnosed with BPD?

Therefore, the primary objective is to identify research exploring the impact on therapists, and synthesise the findings to provide a coherent narrative of the literature.

Methodology

Definitions

'Clinicians' were defined as any mental health professional engaging in psychological therapy with a client diagnosed with BPD. This included a variety of psychologists, counsellors, psychiatrists, and psychiatric nurses, in a range of settings from primary care to inpatient hospitals. 'Psychological therapy' related to any mode of therapy, such as Cognitive Behavioural Therapy, Psychoanalysis etc.

Search Terms and Information Sources

Titles and keywords were searched in three databases: Psychinfo, Web of Science, and Embase. See Table 1. for search terms.

Table 1. Search Terms

Borderline Personality Disorder **OR** BPD
AND
Psychotherapeutic processes **OR** psychotherapy **OR** psychoanalysis **OR** psychoanalyst **OR** counsellor **OR** health personnel **OR** psychologist **OR** clinician **OR** therapy **OR** therapist **OR** therapeutic **OR** therapist attitudes **OR** attitudes **OR** emotional responses **OR** cognitive responses **OR** empathy **OR** transference **OR** counter transference **OR** resistance **OR** relationship **OR** alliance **OR** experience

Truncations were used where appropriate, and terms were mapped to heading and auto exploded when possible.

Study Selection

The search yielded 1,950 results in total (See Figure 1.). After duplicates were removed, 600 records remained. Each study was screened via its title and abstract, in line with the eligibility criteria, producing 24 full text eligible studies (see Table 2. for criteria). Reference lists of each full text article were read, and one additional paper was identified. Five studies were excluded in line with eligibility criteria, leaving 20 research articles to be reviewed.

Risk of bias could include use of the diagnostic category ‘BPD’ in the search terms, in that some authors may, instead, have referred to alternative, psychological understandings. However, it is suggested that the search terms used captured enough of the data to yield reliable findings; and that by searching reference lists, any relevant missed papers were identified. Risk of bias was also reflected upon through triangulation of search terms and study selection by the current review’s authors.

Figure 1. Flow Diagram of Search Process

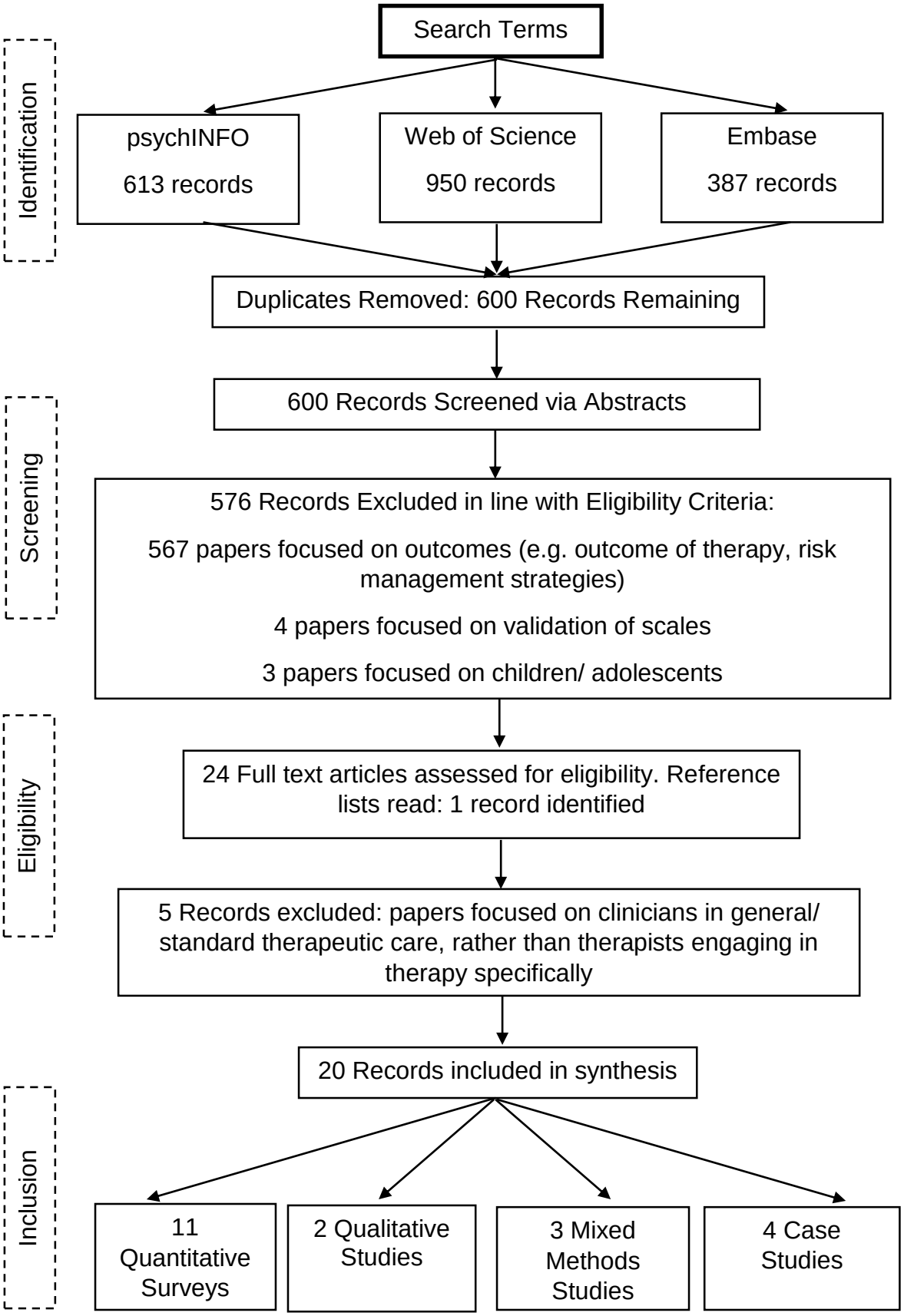


Table 2. Eligibility: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• The study is about BPD, rather than other PD diagnoses (if the study is more general in focus, includes BPD within this) • The study is about therapy for BPD (if the study is more general in focus, includes therapy within this) • The study is about adult mental health (as therapies for children may be experienced differently to adult therapies) • The study is about the impact on the therapist • Date limits applied to original search: between 2000 and 2015 (due to developments in therapeutic approaches, experiences prior to this time period may be less relevant to current clinicians) • The study is peer reviewed and written in the English Language	• No outcome studies (e.g., evaluating the effectiveness of an intervention/ training programme) • No validation of scales studies (e.g., development and evaluation of staff burnout scales) • No studies focusing on therapeutic care as opposed to therapy (e.g., standard therapeutic psychiatric nursing care) • No studies about the 'management' of difficult/ challenging behaviour in clients.

Study Characteristics

The included studies are from a variety of countries (see Table. 3).

Table 3. Country of Origin and Contributors

Country and Contributors
• **Australia** (Bourke & Grenyer, 2013 and 2010; Egan, Haley, & Rees, 2014) and **New Zealand** (Krawits & Batcheler, 2006) • **Israel** (Bodner, Cohen-Fridel, & Iancu, 2011) • **Italy** (Colli, Tanzilli, Dimaggio, & Lingiardi, 2014; Ruggiero, 2012) • **Scandanavia** (Perseius, Kaver, Ekdahl, Asberg, & Samuelsson, 2007; Rossberg, Karterud, Pederson, & Friis, 2007) • **South Africa** (Cambanis, 2012) • **The UK** (El-Adl & Hassan, 2009; Liebman & Burnette, 2013; Millar, Gillanders, & Saleem, 2012; Rizq, 2011) • **And the USA** (Black, D.W., Pfohl, B., Blum, N., McCormick, B., Allen, J., North, C.S., Phillips, KA., Robins, C,. Siever, L,. Silk, K.R,. Williams, J.B., & Zimmerman, M., 2011; Draper & Faulkner, 2009; Jimenez, 2013; McIntyre & Schwartz, 1998; Miller et al., 2010; Servais & Saunders, 2007).

The literature provided similar rationales for conducting their research. For example, authors discussed previous research findings regarding mental health staff, in general, finding it challenging to work with this client group (particularly in comparison to other diagnostic groups) and this being a cause for concern regarding the quality of care provided. This rationale was then followed up in 14 of the studies with a questionnaire survey, or mixed method design. Two studies utilised Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) and the remaining four were case studies. See Table 4. for an overview of study characteristics – a more detailed version can be found in Appendix B.

Table 4. Study Characteristics Key: PD = Personality Disorder; BPD = Borderline Personality Disorder; MDD = Major Depressive Disorder

Title	Authors and Year (alphabetically)	Aims	Sample and Data Collection	Analysis and Findings
Attitudes Toward Borderline Personality Disorder: A Survey of 706 Mental Health Clinicians	Black, D.W., Pfohl, B., Blum, N., McCormick, B., Allen, J., North, C.S., Phillips, KA., Robins, C,. Siever, L,. Silk, K.R,. Williams, J.B., & Zimmerman, M. (2011).	To explore attitudes, mediated by occupation.	*N* = 706. Self-report questionnaire.	An ordinal logistical regression model; analysis of covariance (ANCOVA). Participants: considered BPD to be a valid diagnosis; held some negative attitudes; expressed avoidance of working with this client group; occupation and frequency of contact related to attitude.
Staff attitudes toward patients with borderline personality disorder.	Bodner, E., Cohen-Fridel, S., & Iancu, I. (2011).	To explore and compare attitudes.	*N* = 57. Self-report questionnaire.	A Regression Stepwise Analysis; multivariate analysis of variance (MANOVA). Differences in attitude between professional groups, levels of experience, and gender were found.
Therapists' accounts of psychotherapy process associated with treating patients with borderline personality disorder.	Bourke, M. E., & Grenyer, B. F. S. (2013)	To compare staff distress levels; compare PD/ MDD.	*N* = 20. The psychotherapy Relationships Questionnaire.	Multi Level Modelling (MLM); and Content Analysis indicated therapists experienced a more harmonious therapeutic relationship with clients diagnosed with MDD than BPD.
Psychotherapists' response to borderline personality disorder: A core conflictual relationship theme analysis.	Bourke, M. E., & Grenyer, B. F. S. (2010)	To explore responses towards BPD; MDD used as a comparison.	*N* = 20. Interview; The core conflictual relationship themes (CCRT) method.	Therapists' expressed: a wish to be 'confident'; felt more confident with MDD; more frequently withdrew from BPD; perceived BPD as more negative than MDD.
Treating borderline personality disorder as a trainee psychologist: Issues of resistance, inexperience and countertransference.	Cambanis, E. V. A. (2012).	Case study.	*N* = 1.	The author described: feelings of anxiety; the impact of their supervisor's attitude; and issues of transference/ countertransference, such as anger.
Patient Personality and Therapist Response: An Empirical Investigation.	Colli, A., Tanzilli, A ., Dimaggio, G., & Lingiardi, V. (2014)	To examine emotional responses	*N* = 203. The Shedler-Weston Assessment Procedure-200;	Partial correlation indicated different emotional responses for different PD diagnoses. BPD aroused reactions such as

		according to PD diagnosis.	The Therapist Response Questionnaire.	incompetence, inadequacy, confusion, frustration.
Counseling a student presenting borderline personality disorder in the small college context: Case study and implications.	Draper, M. R., & Faulkner, G. E. (2009)	Case study.	*N* = 1.	The therapist found it: difficult to establish rapport; and the client pulled away from the relationship, eventually stopping attending.
Attitudes of Clinical Psychologists towards clients with personality disorders.	Egan, S.J., Haley, S., & Rees, C.S. (2014)	To investigate attitudes.	*N* = 81. The Australian Survey of practicing Clinical Psychologists.	Bivariate correlations; and hierarchical regression analysis indicated that recency of specialist training and percentage of clients seen were associated with more positive attitudes.
The borderline patient: Mental health clinicians' experience and views.	EL-Adl, M., & Hassan, S. (2009).	To examine experiences and identify training needs.	*N* = 185. A cross-sectional survey.	Percentages indicated that the majority of clinicians found working with this client group challenging and felt more training was needed.
Patients with borderline personality disorder who are chronically suicidal: Therapeutic alliance and therapeutic limits.	Jimenez, Xavier F. (2013).	Case study.	*N* = 1.	The therapist experienced feelings of frustration and helplessness.
Borderline personality disorder: a pilot survey about clinician views on defensive practice.	Krawitz, R., & Batcheler, M. (2006).	To explore views on ‘defensive practice’.	*N* = 29. Self-report survey.	Defensive practice was common among the participants.
It's not you, it's me: An examination of clinician- and client-level influences on countertransference toward borderline personality disorder.	Liebman, R. E., & Burnette, M. (2013).	To examine countertransferenc e.	*N* = 506. Self-report survey.	BPD was associated with negative countertransference reactions; more experience was associated with more positive reactions; training increased empathy and hope.
Therapists' differential countertransference reactions toward clients with major	Mcintyre, S.M., & Schwartz, R.C. (1998).	To examine countertransferenc	*N* = 560. An online survey.	2x2 between subjects design (age and gender); and Chi Square and logistic regression indicated BPD perceived as more

depression or borderline personality disorder.		e, towards BPD or MDD.		dominant and hostile than MDD; experience decreased negative reactions.
Trying to make sense of the chaos: Clinical psychologists' experiences and perceptions of clients with 'borderline personality disorder'	Millar, H., Gillanders, D., & Saleem, J. (2012).	To explore experiences and perceptions.	*N* = 16. Four focus groups.	IPA indicated: negative/ positive perceptions of the client; undesirable/ desirable feelings in the psychologist; awareness of negativity; trying to make sense of the chaos; working in contrast to the system; and improving our role.
A Pilot Study of Psychotherapist Trainees' Alpha-Amylase and Cortisol Levels During Treatment of Recently Suicidal Clients With Borderline Traits.	Miller, G. D., Iverson, K. M., Kemmelmeier, M., MacLane, C., Pistorello, J., Fruzzetti, A. E., Crenshaw, K. Y., Erikson, K. M., Katrichak, B. M., Oser, M., Pruitt, L. D., & Watkins, M. M. (2010).	To analyse therapists physiological stress levels pre and post session.	*N* = 6. Participants provided salivary samples analysed for levels of alpha-amylase (AA) and Cortisol (C).	Linear mixed models indicated that therapists were more stressed before sessions than after (or experienced more relief after). More difficult sessions were related to declines in AA; a stronger working alliance was related to declines in C.
Stress and burnout in psychiatric professionals when starting to use dialectical behavioural therapy in the work with young self-harming women showing borderline personality symptoms.	Perseius, K.I., Kaver, A.,Ekdahl, S., Asberg, M., & Samuelsson, M. (2007).	To assess how DBT affects staff stress levels and burnout.	*N* = 22. The Maslach burnout inventory general survey (MBI-GS); questionnaires; group interviews.	Staff found working with this client group stressful, but felt teamwork and supervision helped; and work was fun and inspiring too.
There's always this sense of failure': an interpretative phenomenological analysis of primary care counsellors' experiences of working with the borderline client.	Rizq, R. (2011).	To explore the experiences.	*N* = 5. An interview schedule.	IPA themes: recognition and implications; managing feelings of inadequacy; and managing dilemmas within a primary care context.

An empirical study of countertransference reactions toward patients with personality disorders.	Rossberg,J.I., Karteruda, S., Pedersenc, G., & Friis, S. (2007).	To explore the countertransferenc e.	*N* = 11. The Feeling Word Checklist-58 (FWC-58).	An independent samples t-test; and levenes test indicated that more negative and less positive countertransference's were experienced in relation to BPD.
The unreachable object? Difficulties and paradoxes in the analytical relationship with borderline patients.	Ruggiero, I. (2012).	Case study.	*N* = 1.	The author highlights difficulty in managing intense destructiveness, and maintaining tolerance.
Clinical psychologists' perceptions of persons with mental illness.	Servais, L. M., & Saunders, S. M. (2007).	To assess attitudes towards depression, borderline features, or schizophrenia.	*N* = 306. A professional characteristics questionnaire; an attitude measure.	ANOVAs; paired samples t-tests; regression analyses indicated participants: distanced or disidentified with PD clients and perceived them as undesirable, most dangerous.

The studies were assessed using an adapted quality criteria framework (developed from Kmet, Lee, & Cook, 2004; Sale & Brazil, 2004; see Appendix A.) and categorised as either high, moderate, or low quality (see Table 5.).

Table 5. Quality of Study

Quality of Study
• **High quality**: Very few minor flaws which are addressed by the authors, scoring highly on the quality criteria; (Bodner et al., 2011; Cambanis, 2012; Colli et al., 2014; Liebman & Burnette, 2013; McIntyre & Schwartz, 1998; Millar et al., 2012; Perseius et al., 2007; Rossberg et al., 2007; Ruggiero, 2012; Servais & Saunders, 2007; Egan, et al., 2014; Rizq, 2011); • **Moderate quality**: Some minor issues highlighted by the quality criteria which are not addressed by the authors, but with no major flaws in the methodology or analysis; (Bourke &Grenyer, 2013 and 2010; Draper & Faulkner, 2009; Jimenez, 2013; Miller et al., 2010). • **Low quality:** Either major flaws with the methodology (e.g., no description of how measures or questions were generated and no discussion of their reliability, validity or credibility) or the analysis (e.g. inappropriate or insufficient data analysis, such as a lack of robust statistical analysis or discussion of credibility of analysis etc., which would impact on validity of results/ conclusions drawn); (Black et al., 2011; El-Adl & Hassan, 2009; Krawitz & Batcheler, 2006).

Brief Overview of Findings

Findings from all of the studies indicated this work as being challenging and complex, with some difficult experiences of therapeutic work considered from a variety of angles including stress and burnout (Miller et al., 2010; Perseius, 2007); negative staff attitudes (Black et al., 2011; Bodner et al., 2011); and demanding

transference/ countertransference experiences (Bourke &Grenyer, 2013 and 2010; Cambanis 2012). However, the work was also found to be fun and inspiring at times (Perseius et al., 2007).

Some of the studies indicated the BPD group was experienced as more challenging in comparison to other diagnostic categories (e.g., in establishing a therapeutic relationship; Bourke & Grenyer, 2013 and 2010). Additionally, some authors reported that therapists trained with social or psychological underpinnings were more caring, empathetic, and optimistic towards the work than medically trained staff (Black et al., 2011).

Several authors suggested that specialised training, regular supervision, increased years of experience, and increased frequency of contact with this client group was positively related to the ability of staff to work well with this client group, such as having more empathy and less judgment towards clients (Egan et al., 2014; Liebman& Burnette, 2013).

Synthesis of Findings

The literature referred to therapists' cognitive and emotional responses, attitudes, and behaviours towards this client group. Many papers discussed the concept of holding a 'negative/ positive attitude' and some implied consequences of this (i.e. that a 'negative attitude' leads to negative quality of care; e.g., Black et al., 2011; Bodner et al., 2011). However, the papers included in the current review did not define a 'negative attitude', how it might differ to a 'positive attitude', and the mechanisms through which this impacts on care. Therefore, before examining the

findings in more detail, the concepts of 'positive/negative attitude', within the context of the reviewed studies, will be deconstructed and discussed.

Negative and Positive Attitudes

The concept of 'attitude' will be deconstructed first, followed by discussion of attitude as 'positive' or 'negative'. The included studies refer to a variety of terms between them when discussing the therapist in relation to the client/ client group, seemingly regarding the same phenomenon (see Table 6.).

Table 6. Characterisations of negative and positive attitudes and who contributes

Characteristics of 'Negative' and 'Positive' Attitudes and Contributors
• **Attribution** (McIntyre & Schwartz, 1998; Millar et al., 2012) • **Attitude** (Black et al., 2011; Bodner et al, 2011; Egan et al., 2014; EL-Adl& Hassan, 2009; Liebman& Burnette, 2013; Millar et al., 2012; Servais& Saunders, 2007) • **Behaviour/ Actions Taken** (Black et al., 2011; Bodner et al, 2011; Krawitz & Batcheler, 2006; McIntyre & Schwartz, 1998; Servais & Saunders, 2007) • **Cognition** (Bodner et al, 2011; Bourke & Grenyer 2011; McIntyre & Schwartz, 1998) • **Emotion** (Bodner et al, 2011; Bourke & Grenyer 2013 and 2011; Colli et al., 2014; McIntyre & Schwartz, 1998; Millar et al., 2012; Rossberg et al., 2007) • **Enactment** (Cambanis, 2012; Ruggiero, 2012) • **Evaluation** (Servais & Saunders, 2007) • **Personal perception** (Bourke & Grenyer, 2013; McIntyre & Schwartz, 1998;Millar et al, 2012; Servais & Saunders, 2007)

- **Relational Patterns** (Bourke & Grenyer 2013 and 2011; Colli et al., 2014)
- **Therapist Response/ Reaction (towards both self and client)** (Bourke & Grenyer, 2013 and 2011; Colli et al., 2014; Liebman & Burnette, 2013; Rossberg et al., 2007)

An attitude can be defined as containing cognitive (beliefs, thoughts, perceptions, attributes), affective (feelings, emotions, physiological responses), and behavioural (behaviours and actions) components (Breckler, 1984). Some of the reviewed studies assume attitude relates mostly to cognitive and emotional processes or responses; whereas others also include actions and behaviours in their understanding; further authors refer to transference/ countertransference; and some emphasise affect (see table 6 above for specific detail on which authors contribute to which understandings of 'attitude').

The inconsistency in focus may be related to the epistemological stance of the researcher/therapist, regarding their underlying assumptions or the psychological models that have informed their thinking. For example, some studies appear to take a cognitive behavioural perspective, but do not make this explicit (such as Black, 2011; and Bodner et al., 2011). Other authors draw on psychoanalytic concepts (i.e., transference and countertransference; Cambanis, 2012; McIntyre & Schwartz, 1998). This lack of consistency may have implications for the current review, in that findings from the literature are based on a variety of implicit theoretical approaches and assumptions, potentially affecting the validity of any overarching conclusions drawn. Therefore, the current synthesis remains mindful of possible bias.

Following on from ‘attitude’, it appears that ‘positive’ and ‘negative’ also refers to a mixture of cognitions, affects, and behaviours, in relation to the self and the client (see Table 7.).

Table 7. ‘Positive’ and ‘Negative’ Attitude Definitions

‘Positive Attitude’ (alphabetically)	**‘Negative Attitude’ (alphabetically)**
• **A belief in the individual being ‘ill’ rather than ‘acting out’** • **Acceptance (absence of anger, irritation, and alienation)** • **Calmness** • **Care** • **Compassion** • **Complementariness** • **Concordance** • **Empathy** • **Enjoyment** • **Enthusiasm** • **Feeling relaxed** • **Friendliness**	• Anger • Antagonism • Anxiety • Apprehension • Avoidance • Being on guard (caution, threat) • Boredom (indifference, emptiness) • Confusion • Defensiveness • Feeling Incompetent or inadequate • Feeling overwhelmed • Feeling tense • Frustration • Helplessness

• **Hopefulness about medication or therapy for prognosis** • **Objectiveness** • **Purpose (sense of meaning in the work)** • **Responsibility and concern** • **Security and consistency** • **Support** • **Treatment optimism**	• Holding views about the client as not being 'ill', but being manipulative, attention-seeking, treatment resistant, non-compliant etc. • Irritation • Judgment • Rejection (dislike, disparagement) • Sadness or distress • Sense of alienation from the client • Unhopeful about medication or therapy for prognosis

A 'negative attitude' combines cognitions, affects, and behaviours that are considered to be unhelpful for the client. Consequently, the literature suggests the way forward for therapists is to move towards a 'positive attitude' which will be more beneficial for both themselves and their clients (Egan et al., 2014; El-Adl& Hassan, 2009; Millar et al., 2012; and Servais& Saunders, 2007). Underlying this stance are some implied perspectives on what constitutes 'positive' and 'negative' thoughts, beliefs, affects, and behaviours. Specifically, definitions appear in alignment with a medical perspective.

A 'positive attitude' is one in which clients are seen as 'ill', which medication should help with, and from whom an objective distance should be maintained; and a 'negative attitude' incorporates feelings such as anger and frustration which are

unhelpful and should be avoided (Black et al., 2011; Bodner et al., 2011; Egan et al., 2014; El-Adl& Hassan, 2009). However, the medical perspective is only one approach; an alternative, psychological viewpoint, may posit that a client is not 'ill' but is responding to difficult life situations with understandable emotional distress.

Accordingly, definitions of what constitute 'positive' and 'negative' cognitions/beliefs/affects can be questioned. For example, an experience of anger may be considered as informative rather than negative, in that it can tell the therapist something about the client, the encounter, or themselves, and can be used productively. In this way, the therapist's response is used within a framework of positive regard that is also genuine and honest. It could be argued that emotions considered as 'negative' in some of the reviewed studies are necessary and desirable, and to strive to be 'positive' may be unattainable and unhelpful, leading to incongruous and inauthentic interactions with clients.

Furthermore, some 'positive' characteristics may reflect a more neutral stance. For example, empathy and objectivity may be more related to open-mindedness than positivity (that is, rather than keeping a narrow focus on how people 'should' be, and becoming frustrated when this doesn't occur, maintaining an open, person centred stance; Rogers, 1961). Regarding the current research question, these implicit assumptions and unidentified values of the authors could colour the interpretation of the results. Hence, the current synthesis will remain cautious of validity issues.

To be clear, not all authors make an assumption regarding what constitutes 'positive' and 'negative' attitudes. Some studies view both therapist and client as having a dyadic relation that evokes a full range of thoughts and emotions in each

other (Bourke &Grenyer, 2013 and 2010; Cambanis, 2010; Colli et al, 2014; Liebman& Burnette, 2013; McIntyre & Schwartz, 1998). This range of transitional cognitions and affects is seen as a valid experience in therapy that provides the therapist with important information that can be used to inform meaningful interactions; rather than something to be avoided or squashed.

Synthesis

Findings from the included studies will now be synthesised to provide a narrative of the literature, bearing in mind issues of validity, reliability, and credibility. This will be organised according to the aims and research questions of the reviewed literature.

Exploring Experiences

Several of the papers set out to understand more about the lived experience of therapists, including challenges and interactional complexities within the therapy. Common themes across the four case studies included experiences of anxiety, frustration, and anger. For example, Cambanis (2012) documented her experience as a trainee clinical psychologist, utilising firstly dialectical behavior therapy (DBT) and then mentalisation based therapy (MBT) with a client over eight sessions.

Cambanis described feelings of anxiety in working with her client, due to inexperience and unrealistic expectations of her own competence as a trainee. Cambanis also discussed issues of transference/ countertransference, such as anger, and how guidance and containment from a supervisor was important in feeling confident in the work.

Jimenez's (2013) case study documents the experience of a fourth year psychiatry resident, also utilising a DBT intervention, within a women's intensive outpatient program. The therapist discussed feelings of frustration and helplessness, which were addressed in therapy, and highlighted the importance of the therapeutic alliance.

Draper and Faulkner's (2009) case study documents the supervision of 'Camille', a first year doctoral counselling psychology student, and the therapy conducted with her client. Similarly to Jiminez (2013) Camille emphasized the importance of the therapeutic relationship, experiencing difficulty in establishing rapport. She felt that the client found validation uncomfortable, and pulled away from emotional bonds, with the client eventually deciding to end therapy. Camille also felt that her client could be rude to her and failed to take accountability for behaviours that impacted negatively on others. Unlike Cambanis (2012) and Jimenez (2013) Draper and Faulkner's (2009) case study positioned the difficulty within the client, without reflection on what the therapist brings to the encounter. It appears that Camille, similarly to the other authors, experienced emotions such as frustration, helplessness, rejection etc., but Draper and Faulkner failed to explicitly address this within the case study. Considering the orientation of Camille as a therapist (interpersonal and object relations framework) more discussion of transference/ countertransference would have been expected.

In contrast, Ruggiero (2012) presented a case from private practice, with a specific focus on transferences, countertransferences, and what the therapist brings to the encounter. Ruggiero outlined key points, including reaching impasses that needed to be worked through, the difficulty in managing the client's intense

destructiveness, and maintaining tolerance in the face of difficult experiences of the work. Unlike Draper and Faulkner (2009), Ruggiero (2012) emphasized the importance of analyzing countertransference, and self-analysis, as a way to understand the client and the therapist more fully.

The differences in therapist self-reflection may be related to level of experience and supervisory guidance, or orientation of training. For example, both Cambanis (2012) and 'Camille' (Draper & Faulkner, 2009) were early on in their career, whereas Ruggiero (2012) had more clinical experience. Comparable relational patterns may have occurred for each therapist, but with more experience this may be easier to recognize and work through rather than enact (repeat the pattern) especially with the support of a helpful supervisor. Other studies in the current review document findings consistent with this suggestion; that years of experience and increased training and supervision may impact helpfully on the perspectives and behaviours of therapists (e.g., Bodner et al., 2011; Egan et al., 2014).

In summary, the case studies documented experiences of anxiety, frustration, helplessness, rejection, and a need to maintain tolerance and a good therapeutic alliance in the face of destructive behaviour. These experiences can be compounded by self-doubt regarding competence as a therapist or inexperience of complex work. In order to manage this level of demand on the therapists, the importance of guidance, supervision, and self-analysis was outlined.

Two papers utilized IPA to explore the lived experience of participants. Millar et al. (2012) interviewed 16 female clinical psychologists in a primary care setting. Eight superordinate themes were identified, including negative perceptions of the client (as being controlling or manipulating for example); and also positive perceptions of

the client (such as being likeable). Participants also described both undesirable feelings in the self (e.g., frustration, anxiety, self-doubt); and desirable feelings, such as empathy and being interested. Participants were aware of the negativity in their perceptions, which could lead to avoidance, and wanted to understand why they felt this way and to 'make sense of the chaos' (e.g., searching for explanations/formulations). Participants also highlighted how their work could feel in contrast to the 'system', including problems with diagnosis and feeling like psychology could have a limited impact within this context. This led to participants describing how they wished to improve the role of the psychologist, through developing their own knowledge and experience, and making use of support.

Rizq (2011) also conducted interviews in a primary care setting, with 5 counsellors. Three master themes emerged, including recognition of the clients' complex difficulties; and their own perceptions of letting the client down, failing, and needing support/ supervision. Participants discussed the need to manage their own experiences of anxiety and inadequacy; alongside feelings of empathy and responsibility. Additionally, participants raised the issue of managing dilemmas within a primary care context, including coping with limits such as time pressures, managing risk, and feeling 'stuck' with the client.

Similarities and differences were apparent across the two IPA studies (which were both assessed to be of high quality). Similarities included feelings of anxiety and self-doubt in the therapist and the need to manage this, often related to feeling overwhelmed and inadequate. Millar et al. calls these feelings 'undesirable', as if participants felt the urge to squash or avoid them. In contrast, Rizq discusses how these experiences may be helpful to provide a sensitivity which is essential to

effective, empathic, therapeutic work. All participants were keen to make sense of their experiences, and feelings of empathy were documented.

A further connection is the constraint of the NHS 'system', such as the limits of both the profession and the context the therapy is delivered within. Changes within the NHS are a regular occurrence, and restrictions related to limited resources within the current sociopolitical are often a source of frustration for staff (UNISON, 2012).

Both authors discussed the need to manage dilemmas and boundaries, including risky behaviour; and the importance of a supportive context, guidance, and supervision, in doing so. It appears that the context for the therapist who works with complexity is very important, and could contribute to the quality of therapy provided. This chimes with Cambanis' (2010) discussion of the importance of containment for the therapist as a parallel process.

Considering therapists' experiences from a different angle, two of the included studies focused on stress and burnout. Miller et al. (2010) analysed therapists' physiological stress levels when working with recently suicidal clients with 'borderline traits'. Participants provided salivary samples immediately pre and post two sessions, to be analysed for levels of alpha-amylase (AA) and Cortisol (C). Additionally, participants completed a working alliance questionnaire (12 items, with subscales of therapeutic bond; agreement between client and therapist on tasks; and agreement on therapy goals); and rated perceived session difficulty post session. Linear mixed models analysis indicated that participants felt more stressed before sessions than after (or experienced more relief after). More difficult sessions were related to declines in AA, and a stronger working alliance

was related to declines in C. The paper was of moderate quality, with the sample size being small (n = 6) and data collection phase brief (two sessions) limiting generalizability.

Cortisol is a stress hormone, which was seen to decrease when a stronger working alliance was present. Considering that developing and maintaining relationships can be difficult for this client group, it could be that this links with elevated cortisol levels in staff, translated as feeling more ‘stressed’. Expanding on this, Perseius et al. (2007) explored stress levels and occupational burnout in staff utilizing DBT with clients. Twenty-two participants completed the Maslach Burnout Inventory General Survey (MBI-GS) pre, twice during, and post intervention (assessing items such as exhaustion, cynicism, and personal efficacy). Additionally, free format questionnaires and a group interview were conducted. The MBI-GS did not demonstrate any significant findings. Qualitatively, staff found working with this client group very stressful; and DBT was seen as stressful regarding learning demands, but did help to decrease stress when using it with clients. Staff found the work fun and inspiring at times too. Teamwork and supervision helped manage stress; and mindfulness (as part of DBT) was also beneficial to use in their own lives.

In summary, staff tended to find the work stressful, but also fun and inspirational, especially when a working alliance was strengthened (e.g., Perseius et al., 2007). The context was again highlighted as important, including cohesive team working and supervision, and the use of mindfulness as a practice for managing staff stress.

Exploring Attitudes

Three of the included studies explored staff attitudes. Bodner et al. (2011) analysed 57 clinicians (including but not focusing on therapists) who completed a self-report questionnaire covering 47 items regarding cognitive attitude (e.g., antagonistic judgment); and 20 items regarding emotional attitude (i.e., negative emotions, difficulties in treatment, and empathy). All practitioners expressed feelings of frustration, anger, impatience, and agitation. Staff seniority was related to a less negative attitude; and a less negative attitude was related to higher levels of empathy. A regression stepwise analysis, and multivariate analysis of variance (MANOVA) indicated that suicidal tendencies in clients mainly explained the negative emotions experienced by staff (24.5% of the variance) and the difficulties working with this client group (27.3% of the variance). However, the sample size was small (n=57) and non-random, limiting generalizability.

El-Adl and Hassan (2009) surveyed 185 mental health clinicians (not focusing on, but including, therapists). Findings indicated that only 15% of respondents felt 'very good' about working with this client group; only 5% of participants found it enjoyable; 60% found it challenging; 15% found it stressful; and 85% wanted more training. However, this paper was of poor quality. The authors provided no description of what the survey was or how it was developed (impacting on the reliability and validity) and only percentages were generated in the analysis, with no rationale regarding the absence of statistical analyses.

Both authors report this work as challenging, frustrating, and stressful, suggesting this is directly related to the level of risk staff manage (i.e. higher risk, such as suicidal tendencies, creates more stress). This chimes with the previous papers,

indicating that managing risk is a key challenges for staff, increasing the need for supervision. Bodner et al. (2011) also reported that as staff increased in experience, they expressed less negativity and more empathy, perhaps reflecting the development of understanding and increased ability to manage complex work. However, Bodner et al. (2011) and El-Adl and Hassan (2009) included a variety of mental health clinicians within their sample, and it was not made particularly clear which responses were attributed to which professions. Therefore, conclusions drawn from the data must be considered cautiously, as the reviewed literature also suggests that different professional groups hold different attitudes (see below for further discussion of this).

Returning to therapists specifically, Egan et al. (2014) investigated 81 clinical psychologists' attitudes, to a high quality standard. Participants completed The Australian Survey of Practicing Clinical Psychologists, covering questions such as, "What percentage of clients do you have that are diagnosed with a PD? When was the last time you attended specialist professional development for treating PD?". The Attitude to Personality Disorder Questionnaire was also completed. Bivariate correlations, and hierarchical regression analysis indicated that recency of specialist training and a higher percentage of clients seen were associated with more positive attitudes; and a higher caseload of PD clients was the most important predictor of positive attitudes such as enjoyment, absence of anger, irritation or anxiety, and having a sense of purpose in the work.

In summary, the three studies exploring attitude imply some similarity of experience, such as finding the work challenging (e.g., in managing risk). Additionally, an emphasis was placed on the need for a supportive clinical context.

The authors' all take the causal stance of a 'negative attitude' being undesirable (e.g., feelings of anger, irritation, anxiety); and a 'positive attitude' being desirable (e.g. enjoyment, absence of 'negative' emotions); with the meanings of 'negative/ positive' aligned with a medical perspective. The implication is that training and supervision can eradicate unwanted negative emotions and cognitions. However, training/supervision does not often aim to eradicate 'negative attitudes'; but rather, focuses on becoming more aware of them, what they suggest about the process of the work, and how to use this for therapeutic benefit (discussed in wider literature, e.g., Scaife, 2009).

Comparing attitudes by occupation

Two of the studies were interested in how the experience and attitude of therapists may also differ across occupations. Black et al. (2011) utilized a survey to explore and compare the attitudes of 706 mental health clinicians (again, including, but not exclusively focused on, therapists). The sample as a whole demonstrated some 'negative attitudes' towards the client group, and almost half of respondents stated they avoided working with them. The 89 psychologists and 98 social workers included in the sample were most optimistic about the effectiveness of psychotherapies, and clinicians who had worked more extensively with clients with a diagnosis of BPD reported significantly more positive attitudes. However, this paper was of low quality. The 31-item survey used was not adequately described, and was not a standardized measure, raising questions regarding reliability/validity. Additionally, the analysis is not described in sufficient detail, in line with the standards laid out by the utilized quality criteria, and so conclusions should be treated with caution.

Bodner et al. (2011) reported that psychologists scored significantly lower on antagonistic judgments, and higher on empathy, than nurses or psychiatrists. This paper was of a higher quality than Black et al. (2011) with a good methodology. However, it was conducted in Israel which is culturally different to the western world, and issues of cross-cultural validity were not discussed.

Considering the limitations, conclusions should again be considered with care. Additionally, the benefit of comparing professional groups regarding 'negative attitude' remains unclear, and appears critical of medical professions for being more judgmental and less empathetic than social/psychological professions. Ideas about how a person, or group of individuals, can be constructed by others was discussed earlier in the current review. Within the context of the research by Black et al. (2011) and Bodner et al., (2011) the idea of 'negative attitudes' as being contained in the person emerges. The medical oriented professions 'contain' more negative attitudes about the BPD that their patients also 'contain'. It could be that this is a parallel process, constructing and objectifying both the professional occupations and the client group as being somehow 'faulty' and in need of 'positive' change.

Comparing Diagnoses

Seven studies compared the experience of therapists working with clients diagnosed with BPD to working with clients with other diagnoses. For example, Colli et al. (2014) analysed a random national sample of 203 psychiatrists and clinical psychologists. Participants completed the Shedler-Weston Assessment Procedure-200 (to assess the PD diagnosis of their clients); and the Therapist Response Questionnaire (79 items identifying patterns of emotional responses to

clients, including thoughts, feelings, and behaviours). Partial correlations indicated different emotional responses for different PD diagnoses, with the BPD client group arousing the strongest reactions. This included feelings of incompetency, frustration, anxiety, resentment, guilt, and a desire to avoid or flee the client.

Rossberg et al. (2007) explored countertransferences in relation to clients with a cluster A or B personality disorder diagnosis (mainly BPD); and compared this to the countertransference experienced in relation to clients with a cluster C PD diagnosis (mainly avoidant PD). Eleven participants completed the Feeling Word Checklist-58 (FWC-58) 2 weeks after admission and 2 weeks before discharge concerning 71 clients in a day programme. The checklist consists of 58 'feeling words', including for example, empathic, caring, confident, rejected, disliked, anxious, etc.

Independent samples t-tests indicated more negative and less positive countertransferences in relation to clusters A and B than cluster C. Significantly more negative experiences were in relation to clients who dropped out of therapy than those who completed it. Strong correlations were found between countertransferences and change during therapy (that is, positive change was associated with the feeling words 'important' and 'confident'; and negative change was associated with 'rejected', 'overwhelmed', and 'inadequate'). The authors indicated that staff working with BPD diagnosed clients felt more negative and less confident in the work than with other PD diagnoses, unless clients completed their therapy process and made positive changes.

Colli et al. (2014) and Rossberg et al. (2007) both discuss staff finding it more distressing and challenging to work with clients diagnosed with BPD than other PD

diagnoses. This incorporated feelings that align with previous research, including anxiety, frustration, hopelessness, resentment; and associated behaviours such as avoidance. It may be that staff want to avoid these experiences because it can feel too distressing or overwhelming; or because it prompts self-doubt regarding their own competence and self-efficacy in effecting positive therapeutic change. This links to the literature discussed in the NIMHE publication (suggesting why some staff prefer not to work with the BPD client group, leading to PD still being a diagnosis of exclusion).

The NIMHE authors hypothesised that clinicians can be reluctant to work with this client group because they find interactions so challenging; or due to a lack of skills, training, or resources to provide an adequate service. However, if the findings from the reviewed studies are considered, clinicians may be working within a context that draws from a medical perspective (e.g., taking a 'positive attitude' vs. a 'negative attitude').

This may mean that staff encounter feelings that would be understandable in light of working with complexity, such as of frustration, anger, hopelessness etc; but rather than being encouraged to use these feelings to inform interventions, are compelled by the environment to view these experiences as somehow unacceptable, reflecting their lack of skills/competence, and which they need training/supervision to 'get rid of'. This could understandably result in avoidance or dismissal of the client group. This would also link to the findings in the reviewed papers' regarding the need for a supportive context and responsive supervision.

Further literature compared BPD to other diagnostic groups entirely. Bourke and Grenyer published two studies in 2010 and 2013 with the same sample of 20

therapists. In 2010 they used clients diagnosed with major depressive disorder (MDD) as a comparison. They found that participants expressed a shared wish to be ‘confident’ in their role, regardless of diagnosis; but often felt more confident working with the depressive client group, and, similarly to Colli et al. (2014) more frequently withdrew from BPD clients. Participants also frequently perceived their BPD clients as responding to them in a withdrawing and negative manner; contrasting with depressive clients who were perceived as responding in a positive manner, with an attentive and friendly style. Additionally, participants responded to themselves in a more negative way when working with the BPD client group. However, although the paper is qualitative, it is left until the discussion to introduce extracts from participants. Consistent with the quality criteria, it would have been helpful to see some of the quotations from participants alongside the presented results, to contextualise the findings more and thus lend more support to the conclusions drawn.

In Bourke and Grenyer (2013) the Psychotherapy Relationships Questionnaire was utilised (an already established measure, unlike in some of the other studies) which explores transference issues. Findings indicated that the participants perceived the BPD client group as expressing a greater variety of attitudes and affects in their interpersonal interactions than the MDD group, endorsing questionnaire items such as: hostile, anxious, avoidant, and dismissive. Participants felt a greater harmonious working alliance with MDD clients, experiencing BPD clients with more of a push-pull interpersonal dynamic under greater pressure to be forged well.

These findings are unsurprising, considering the BPD client group experiences difficulty with forming and maintaining relationships, and managing emotions (Hatloy, 2012). This also aligns with the literature highlighting the importance of the therapeutic relationship, and how stressful it can feel for staff to establish and maintain this, especially in the face of challenging and risky behaviour. However, the sample size of 20 was small, and the authors seemed to generalise what a 'BPD client' and an 'MDD client' are like and how they respond interpersonally without explicit discussion of this or the research base supporting their assumptions.

Liebman and Burnette (2013) further explored how the emotional experience differs for therapists in relation to other client work, surveying 560 clinicians across seven domains: beliefs regarding whether BPD/MDD was a behavioural problem or a 'mental illness'; issues relating to distrust and interpersonal efficacy; feelings of empathy towards the client; perceived chronicity of the client's difficulties; and the client's level of dangerousness and conduct problems. The scale was developed from versions of existing surveys, and piloted for validation.

Participants' experiences of countertransference were more negative and less empathetic towards clients with a BPD diagnosis than MDD. Chi square and logistical regression also indicated that more clinical experience was associated with a more positive reaction; more specialized training increased empathy and more hope for the person to improve; Masters level therapists were more empathic than psychiatrists; and older clinicians viewed the client as less interpersonally efficacious and more dangerous. Similarly to the previous findings, this suggests that in some ways the BPD work becomes more easily understood,

empathized with, and managed as the therapist progresses through their career, works in potentially more supportive contexts that provide training, and spends more time with this client group.

McIntyre and Schwartz (1998) explored 155 psychotherapists' countertransference reactions, including personal perceptions and emotional reactions, after listening to a typical diagnostic interview session (clients diagnosed as either BPD or MDD). Following this, participants completed the Impact Message Inventory (assessing perspectives on the client as being dominant, hostile, submissive, or friendly); and the Stress Appraisal Scale (assessing perspectives of the participant in relation to the client, such as feeling caring towards them and their ability to conduct 'successful' therapy).

ANOVAs indicated BPD clients were perceived as significantly more dominant and hostile, evoking reactions such as mistrust and detachment; and MDD clients significantly more submissive and friendly, evoking reactions such as caring and nurturing. These findings may link to the earlier reports by Colli et al. (2014) Rossberg et al. (2007) and Bourke and Grenyer (2010; 2013) regarding the urge for staff to detach, withdraw, and avoid, because the work provokes undesirable and unwanted feelings.

Expanding the diagnostic categories, Servais and Saunders (2007) assessed 306 psychologists. Participants rated either themselves, a member of the public, or people with a diagnosis of either moderate depression, borderline features, or schizophrenia on six semantic differential scales (a continuum). This comprised of: effective – ineffective; understandable – incomprehensible; safe – dangerous; worthy – unworthy; desirable to be with – undesirable to be with; and similar to me

– dissimilar to me. This covered ‘disidentification’ (the process of characterizing the self as ‘normal’ and those with mental health problems as ‘different from normal’).

ANOVAs, t-tests, and regression analyses indicated that participants perceived client groups differently. This included a tendency to distance or disidentify more with clients diagnosed with personality or psychosis problems. People with borderline features were perceived as undesirable and the most dangerous. However, the scale used in this study was not a standardised measure, and so validity and reliability can be questioned.

Limitations with these studies include the other diagnostic categories BPD clients are compared to (i.e. predominantly MDD). Research literature does not point to the same level of interpersonal challenges when working with someone diagnosed with MDD (which from the reviewed studies appears to be a central tenet of what is challenging and stressful about working with BPD). Therefore, it may make for more valid conclusions if comparison groups were matched taking into account their formulated difficulties, rather than diagnosis alone (for example, comparing clients who all find attachment/interpersonal relationships difficult but have a variety of diagnoses).

Exploring Responses and Behaviours

The final study was conducted by Krawitz and Batcheler, (2006) who focused on the behaviours of staff. Again, this study included, but did not focus specifically, on therapists.

The authors examined clinician views on ‘defensive practice’ through use of a survey. Defensive practice referred to working in a way that decreases short term risk but that may increase overall risk (e.g., self-harm and/ or suicide) such as prolonged hospital admissions, lengthy one-to-one observations, and lengthy use of mental health legislation. The authors argue that this kind of practice could have a negative impact (e.g., by reducing the chance for a client to learn they are capable and how they can increase their own safety).

Findings indicated that defensive practice was common among the participants, with 85% practicing in a way they felt was not in the best interests of their client in the previous year, but that protected them from workplace repercussions of risky behaviour. The challenges of working with risky behaviour, such as self-harm and suicide, has emerged in the reviewed studies as one of the most difficult aspects of working with this client group.

Reasons suggested by participants for defensive practice included media influence (73%); senior managers perspectives (55%); concern about having to attend coroners hearings (55%); and direct/indirect information from the ministry of health (10%) clients family/ friends (46%) immediate line managers (41%) clients themselves (36%) and politicians (36%). However, the sample size was small (n = 29) limiting generalizability, and no statistical analysis was carried out, minimizing the reliability and validity.

Discussion

The current review asked the question, what does the literature suggest it is like to work with clients diagnosed with BPD? Twenty studies were identified and reviewed, including case studies, survey designs, and qualitative explorations. Quality varied, with only 60% deemed to be of high quality with very few minor flaws. This indicates that the literature to date is underdeveloped and in need of further investigation.

Conceptual flaws were noted in many of the studies, for example, in relation to implicit underlying epistemological perspectives that were not consistent across papers. This included issues around ‘negative/ positive attitudes’ and the assumptions inherent within these concepts. This impacts on the validity and reliability of conclusions drawn, restricting the scope of the literature, in turn impacting on the current synthesis.

Regarding how therapists find this work, common themes across all papers included feelings of anxiety, frustration, hopelessness, helplessness, rejection, and inadequacy; and associated cognitions and behaviours such as judgment, avoidance, and ‘defensive practice’. This was indicated to be more challenging than working with other diagnoses, with medically trained staff reporting more ‘negative attitudes’ than socially/psychologically trained staff. However, experiences of finding the work fun and inspiring were also evident. A need to maintain tolerance and a good therapeutic alliance in the face of destructive behaviour was highlighted, made more difficult by managing risk. The challenges were suggested to be compounded by self-doubt regarding competence as a therapist or inexperience of complex work.

Overall, experiences emerge from the literature of the work as clinically challenging, stressful, and more emotionally distressing than working with other client groups (which is directly related to managing risk and destructive behaviour; and the difficulty in establishing a therapeutic relationship). This level of demand can lead to therapists avoiding or withdrawing from clients, either because the work feels too difficult or the feelings evoked regarding the therapists' own competency/ efficacy are unwanted. Most authors emphasise the importance of good supervision, guidance, teamwork, and further training/ experience.

The literature suggests hypotheses regarding the findings. Concerning the different responses of the various professional groups, Black et al. (2011) and Bodner et al. (2011) propose that medical staff often work on the 'front line' with clients whilst they are at their most 'ill' and when the work is most stressful. Egan et al. (2014) explored the attitudes of psychologists specifically, and concluded that they might have chosen to work with this client group out of clinical interest, holding 'positive' attitudes to begin with; whilst Bodner et al. (2011) suggest the profession as a whole has skills sets contributing to a better understanding of complexity, such as acceptance and empathy. Millar et al. (2012) elaborates this point, discussing how psychologists may hold negative perceptions, but want to 'make sense of the chaos' through psychological formulation.

Alternatively, Rossberg et al. (2007) suggest that the variance in therapists responses could be due to 'splitting' within teams. Bourke and Grenyer (2010) share similar ideas, proposing that the interpersonal interactions between clients and therapists are very intense, and defenses that involve 'splitting' and 'projective identification' could cause strong countertransference reactions in therapists.

Regarding risk of self-harm and suicide, many of the reviewed papers suggest this is one of the most difficult aspects of the work. Krawitz and Batcheler, (2006) discuss that 'defensive practice' may be a consequence of clinician anxiety about the wider consequences of an adverse client outcome; which in turn may be influenced by the service context and system. Bodner et al. (2011) suggest that suicidal tendencies are seen as risky and dangerous, which can infuriate staff and result in 'negative' attitudes and feelings. They suggest that training, supervision, increased confidence, and heightened objectivity (all as products of increased experience), impact 'positively' on staff.

The proposal for more supervision and training is shared by most of the authors, partly to reduce stigma and bias, and increase empathy and hope (Black et al., 2011; Servais& Saunders, 2007). Perseius et al. (2007) recommend that burnout might be avoided utilizing elements of DBT with staff, such as peer support and supervision; alongside the benefits of mindfulness. Egan et al. (2014) also argue how more 'positive' attitudes occur when clinicians receive specialist training, perhaps because they feel more knowledgeable and empowered.

However, quality issues also need to be considered, and the effect of these on the current conclusions drawn. Most of the survey studies (e.g., Black et al, 2011; Bodner et al., 2011) relied on measures that were constructed for the purpose of the research, without any prior standardisation. These measures were generated from professionals within a specific context, and so can be accused of being artificial and representing the implicit assumptions of the researcher and their epistemological stance, raising questions regarding reliability, validity, and generalisability. Furthermore, the research predominantly uses self-report data,

which could create bias (e.g., answers that are inaccurate in order to avoid judgment of others for being a ‘bad therapist’). Many studies use small sample sizes, or use the same sample multiple times, which again could impact on reliability and generalisability.

Moreover, the reviewed studies held an implied causal stance inferring that a ‘negative attitude’ is unhelpful because it impacts negatively on clients; and instead, staff should move towards a ‘positive attitude’ that benefits clients. This, again, seems related to the epistemological stance of the researcher/therapist. Underlying this stance are some implicit perspectives on what constitutes ‘positive’ and ‘negative’, in line with a medical model, which can be questioned by alterative perspectives (e.g., considering anger as an informative emotion, rather than representative of a ‘negative attitude’, that may be necessary and desirable for a helpful therapeutic encounter). Furthermore, some of the ‘positive’ characteristics may refer more to neutrality (e.g., empathy and optimism could be considered as ‘open-minded’ rather than ‘positive’).

Consequently, it could be concluded that the ‘positive’ and ‘negative’ terminology is not named in a helpful way. A ‘negative’ attitude seemingly refers to a therapeutic stance that is judgmental and moralising, and incorporates behaviours such as avoidance and withdrawal that could be therapeutically harmful for the client. This is also mixed with emotional experiences that could be distressing, but on their own are not necessarily a ‘bad’ thing, but can be used for therapeutic benefit. A ‘positive’ attitude seemingly refers more to an open minded, neutral stance, which is not clouded with biases and assumptions, and incorporates the process of therapy as well as the outcome.

This implies that the conceptualisation of ‘negative/ positive attitude’ is flawed, and therefore staff experience could be explored in a more helpful way. For example, openly discussing with staff their experiences of the work without prior assumptions regarding ‘attitude’, and how they make sense of their therapeutic encounters; and how these experiences and the meanings attached to them could be used to improve outcomes for clients and encourage a better working environment. With this approach, the experiences could become part of the process of improving services for people diagnosed with BPD, rather than being viewed as a barrier that staff need to overcome in order to work with this client group ‘successfully’.

The notion of therapists wanting to conduct ‘successful’ therapy, which encompasses helpful therapeutic change, emerges strongly (and mostly implicitly) in the reviewed literature. This may be an understandable, shared wish amongst many therapists, to be ‘good enough’ at their job in order to best support clients, but that may also impede therapy if not addressed; which has also been outlined by authors in other fields of work (e.g., Chadwick, 2006, discusses therapist beliefs that can inhibit therapy). Additionally, with a more outcome driven emphasis on evidence based services, pressure can be on therapists to document their competency for service commissioners (British Psychological Society, 2012).

If there is no helpful change, a deterioration occurs, or the client drops out, the literature implies that a reason needs to be found as to *why*. This also infers assumptions regarding therapeutic change, in that if barriers to ‘self-actualisation’ are removed, then a person naturally moves towards growth and development (Maslow, 1943). Taking this stance, therefore, if ‘positive change’ does not occur,

it appears that blame is searched for. Blame either towards the client or the therapist for failing in some way (e.g., the client failing to take accountability for their behaviours; or the therapist having a 'negative attitude' that impacted negatively on the therapy). For example, Draper and Faulkner (2009), Rossberg(2007), and Bourke and Grenyer (2010) seem to blame the client on some levels (e.g., for not taking accountability for their behaviour and disengaging); and Egan et al. (2014), Bodner et al. (2011), and El-Adl and Hassan (2009) seem to blame the therapist (e.g., for having a 'negative attitude').

However, there are many reasons that have been discussed throughout the current review highlighting why therapeutic change can be challenging (e.g., difficulty in establishing relationships; lack of training and supervision; the context of the service and the wider culture/environment etc.). Additionally, the concept of a natural pull towards growth and development has been criticised for being reductionist and failing to account for relational aspects of life (Geller, 1982).

Understanding 'why' could be a beneficial exercise to help improve services, but rather than attempting to blame or position a deficiency within individuals, more helpful ways of understanding could be drawn upon. For example, an intersubjective understanding of the space between client and therapist, so that blame cannot be attributed to one or the other. Rather, the encounter is more than the sum of its parts, and importance is placed on understanding the dynamic space between people and what happens in the therapeutic encounter (Lemma, 2005).

Recommendations for Future Research

A move away from causal, blaming approaches, could be helpful in further understanding what it is like for staff to work with this client group; and how this may be worked with to promote best practice care for clients and improved working environments for staff (e.g., more exploratory research into staff experience of the therapy, their understanding of it, and the context they work within).

The current review has focused on the experience of therapists. It may be useful to understand more about the experience of clients diagnosed with BPD engaging in therapy; or, bearing in mind the current synthesis of the literature, it may be helpful to focus on the process of therapy and interpersonal relationships (e.g., conducting research with dyads of therapists and clients to understand more about their intersubjective experience). Much research to date has highlighted how services do not meet the needs of this client group, do not provide best practice care, and how unhelpful and obstructive mental health staff can be. Therefore, it may be useful to focus on 'what works' – specifically, what has been found to be of benefit when engaging in therapy.

Limitations

Limitations in the current review included use of several studies that did not focus specifically on therapists alone, but incorporated a variety of staff groups. This may have influenced the conclusions drawn, in that some views represented may belong to professional groups not engaging in therapy. However, care was taken

to extract the data relating to therapists alone as much as possible dependent on the clarity of the reviewed papers.

Additionally, some of the reviewed literature was of poor quality (i.e., major flaws with methodology or analysis, affecting reliability, credibility, and generalisability) and the concepts contained (such as attitude) not being fully sound (which could impact on the validity of conclusions drawn). However, the current review attempted to deconstruct these concepts and lay bare the implicit assumptions contained within, taking a cautious approach to handling conclusions.

Summary and Conclusions

Overall, findings in the current review indicate that therapists find it stressful, challenging, and emotionally distressing to work with clients diagnosed with BPD, more so than other diagnoses. It seems that the work involves facing uncomfortable thoughts and feelings in both the client and the self, which is emotionally demanding and involves difficult relational patterns, which many staff prefer to avoid. The clinical context and supervision/ training are important in order to work with this level of complexity and emotional demand. Alongside this, many staff also find the work to be fun and inspiring at times. However, the literature is underdeveloped and has many quality and conceptual issues, meaning more research into the area is required, particularly exploratory research to understand more about staff and service-user experiences.

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Chapter Two: Empirical Paper

Writing online: An interpretative phenomenological analysis with mental health bloggers

Abstract

Background: Weblogs, or 'blogs', are internet-based pieces of writing that can be read and responded to by others who are online, with many taking the format of an online personal journal (Jung, Song, & Vorderer, 2012). A link has been indicated between blogging and improved social wellbeing (Baker & Moore, 2008). Research suggests that blogging appeals to people who feel isolated because of their own difficulties and the associated societal judgments (e.g., difficulties such as managing emotions and connecting with others in the offline world, consistent with a diagnosis of Borderline Personality Disorder).

Aims: The current research asked the question, what is it like for people who write personal journal style blogs? The aims were to explore what the experience of blogging and why people might blog; the links/associations between personality and blogging; and how blogging might or might not be beneficial (including the impact on wellbeing).

Methodology: The design and analysis were based on the principles of Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009). Thirteen participants who self-identified with a diagnosis of BPD were recruited via purposive sampling, and semi-structured interviews were conducted through sequential emailing.

Findings and Conclusions: Five super-ordinate themes were interpreted from the data, including 'Writing Online as Emotional Regulation'; 'The Blog as Communication'; 'The Blog as a Living Document'; 'Online Empowerment'; and 'Problems Associated With Blogging'.

Introduction

Weblogs, or 'blogs', are internet-based pieces of writing, or 'posts', that can be read and responded to by others who are online, with many taking the format of an online personal journal (Jung, Song, & Vorderer, 2012). Journal-style blogs mainly focus on expression of thoughts and emotions, encompassing experiences of mental distress.

Drawing on the existing literature, the therapeutic benefits regarding offline journal writing (as a way to release tension, express emotions, work through feelings, and develop a greater self-awareness and self-understanding; Pennebaker, 2004) could equally be applied to writing a blog (Boniel-Nissum & Barak, 2011). Following on from this, blogging also encompasses a social element enabling support, acceptance, and acknowledgment from an audience (Boniel-Nissum & Barak, 2011; Rains & Keating, 2011; Jung et al., 2012).

A link has been indicated between blogging and improved wellbeing, particularly social wellbeing (Baker & Moore, 2008). Wellbeing can be defined as physical and psychosocial wellness, leading as good a life as possible, and experiencing meaning in life, including through reciprocal relationships (Papadopoulos et al., 2011). Communicating online, via blogs, may create a sense of social wellbeing by

developing feelings of connectedness and belonging, and decreasing feelings of loneliness (Jung et al., 2012; Ko & Kuo, 2009).

The development of connectedness and belonging could also be linked to literature concerning 'perceived social support' (in that, individuals perceive social relationships as providing emotional and instrumental resources, affirmation, and comfort); which can impact positively on coping with stress and enhancing wellbeing (Ammar et al., 2013; Hale et al., 2005).

Furthermore, research suggests that the social aspect of blogging may serve as an 'identity workshop' for individuals to experiment with 'who they are' (McKenna & Bargh, 2000). For example, if an individual feels restricted in their offline roles and responsibilities, or stigmatized by a mental health diagnosis, they may also feel unable to develop or present new or alternative sides of themselves that don't fit with the 'problem saturated story' (White, 2007; McKenna & Bargh, 2000). Blogging could be a space that enables an individual to develop/present new versions of the self and alternative stories of their life, to an audience that is able to acknowledge, validate, and accept through dialogue. A preferred self can be socially constructed, and can continue to be constructed in the offline world (McKenna &Bargh, 2000).

Regarding who might be drawn to, and gain benefit from, personal journal style blogging, the literature indicates people who feel socially anxious or lonely, without large offline support networks; or who feel cut off or stigmatized by society due to health conditions (Baker & Moore, 2011; Amichai-Hamburger, McKenna, & Tal, 2008; McKenna & Bargh, 2000). Further research reports that individuals who may fit into the 'neurotic' group of the Big Five Personality Model (categorised by

anxiety, worry, emotional reactivity, and nervousness); or have 'borderline cognitions' (relating to borderline personality disorder, or 'BPD') may also be drawn to blogging (Blumer, & Renneberg, 2010; McCrae & Costa, 1996; The Diagnostic and Statistical Manual of Mental Disorders 5th Edition). Research suggests that blogging may appeal to people who feel isolated because of their own difficulties and the associated societal judgments (e.g., difficulties such as managing emotions and connecting with others in the offline world, consistent with a diagnosis of Borderline Personality Disorder).

Concerning the literature highlighting personality as a factor, the difficulties associated with a BPD diagnosis include: problems making and maintaining relationships; feeling isolated or 'different'; struggling to cope with strong emotions; struggling with a negative sense of self or having an unstable sense of identity; and dealing with receiving a diagnosis that can be stigmatizing (Hatloy, 2012). However much literature has criticised the diagnostic construct of 'personality disorder'. For example, consideration of how the label can pathologise a person's experiences and locate the problem 'within' the individual; as opposed to more fully recognising the life events that may have contributed to the formation of these particular difficulties (such as chaotic, neglectful, or abusive childhoods) (Berger, 2014; Walker, 2006).

Remaining mindful that BPD can be considered as a psychiatric construct, the concept can be drawn upon to highlight why blogging may appeal to people with this diagnosis, and how they could benefit from the process. For example, developing and maintaining relationships may be experienced as 'easier' online,

due to factors such as greater control over interactions (e.g., rate and pace of communication, and depth of information shared; Blumer & Renneberg, 2010).

Only a limited amount of research has been conducted on blogging to date, with some authors recommending further exploration of individual motives and benefits, and the implications for mental health services (e.g., Younbo et al., 2012; Tan, 2008). Considering quality issues in relation to the existing research, it is mostly with Chinese or Korean populations, or Western adolescents, limiting the generalisability and cross-cultural validity/reliability of the findings. Additionally, very limited research has been conducted on personality as a factor in blogging, with no robust studies drawing on lived experiences of people who blog. Quantitative surveys have been conducted regarding blogging and wellbeing, but again they do not consider the influence of personality, and mostly make assumptions about specific concepts such as 'loneliness' or 'belonging' as being important. Alongside this, only limited research considers the potential hazards of blogging, such as making sensitive personal information available online which could be used inappropriately by others (e.g., Wuyts et al., 2011).

It will be useful to further understand the experiences of people who blog and its effects, and potential links to wellbeing, in order to inform the availability of mental health services. For instance, Dialectical Behaviour Therapy (a National Institute of Clinical Excellence recommended therapy for people with a BPD diagnosis) includes email or phone contact between therapy sessions (Linehan, 1993). Introducing an element of blogging/ computer mediated communication may also be of benefit for service users, particularly in an age where internet communication is already prominent in many people's lives. Additionally, there is a new push

towards peer support networks in mental health services (defined as the help and support that people with lived experience of mental distress can provide to each other; Mental Health Foundation, 2013). This could include a blogging forum to share knowledge, experiences, and emotional, social and practical support, especially for people who may live in rural areas or are house bound.

Aims

The current research asked the question, what is it like for people identifying with BPD who write personal journal style blogs? The aims were to explore what the experience of blogging and the reasons why people might blog; the links/associations between personality and blogging; and how blogging might or might not be beneficial (including the impact on wellbeing).

Methodology

The design was based on the principles of Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009). This is in part due to the narrow scope of research conducted to date. When there is a lack of theory and knowledge, a good first step towards understanding *why* something might be happening is to understand exactly *what* is happening (provision of an initial conceptual description/ interpretation) (Barker, Pistrang, & Elliott, 2002).

Participants and Data Collection

Participants were recruited via purposive sampling in order to generate information-rich, rather than representative and generalizable, data (Smith et al., 2009). This was achieved via advertisements placed on mental health websites;

and approaching bloggers online, directly through their open access blog or linked social media account (through a purpose specific social media account created by the researcher). Following either of these recruitment approaches, participants were directed to the University of Birmingham's website, where there were further details of the researcher and supervisors, and full information on the nature of the study and what was involved (including an information sheet and consent form; see Appendix C.)

Eligibility criteria required participants to be aged between 18 and 65, and to currently or in the recent past, have kept a personal journal style blog. Given that the diagnostic category of BPD has been criticised for reliability and validity, self-identification with BPD was accepted, with no formal attempt to establish accuracy of diagnosis.

Thirty-five people in total made contact with the researcher expressing an interest in taking part. The first 14 eligible participants to volunteer were asked for written informed consent (via email). The remaining 21 people who made contact were thanked for their interest and informed that recruitment had been completed, however, if more participants were required at a later stage (in case of high attrition rates) then the researcher would contact them to enquire if they were still interested in being involved. Following a 24 hour 'cooling off' period between consenting to take part and being involved, the semi-structured interviews began with the 14 included participants. One participant decided not to complete the interviews towards the end of the process, leaving the sample size at 13.

The semi-structured interviews were conducted via sequential emailing rather than face-to-face verbal discussion (in order to remain with the online focus of the

research). This involved the researcher emailing an open-ended question and its prompts; allowing time for the participant to respond; then following up with further exploratory questions where required to elaborate on participants' initial responses. Then, the next question and its prompts were asked and so on, until the interview schedule was completed (see Appendix D. for a copy of the interview schedule). This enabled the researcher to draw out details and elaborate on various points, as well as providing the participant time to reflect on their responses, generating richer data. Participants were also encouraged to share extracts from their blogs to further support the researcher in understanding their lived experiences. This process occurred over a period of several weeks, with the researcher spending an allotted amount of time each day to consistently and regularly respond to participants. Participants responses varied between questions and across individuals regarding the amount of data generated, from single paragraphs to longer replies.

Ethical Considerations

Ethical approval was granted by the University of Birmingham Ethics Committee prior to beginning the research process (see Appendix E.). Informed consent was sought prior to conducting the research, and participants were informed of their right to withdraw from the research process at any point, and for 2 weeks after finishing their interviews. In line with the Data Protection Act (1998) electronic data and information was stored in password protected files. Any personal information provided for the interviews, such as names and email addresses, were separated from the final data set, in order to retain confidentiality and anonymity; and

pseudonyms were assigned to each participant. Emails were sent from a secure university server, which was also password protected.

Data Analysis

Data were analysed through use of IPA. IPA is phenomenological in being concerned with participants' lived experience, and hermeneutic because it considers that experience is only accessible through a process of interpretation on the part of both the participant and the researcher (Smith et al., 2009). IPA is also idiographic, as it is committed to a detailed analysis of each case, selecting a small number of participants for their ability to illuminate specific research questions in greater depth (Smith et al., 2009; Smith & Osborn, 2003). IPA has now become well established as a qualitative methodology in psychology and fits well with the aims of the current research (i.e. to explore participants' experiences of mental health blogging from an inductive, open and reflective stance that is not focusing on already established hypotheses; and to contribute to a greater understanding of mental health blogging within the psychological literature; Smith et al., 2009; Smith & Osborn, 2003).

Data were not transcribed because the email interviews were already represented textually. Each participant's transcript was analysed following guidelines outlined by Smith et al. (2009). In this way, transcripts were read and re-read several times, noting initial ideas, feelings, and observations in one margin; and more abstract psychological concepts and interpretations in the opposite margin. This process enabled the researcher to draw out the inter-relating elements, themes and characteristics that contributed to the experience at hand and the meanings attached to it. Similar topics for each transcript were then clustered into themes;

which were used to cross reference each participant's account, eventually drawing together a superordinate table of themes paying attention to both the similarities and differences across all of the descriptions.

Validity and Quality

Quality criteria developed by Yardley (2000) was drawn upon, for example in relation to 'sensitivity to context' (e.g., awareness of the background literature regarding both blogging and BPD) and 'commitment', 'rigour', 'transparency', and 'coherence' (for example, triangulation with the researcher and supervisors regarding emerging themes). Credibility of analysis was also considered through use of a reflective diary; supervision with 2 psychologists experienced in the use of IPA; and peer supervision with another trainee psychologist also utilising IPA in their own research.

Research as Process

The interviews were conducted via sequential emailing. This was intended to capture some of the experience within the process, as both participants and researcher were 'writing online' to generate the data. Many of the participants reflected on the process of 'writing about their writing' and how this had illuminated understandings they had not considered before (e.g., that blogging had provided many helpful and valued experiences). The researcher also found this process beneficial, in that the experience of writing rather than speaking did feel different to previous research projects, highlighting the benefits and drawbacks of computer mediated communication (CMC) (e.g., attempting to ensure the written words reflected the emotional intention behind them, without the aid of non-verbal communication to support language).

The Researchers

The primary researcher was a trainee clinical psychologist conducting her final year research project at the University of Birmingham. The epistemological position taken reflects a social constructionist stance, considering the co-creation of meaning in the intersubjective space between people. The research was co-supervised by a practising clinical psychologist with experience of supervising IPA research in the field of mental health; and a qualitative researcher with interests in the context and experience of psychological distress.

Findings

Background Information

Participants consisted of 12 females and 1 male, aged between 18 and 50. The mean amount of time participants had been blogging for was just over 4 years, and all blogs encompassed experiences of mental distress alongside other topics of interest (see Table 8.).

Table 8. Participant Characteristics

Participant Pseudonym	Age Range	Gender	Time Blogging
James	41-50	Male	10 years
Lauren	18-30	Female	15 months
Gail	41-50	Female	4 years
Sophie	18-30	Female	3 months
Emma	18-30	Female	3 years
Alexa	31-40	Female	3 years
Hazel	18-30	Female	1 year
Ash	18-30	Female	2 years
Rose	18-30	Female	Unavailable
Rachel	18-30	Female	3 years
Ruby	18-30	Female	4 years
Crystal	31-40	Female	5 years
Zara	31-40	Female	3 Years

Themes

Five super-ordinate themes were interpreted from the data, which will now be considered alongside relevant quotes from participants (see Table 9. for an overview).

Table 9. Superordinate Themes

Super-Ordinate Theme	Sub-Theme	Contributors
Writing Online as Emotional Regulation	Blog as a Containing Space to Project Into	Everyone (except Gail and Zara)
	Processing Emotions	Lauren, Gail, Sophie, Alexa, Ash, Rose, Rachel, Ruby, Crystal
	Ordering Thoughts and Sense Making	James, Lauren, Gail, Sophie, Alexa, Ash, Rose, Rachel, Ruby, Crystal
The Blog as Communication	Computer Mediated Communication (CMC) as Different to Offline Communication	James, Emma, Alexa, Hazel, Ash, Rose, Rachel, Ruby, Crystal, Zara
	Communicating to a Specific Audience	James, Lauren, Gail, Sophie, Emma, Alexa, Ash, Rose, Rachel, Zara
	Communicating to a Generic Audience	Lauren, Gail, Sophie, Emma, Alexa, Ash
	Therapeutic Group Factors	Everyone (except James)
The Blog as a Living Document	The Blog Reflecting a Journey	Everyone (except Crystal and Zara)
	The Blog as 'Testimony'	James, Lauren, Emma, Ruby, Zara
	The Blog as Constructing a 'Real Me'	Everyone (except Lauren, Hazel, and Crystal)
Online Empowerment	BPD as a Diagnosis of Exclusion – Having a 'Voice' to Speak Out	Everyone (except James, Hazel, Rose, and Crystal)
	Pro's and Con's of a Diagnostic Label	Alexa, Hazel, Rose, Crystal, and Zara

Problems Associated With Blogging	Experience or Fear of Receiving Negative Feedback	Lauren, Gail, Sophie, Hazel, Ruby
	Experience or Fear of Having no Response	James and Ash
	Issues With Confidentiality	James, Lauren, Gail, Emma, Ash, Rose, Crystal, and Zara

Writing Online as Emotional Regulation

The act of writing about their experiences online seemed to help emotionally regulate almost all of the participants. For many, the blog served as a containing space to project emotional distress into. Projection is a psychoanalytic concept referring to the process of moving distress outwards, away from the self (Lemma, 2003). Containment refers to Bion's notion of a space that is able to receive these projected thoughts and emotions, contain them, and communicate them back in a more digested manner (Bion, 1967). This can be interpreted from many of the participant's transcripts, such as Alexa's description:

> *My blog is a tool to help me cope with living with Borderline Personality Disorder. At 3am, it is there for me to vent all of my thoughts and emotions to. It is a bit like having a friend...you can work out what to do by putting your problems into words on a page. I find writing very therapeutic, and it has always helped me to cope. I can tell my blog when I am happy, sad, angry or depressed. (Alexa, line 211)*

Bion (1967) suggests the process of containment restores the capacity in the individual to manage their feelings, and think about them without becoming overwhelmed. This was reflected by Sophie: “Blogging helps me to organise my jumbled thoughts into something more coherent.” (line287); and Ruby:

> *It helps me deal with emotions that I have no outlet for. Previously I would have dealt with this by self-harming and other maladaptive behaviours. It helps me to be happier to some degree. I helps me during the day deal with things because I think about what I might write later rather than focusing on the bad feelings or difficult situation in the moment, so that can help minimise the dysregulation I experience. (Ruby,line967)*

Participants, like Ruby, often used mental health terminology (e.g., ‘maladaptive’ and ‘dysregulation’) to describe their difficult thoughts, feelings, and behaviours, perhaps absorbed from services or other people writing online. These terms are discussed in relation to the process of ‘venting’ and moving distress outwards, projecting this into the blog as words on a page. This process enabled participants to make sense of their experiences, feeling more able to ‘cope’ with them.

The Blog as Communication

Relating to communication, the blog appears to be multi-purpose, incorporating a ‘personal, social, and political’ agenda. Concerning the ‘personal’ aspect, computer mediated communication (CMC) is clearly noted as being different to

offline communication. It appears that CMC regulates an apprehension of being 'seen' for most participants, related to a sense of vulnerability (in that allowing others to see the pain and distress being experienced is anxiety-provoking). By taking time to construct a reflective narrative, the fear of being misunderstood by others is slightly alleviated. This is highlighted by Alexa:

> *Give me words to write, and I feel at peace. I can twist them and shape them into a beautiful gift which people can relate to. Give me words to say, and it often comes out sounding wrong…if you are having a conversation verbally, you have to engage with the reactions of the person you are speaking to. Online you don't need to have that level of attention - so I can write a blog post when I am feeling depressed and not have to worry about how I look or sound, because nobody can actually see me. It is an extra layer of protection, I think. (Alexa,line456).*

CMC provides a safe distance that feels more controlled, through the absence of physical and verbal representation. Additionally, CMC enables mediation of content, level of self-disclosure, and pace of discussion for the writer; alongside filtering the response of the reader, also reflected in Ash's words:

> *Part of the appeal for communicating things in writing is the space that it gives people to think about it properly. I remember when I was a teenager I would sometimes write a letter to my parents about things that were going*

on, because it was better for them to be able to talk to each other about it, and digest the information because too often they would react emotionally and end up being angry or scared of what I was going through. Thinking about it, that's probably why I find blog writing so helpful. That's also probably why I shy away from the immediacy of telling people how I feel in person! (Ash,line562).

Ash describes different mediums of written communication as being helpful throughout her life, including letters when she was a teenager. Participants, like Ash, can seek connection with others through the written word, whilst feeling protected from the immediacy of interactions. Support can still be sought without fear of the response becoming emotionally overwhelming. It also provides the reader with time and space to process and digest the information, enabling a more helpful and contained reaction.

Some participants value CMC as a way to reach a specific audience, such as friends and family, because of the way in which it regulates communication (as discussed above) but still promotes an open and sharing relationship:

[my audience are] Friends. Those that read it anyway. I can tell sometimes through twitter or skype conversations if they have. Doesn't bother me at all if they haven't. It's there IF they want…So my audience are those people who know it's me. No-one else. And I'm just really keeping them up to date

with me and mine rather than just me and bpd (even though it seems to mainly be bpd). (James, line448).

Other participants also communicate with a more generic audience, often to promote mental health awareness and challenge stigma (a 'political' agenda):

Blogging is also an opportunity to share your experience with others. In terms of mental health, this can be very effective in reducing stigma, and for me, that was a big part of blogging as well. Although as a personal blogger I wouldn't expect to particularly tackle what is making the headlines, I hoped by writing my own experiences people might be able to see that I am just a young woman who happens to have a mental health problem but it doesn't make me big and scary like can be portrayed. (Emma,line233).

Emma described wanting to make a difference to the way that people with mental health diagnoses are viewed in society; attempting to deconstruct the societal expectation of what a 'mentally ill' person is; and normalise these experiences as being part of a typical person's life, that does not define the person's whole identity.

From the data, almost all of the participants also touch on a 'social agenda', very much aligned with Yalom's therapeutic group factors (1995). This is discussed explicitly by Hazel: "I would describe it as a way of joining the online community which acts in a similar way to conventional support groups. I can share my

experiences, ask advice, or simply use it to vent” (line214); and also reflected by Rose: ““I think there is an aspect of validation - hearing other people say 'I feel that too' is very helpful for me” (line 421). This includes the instillation of hope, creating the expectation that things will get better, and that recovery is possible; a shared sense of universality, regarding the experience of not being alone in their struggles; the process of imparting information to others, and the reciprocal giving and receiving of support; and a sense of cohesion and belonging (all of which also fit with the concept of ‘social wellbeing’):

> *At times my blog has helped me work through realisations about me and my condition and allowed me to share new learning and to gain appropriate validation for the progress I have been making…with a wider pool of people in 'recovery' it is easier to find more people I can identify more readily with. (Gail, line 213).*

It appears that all participants utilised their blog as a space to communicate with others. This included for personal reasons, such as seeking support and connection with friends and family, whilst feeling protected from the immediacy of emotional interactions. It emerged from the data that many participants felt anxious about communicating their distress to others, finding it difficult to let people see their pain. This was related to an anxiety about what the other person might do with this perceived vulnerability, for example, if they might be judgemental, rejecting, or overwhelming in some way. Both the writer and the reader have more time and space to convey and digest written information, unlike

in a face-to-face interaction which can be more emotionally reactive and lead to conflict and misunderstanding.

Despite this anxiety, all participants continued to communicate with others through their blog. Almost all participants found that the response from the blogging community was supportive, experiencing a sense of connection and identification with others in similar situations (related to the benefits of therapeutic group work, such as increased hope in recovery and improved wellbeing). Participants also outlined how the blog facilitated a political agenda, for example, in challenging the ways in which mental distress is constructed unhelpfully in society, and attempting to normalise these experiences.

The Blog as a Living Document

All of the participants were at different stages in their lives and their journeys of recovery. For most participants, the blog reflects where they are in their journey, often beginning writing online at crisis point, when they felt most alone and isolated. The blog changes over time alongside the individual, documenting how they are travelling through life:

> *My initial blogs were very self-conscious and reflected my own confusion at the time…Essentially I think that my blog reflects the changes that have been taking place in my life as I have moved through the DBT therapy and am continuing beyond discharge. I have established stable foundations for my life and blogging has become an activity which is part of the changes I have made. (Gail, line178).*

As part of this, participants documented important events and junctures in their life. For some, this included writing about traumatic experiences:

> *I agreed with my Named Nurse that I would start writing about what professionals have named my 'trauma.' It would be hard because for the first time in a long time, I wasn't going to leave anything out; no missing details. So I began the blog for these two reasons; as a way to document my journey and to speak without feeling I had to censor anything at fear of any kind of retribution. (Lauren,line177).*

Herman (2010) suggests that individuals who have experienced trauma in their lives may reach a point in their journey of recovery where they find it helpful to reconstruct and transform the trauma narrative:

> *Quite often I write about past events in a more narrative/descriptive style, basically like it's not me and kind of romanticising the setting etc. I find it can help 'put to bed' certain events that trouble me from the past, I like the control of the retelling. (Ruby, line212).*

In the telling, the trauma story becomes a 'testimony', to which others may bear witness. This can enable an individual to feel a sense of emotional healing, transforming the trauma story from one of shame to one of dignity, reclaiming control over what has been lost (or unable to have been formed to begin with). This relates to Narrative Therapy, which posits that individuals can claim back

their story and their voice, re-authoring their lives from being problem-saturated, to 'thicken' the alternative, preferred narratives (such as stories of resistance and courage; White, 2007).

It seems that for some of the participants, their blog did serve as an 'identity workshop' to play with their self-narrative, and construct a more coherent self, noted strongly in Zara's reflections:

> *My blog is my attempt to get back in touch with the 'me on the inside'. So much of my personality and creativity was suppressed by my upbringing. I have a strong conviction that if I could reprise the parts of myself that were lost I would have a more stable, grounded self-perception, even an identity (something I've never felt I've had before – my abusive background made me too proficient at delivering what people wanted rather than being myself). (Zara, line 264).*

Goffman (1990) compares social interaction to a theatre, in which 'actors' (individuals) are on the stage of life, performing a version of the self in front of an audience. Through this performance, an individual is able to give meaning to themselves, to others, or their situation, in front of others; enabling an identity (or role) to be accepted, validated, and confirmed (or not, depending on audience response). It may be that participants use their blog as a safe space within which to play with 'who they are', and find what they believe to be a 'real me' that fits

more comfortably, and is more desired, than how they may previously have been constructed by others offline:

> *There's a gulf between the 'me on the inside' (the real me) and the 'me on the outside' (the me I present to the world). I feel if I can bring the two selves closer together I would decrease the amount of dissonance and anxiety I experience. At the moment, the closest I come to communicating as the real me is like this, in writing. I'll know I'm making progress when I can replicate how I speak here in the real-time world… My hope is that I become proficient enough at expressing my genuine self through writing that it will start to flow from my lips. (Zara, line308).*

The blog appears to be a 'living document' that grows and changes with the individual writing it. Participants use the space to record what has happened in their lives, including extremely difficult and traumatic experiences, that shape who they are and how they identify themselves. The blog serves the purpose of recording and documenting; but additionally, facilitates others to 'bear witness' to participants' life stories. In this manner, life is not only documented, but actively constructed and reconstructed – events from the past can be re-told and re-narrated in order to emotionally heal and feel in control; and, like Zara suggests, different 'selves' can be integrated and presented to others (e.g., the 'me on the inside', the 'real me', the 'genuine me', and the 'me others see') until an individual feels less fragmented, and more integrated and comfortable with their own self-concept.

Online Empowerment

It appears that for many participants their journey to diagnosis was confusing or distressing, and the help available was limited. This led to participants needing to write about their distress or seek alternative support:

> *The diagnosis was made in an appalling fashion, being just in a copy of the letter sent to my GP after my assessment, no-one to sit me down and explain, no offer of help - just words on a piece of paper. I wrote about my diagnosis in many blog posts, on my own site and for [charity] and as a guest blogger on other blogs. (Crystal, line489).*

It seems that BPD was a diagnosis of exclusion for many participants, who felt stigmatised by society, including mental health services. This was highlighted by Emma: “In real life, a lot of people are judgemental and ignorant to mental health. I've documented it a lot on my blog about how difficult I have found some health care professionals” (line475); and Ruby:

> *I think it's a shame the label carries such negative connotations, and that beyond that there's such little understanding of it. I hate that mental health in general is so stigmatised that I can't tell people it's a factor in my life. I've tried to share it to close friends but had very negative experiences, that's a reason I blog - I find people online I identify with and think my blogs speak*

to people who may understand what my friends and family can't. (Ruby line791).

Feeling excluded, and often isolated, offline, meant participants sought a space where they could re-connect with people who did understand and empathise (i.e., the mental health blogging community). This indicates that many participants felt 'different' and stigmatised in their offline lives, having to search for alternative communities in which they felt a sense of belonging. Foucault (1965, 1973) has spoken about the ways in which power works in society, and how people who are 'different' are marginalised, and silenced. Ash discusses her experiences of this, feeling like she was disempowered and her voice ignored, prompting her to find a platform from which she could maintain her voice and challenge discrimination:

The thing that prompted me to start blogging was my experience of living in sheltered accommodation. A part of me wanted to expose what it was really like, and another part of me wanted to keep my voice heard. I had become quite ill, and I found that a lot of people just assumed that I needed babysitting and didn't still have opinions and thoughts and feelings. Also, the experience of living there made me feel like I was at the bottom of society and didn't really matter, so publishing some of my thoughts online was empowering in lots of ways. (Ash, line 245).

Wanting to challenge discrimination and address issues of power in society was a shared experience amongst many of the participants. The concept of 'writing online' emerges from the data, in that many participants identified with a political purpose that went beyond keeping an online journal (i.e. participants felt empowered to utilise their blog as a platform from which to speak out rather than remain silenced, challenging stigma and experiences of marginalisation). This is observed in Rachel's comments: "One of my main goals maintaining a blog is to act as an information source for people." (line73); and appears strongly in Sophie's words:

> *What prompted me to start? Well a need to be heard, a need to reach out to others like me and to explain myself to those who aren't like me…What keeps me blogging now? Sheer determination and the need for more people to understand what it's like to have a mental illness and for those who have one to feel understood and less alone…I continue because I'm sick of suffering in silence, without a voice, with the majority of the world not having a clue what it's like to have a mental illness and judging as a result or just feeling at a loss to know what best to say or do to help. I keep going to raise awareness and I hope to inspire others to keep on keeping on. (Sophie, line 249).*

Apparent in Sophie's description is the shared nature of challenging stigma, and how many participants felt connected to a wider political movement in society. The concept of a BPD diagnosis was prominent in these discussions of stigma and

marginalisation, with many participants reflecting on the benefits and drawbacks of receiving the label, like Hazel: “I hate personality disorders and especially BPD and the stigma that surrounds it. A personality disorder suggests that there is something inherently wrong or broken with the patient” (line 425); and Rose:

> *[I] am not a fan of the term BPD, I don't find it a helpful one… My issue is really with the use of the term 'personality disorder'. I feel it locates the problem in the core of the person, rather than understanding BPD as a response to experiences. From a feminist point of view I feel uncomfortable with labelling women who are often victims of abuse as having something 'wrong' with their personality. It's like a permanent form of victim blaming. (Rose, line 674).*

It surfaces that for many participants, mental distress and BPD is bound up with their blogs. The benefits and drawbacks of the diagnosis are prominent and ongoing sources of discussion in many participants’ lives; and the experience of feeling different, stigmatised, and silenced is shared. Numerous participants use their blog as a way to maintain their voice, challenging societal power dynamics and discrimination. This often occurs collectively, as part of an empowering community, in which a sense of belonging has developed. This community is also continued offline, by involvement for several participants in national mental health campaigns.

Problems Associated With Blogging

Most participants also outlined some problems associated with blogging. For some individuals, this included an experience, of fear of, receiving negative feedback:

> *My writing is probably where I fear criticism the most. Even posting on here knowing that anyone in the world could come across it, terrifies me if I think about it too much… My past has led to a real fear of criticism which can affect my blogging but blogging on a regular basis is also my way of fighting back against that. The more I write, usually the better I feel. (Sophie, line 364).*

This links to earlier themes, concerning the anxiety many participants faced in relation to letting others see their distress. This was linked to apprehension of what the response of the reader would be, in that it may be judgmental, rejecting, or in some way overwhelming. Writing may be where criticism is feared most because this is also the arena in which most participants feel most able to share details about themselves that could create feelings of vulnerability. There is fear of the unknown in terms of how the reader will respond. Apparent for all participants, and noted in Sophie's comments above, is a desire to continue communicating with others despite this fear, finding ways to manage the anxiety. A significant way of handling this anxiety is the distance, space, and mediated interaction that CMC facilitates; and the context of a supportive online community.

For some participants, the concern was about receiving no feedback at all:

It's very unnerving to know that you've got 17 page views, and nobody has said a word about it. Sometimes I think it's because I write stuff that's too personal, and people get overwhelmed by that. Sometimes it makes me angry, and I wonder why I bother writing a blog at all. (Ash, line *424).*

This may be where fear of the unknown comes into sharper focus – if readers have not commented, the writer does not know how their communication has been received. Not knowing could precipitate contemplation and concern regarding what might be in the mind of the other, anticipating that it is harsh, critical, or rejecting. This could lead to thoughts of withdrawing, through stopping blogging, like for Ash; but the current participants all explained how the difficulties encountered were outweighed by the therapeutic benefits they perceived.

Some participants remained anonymous online, while others were open about their identities. This was mostly due to concerns around confidentiality, either for themselves or for others. For example, some participants were concerned of the implications regarding their mental health team:

I would feel very uncomfortable with anyone from my Mental Health Team reading my blog, even though I strive to be fair and avoid writing anything that would identify anyone individually - I have never named my Community Team or the hospital I was in for that reason. (Rose, line 368).

This included concerns that staff would be unhappy that they had been identified; or participants preferring to keep some aspects of their lives private from their care team. The anxiety regarding other people holding information about participants was apparent, in that, if participants were communicating to a specific audience of friends and family, they may not necessarily want to share all of these experiences with others, such as mental health staff, or people at work. The concern about work colleagues was outlined by Crystal:

> *Most people were supportive but a few expressed concerns in particular about the possible impact of using my own name online and how this could affect employment opportunities. Now that employers have a tendency to 'spy' on a candidates online behaviour, writing openly about mental health problems could potentially be career damaging. This did concern me to a degree but I felt not being open would be even worse. I have since presented to my most recent employers team about my mental health problems, which led to a decision to train mental health first aiders in the workplace, a positive response, I believe. (Crystal, line 631).*

Crystal's reflections link with earlier themes, regarding stigma and marginalisation in society towards those who experience mental distress. Concerns regarding the discrimination she may face if future employers 'find out' about her difficulties are visible, similarly to other participants. However, Crystal, and others, chose to speak out about this kind of marginalisation and discrimination, rather than remain compliant with existing power dynamics in society. Using her blog as a platform,

Crystal challenges the idea that it is acceptable to limit a person's career due to mental health problems and associated judgments regarding their capability in the work place.

There were also some concerns about how family members might react, or the legal implications if a crime (e.g., abuse) was going through the courts:

> *I worry about how my family will react if they ever read the blog as it's not always complimentary towards them. I worry that I will be criticised for feelings and memories that can still be raw at times but I also hope that I can provide comfort to people that need it as they read how at least one of other person in the world understands what they are going through. In fact there are many of us experiencing these issues. (Sophie, line 334).*

Sophie sums up many of the participants' concerns, discussing the overall worry regarding the reactions and responses of others. This includes the reactions of friends and family, staff, employers, and wider society. Despite these fears, participants continue to blog, finding ways to manage concerns and anxieties, and connecting with each other in doing so. This mutual support, and finding their own boundaries for online communication, helps to manage problems with blogging for the current participants (e.g., in remaining anonymous, or not naming staff members; or challenging stigma through writing online about discrimination).

Discussion

The current research aimed to explore the lived experience of bloggers who self-identified with BPD, and wrote online about their mental health. Overall, these particular participants' outlined many therapeutic benefits, and some difficulties. Five super-ordinate themes were interpreted from the data, including 'Writing Online as Emotional Regulation'; 'The Blog as Communication'; 'The Blog as a Living Document'; 'Online Empowerment'; and 'Problems Associated With Blogging'.

All participants discussed the blog as a helpful way to regulate emotions and make sense of their thoughts. This was linked to the process of projecting their distress into the blog, which acted as a containing space. The process of moving internally held distress outwards, to become words on a page, enabled participants to manage their emotions and make sense of their jumbled thoughts.

Alongside this process of writing, the social element of blogging became apparent. For example, all participants touched on fear of letting others see their distress, but wanting to connect and communicate with friends and family or a wider community. Through computer mediated communication (CMC) participants were able to seek this connection and support, whilst feeling protected from the immediacy of face-to-face interactions. Due to this added layer of protection, many participants discussed relationships being easier to engage with online (e.g., in keeping friends and family up to date with their lives and experiences through a medium that facilitated self-expression in a safer, less immediate, and contained way). These findings align with other literature on CMC, indicating benefits such

as more control over rate, pace, and depth of communication (McKenna &Bargh, 2000).

From the data, it appeared that participants began their blog whilst at crisis point, when they felt at their most isolated and unwell, and in their greatest need of support. This resonates with the literature indicating who might be drawn to and benefit from blogging (i.e., people who are at an extremely difficult point in their life, and feeling anxious and isolated; Baker & Moore, 2011; Amichai-Hamburger et al., 2008; McKenna & Bargh, 2000). The reciprocal process of both receiving and providing support was important for many participants. The online community contributed to their wellbeing, including a sense of connection and belonging for most participants, instilling hope in their own future and feeling understood by others who had shared similar experiences in life (universality). This correlates with Yalom's (1995) therapeutic group factors, with current participants likening their online experiences to those of belonging to a conventional offline support group. This may be especially important for people who feel isolated, or marginalised by society due to their mental health difficulties.

These findings also fit with previous research indicating a link between blogging and improved wellbeing, through the process of connecting with like-minded others and an increased sense of perceived social support (Jung et al, 2012; Baker & Moore, 2008). This also chimes with Pennebaker's (1997) research highlighting that when individuals share their thoughts and feelings with others through writing, they can feel more socially integrated and socially supported.

As participants moved on from crisis point, the blog changed and reflected their journey in life. For some participants, this included telling their stories of trauma,

and reclaiming their sense of power, control, and a greater understanding of what they had been through. This aligns with research documenting how writing facilitates catharsis, awareness, and making sense of thoughts (Pennebaker, 2004); and the literature discussing the healing power of narrating a trauma 'testimony' (Herman, 2010; White, 2007) reflected by Lauren who wrote about her past trauma:

> *It's become somewhere for me to process my thoughts and feelings on things that have gone on. I've also received a lot of praise for my blog and to be told by just one person that I've helped them, is enough to make me continue blogging. (Lauren, line 211).*

Having a wide audience that can bear witness to, and validate, records of trauma and re-narration of the past, whilst also being inspired themselves, distinguishes blog writing from other forms of narrative therapies. For example, documents that are written online have the potential to be read and responded to by many different people and online communities, which could provide a strong therapeutic effect for both the writer and the reader; but also potential risks, as noted by some participants who raised concerns regarding who held sensitive information about them.

Many participants did outline the hazards of making information about themselves available online, such as the implication for their work lives or their mental health care, and issues of confidentiality if they discuss family members and friends.

However, all participants felt that this was a manageable problem, with some choosing to remain anonymous to avoid these potential pitfalls; and others finding ways of working with it (such as setting boundaries for the level of information shared; or challenging discriminatory practices).

From the data, the notion of online empowerment emerged strongly. Participants felt empowered to speak out about their life experiences, and maintain a voice in the face of marginalisation and discrimination. The fear of judgment, criticism, and rejection from others was mediated through the sense of protection afforded by CMC. Empowerment has been suggested as linking an individual and their wellbeing to the wider social and political context; and has been associated with mutual help, responsive communities, and increased feelings of control and competence (Amichai-Hamburger et al., 2008). Writing has been linked to feelings of personal empowerment (Pennebaker & Seagal, 1999); and in other literature, the internet has also been indicated as a possible space for empowerment (for example, in constructing an identity that is socially validated, increasing feelings of self-efficacy and self-reliance, identifying with and helping others, and increasing wellbeing; Amichai-Hamburger et al., 2008; Barak, Boniel-Nissim, & Suler, 2008). For current participants, empowerment and improved wellbeing were strong themes, aligning with the wider literature.

Some participants valued the community as a way to experiment with their identity, and construct a more coherent sense of self within a supportive environment. Social constructionism emphasises that there is not just one ‘true’ version of reality, but rather that meaning is co-created in the space between individuals, acknowledging the importance of the interpersonal exchange of ideas

(White, 2007). This perspective resonates with some of the current participants' experiences; alongside the broader literature taking a discursive approach to online interaction, which suggests that language is not simply a passive medium that transmits information; but rather, is a social action that actively constructs meaning, dynamically defining and redefining identities (Lamerichs & TeMolder, 2003). For current participants their blogs often became a space to present and integrate different aspects of the self in dialogue with supportive others (Goffman, 1990).

For participants who felt silenced and marginalised due to their mental health problems and other, often related, situations (such as becoming homeless) the blog became a platform from which to maintain a voice and challenge societal judgment and stigma. For many participants, this provided a sense of meaning and purpose in life, especially when coming together with other people who also wanted to challenge stigma both online and offline.

In summary, the current participants described their blogs as a way to manage their thoughts and emotions; connect with others; record and narrate their life stories with a supportive audience; develop and integrate different aspects of their identity in dialogue with others; and challenge the stigma surrounding mental health. Some difficulties were outlined, such as fear of reader response, and others holding sensitive information about them; but all participants felt these issues could be managed, as the therapeutic benefits outweighed any problems.

The current research findings contribute to the understanding of what blogging is like for people identifying with BPD, and their motivations for writing online. It highlights potential points of therapeutic benefit (e.g., sharing writing within a

supportive online community that also serves to mediate fear of self-expression); and ways specific difficulties with interpersonal communication, and identity, may be explored by individuals who experience distress in these areas of their life.

Limitations

There are several limitations within the current research. Participants were approached via purposive sampling, which could have implications for findings, e.g., the participant sample was not random and hence not representative of the wider population. However, the methodology intended to illuminate the specific experiences of a particular group of people, and so the research does not attempt to generalise findings to the wider population.

Additionally, participants were currently, or very recently, blogging (which is how they were identified for purposive sampling). This may indicate bias regarding the views of the people who chose to volunteer, in that they may have held strongly positive beliefs about blogging. The research, therefore, may have failed to capture the experiences of people who hold less favourable views, and had stopped writing online because of this. However, participants in the current study did identify drawbacks and difficulties, and so the themes represented do attempt to cover the limitations as well as the benefits of blogging.

Finally, the interviews were conducted via sequential emailing. This was intended to include some of the experience of writing online within the process of the research. However, this technique may have missed information or prompts that could have been captured in verbal, face-to-face conversations. The data generated was reflected upon in supervision, and deemed rich enough to interpret in line with the tenets of IPA.

Clinical Implications and Recommendations for Future Research

The research findings indicate helpful therapeutic benefits of blogging for this set of participants. The research was conducted with a purposive sample, intended to generate data on the specific phenomenon at hand. Therefore, the findings are not intended to be generalizable. However, the conclusions drawn would indicate that other people may also benefit from mental health blogging, which would be helpful to investigate further.

For example, more qualitative studies could be conducted with larger sets of participants, intended to generate theories describing the mechanisms through which therapeutic benefit is attained through blogging. This could draw on Grounded Theory methodologies for instance, which gathers synthesises, analyses, and conceptualises qualitative data to construct a theory (Smith, 2008).

Additionally, further research could focus specifically on how blogging could be applied within clinical settings and the outcomes of this. For example, Gail noted benefits in line with Yalom's (1995) therapeutic group factors, and as part of this, talked about how blogging alongside her DBT therapy has been helpful:

> *One of the key planks of DBT is the idea of 'contributing' and I had been helped in particular by other BPD bloggers such as [Blog Address]…Both of these bloggers had positively managed their conditions using DBT and this encouraged me to persevere with my own mindfulness practice…[I have] focused on my experience of DBT, BPD and what has helped me to*

recover. It helps to belong to a community of like minded individuals. (Gail, line 188).

This fits with previous literature which has documented the benefits of combining blogging with therapeutic interventions (Boniel-Nissum & Barak, 2011). It may be beneficial to pilot a blogging element within a DBT course of therapy (to begin with, being mindful of ethical and risk issues, this could be a closed blogging community, with only service users involved in the offline DBT programme participating) and evaluate the process and outcome. However, it is also important to consider that people who are drawn to blogging may also be people who are drawn to writing interventions, in that not every individual who would like to access therapy would also find a writing intervention helpful.

The current research was conducted with people who self-identified with BPD, linking with previous research indicating who might be drawn to blogging. It may be helpful to further understand how personality may impact on blogging, by comparing and contrasting findings with other client groups identifying with a variety of mental health difficulties. It may be that personality does impact on who decides to blog and how they experience the process; or many people may experience similar benefits and difficulties, regardless of what mental health problems they may be facing.

In conclusion, more research is required regarding how blogging may be clinically beneficial; in which conditions, and who, it works best for; and how it might work practically; alongside any ethical considerations and potential problems.

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Chapter Three: Public Domain Briefing

Literature Review

Outline

This literature review was completed by Laura Dennick and presented as part of a thesis submitted to the School of Psychology, University of Birmingham, for the qualification of Doctor of Clinical Psychology (Clin.Psy.D).

Introduction and Rationale

Personality Disorder (PD) is a diagnostic classification applied to people who experience persistent and longstanding difficulty in relation to the self and others. Within this, the category of Borderline Personality Disorder (BPD) is well-represented in clinical services, and incorporates problems in areas such as: affect (e.g. rapidly fluctuating emotional experiences); extreme feelings of anxiety and depression; and experiences of impulsivity or risk taking (defined by the Diagnostic and Statistical Manual of Mental Disorders 5th Edition; DSM-V).

Considering the difficulty for this client group in managing relationships and emotions, it can be understood how mental health staff could become frustrated in their efforts to engage with their clients, feeling 'stuck' with what to do next. Research demonstrates that staff often do find this work difficult, complex, and challenging, more so than working with clients with other diagnoses (e.g., Bourke &Grenyer, 2013).

In 2003, the guidance 'Personality Disorder: No Longer a Diagnosis of Exclusion' was published by the National Institute for Mental Health in England, to encourage

the development of services for those with PD diagnoses, including Borderline Personality Disorder (BPD). Unfortunately, research shows that many clients still experience BPD as a diagnosis of exclusion. In order to understand why this is still happening, it is important to explore clinicians' experiences of working with this client group – what it is like, how they feel about it, how it impacts on them, and how it is managed.

Aims and Objectives

A previous brief review was conducted by Sansone and Sansone (2013) which focused broadly on the 'responses' of all mental health staff to working with a BPD client group. In contrast, the current review intends to choose depth over breadth; and so the focus will be specifically upon the full experience of staff providing therapy only, who have clinically engaged with clients diagnosed with BPD.

The main research question posed in the current review is: what does the literature suggest it is like to work with clients diagnosed with BPD? The primary objective is to identify research exploring the impact on therapists, and synthesise the findings to provide a coherent narrative of the literature.

Method

Three databases were searched for keywords, including Psychinfo, Web of Science, and Embase. See Volume I, Table 1. for search terms.

The search yielded 1,950 results in total. After duplicates were removed, 600 records remained. Each study was screened via its title and abstract, in line with the eligibility criteria, producing 24 full text eligible studies. Reference lists of each full text article were read, and one additional paper was identified. Five studies

were excluded in line with eligibility criteria, leaving 20 research articles to be reviewed.

The studies were assessed using an adapted quality criteria framework (developed from Kmet, Lee, & Cook, 2004; Sale & Brazil, 2004) and categorised as either high, moderate, or low quality. See Volume I, Appendix B for an overview of reviewed studies.

Findings and Conclusions

Twenty studies were identified and reviewed, including case studies, survey designs, and qualitative explorations. Quality varied, with only 60% deemed to be of high quality with very few minor flaws. This indicates that the literature to date is underdeveloped and in need of further investigation.

Findings from all of the studies indicated this work as being challenging and complex, with some difficult experiences of therapeutic work considered from a variety of angles including stress and burnout; negative staff attitudes; and demanding transference/ countertransference experiences. Some of the studies indicated the BPD group was experienced as more challenging in comparison to other diagnostic categories (e.g., in establishing a therapeutic relationship). Additionally, some authors reported that therapists trained with social or psychological underpinnings were more caring, empathetic, and optimistic towards the work than medically trained staff. Several authors suggested that specialised training, regular supervision, increased years of experience, and increased frequency of contact with this client group was positively related to the ability of staff to work well with this client group, such as having more empathy and less judgment towards clients.

Overall, findings in the current review indicate that therapists find it stressful, challenging, and emotionally distressing to work with clients diagnosed with BPD, more so than other diagnoses. One of the most difficult aspects was in managing risk and destructive behaviour. It seems that the work involves facing uncomfortable thoughts and feelings in both the client and the self, which is emotionally demanding and involves difficult relational patterns, which many staff prefer to avoid. The clinical context and supervision/ training are important in order to work with this level of complexity and emotional demand. Alongside this, many staff also found the work to be fun and inspiring at times.

However, the literature is underdeveloped and has many quality and conceptual issues, meaning more research into the area is required, particularly exploratory research to understand more about staff and service-user experiences. For example, many papers discussed the concept of holding a 'negative/ positive attitude' and some implied consequences of this (i.e. that a 'negative attitude' leads to negative quality of care. However, the papers included in the current review did not define a 'negative attitude', how it might differ to a 'positive attitude', and the mechanisms through which this impacts on care (all of which the full review addresses).

Limitations

Limitations in the current review included use of several studies that did not focus specifically on therapists' alone, but incorporated a variety of staff groups. This may have influenced the conclusions drawn, in that some views represented may belong to professional groups not engaging in therapy. However, care was taken

to extract the data relating to therapists alone as much as possible dependent on the clarity of the reviewed papers.

Additionally, some of the reviewed literature was of poor quality (i.e., major flaws with methodology or analysis, affecting reliability, credibility, and generalisability) and the concepts contained (such as attitude) not being fully sound (which could impact on the validity of conclusions drawn). However, the current review attempted to deconstruct these concepts and lay bare the implicit assumptions contained within, taking a cautious approach to handling conclusions.

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Empirical Paper

Outline

This study was completed by Laura Dennick and presented as part of a thesis submitted to the School of Psychology, University of Birmingham, for the qualification of Doctor of Clinical Psychology (Clin.Psy.D).

Introduction and Rationale

Weblogs, or 'blogs', are internet-based pieces of writing, or 'posts', that can be read and responded to by others who are online, with many taking the format of an online personal journal (Jung, Song, &Vorderer, 2012). Journal-style blogs mainly focus on expression of thoughts and emotions, encompassing experiences of mental distress.

A link has been indicated between blogging and improved wellbeing, particularly social wellbeing (Baker & Moore, 2008). Wellbeing can be defined as physical and psychosocial wellness, leading as good a life as possible, and experiencing meaning in life, including through reciprocal relationships (Papadopoulos et al., 2011). Furthermore, research suggests that the social aspect of blogging may serve as an 'identity workshop' for individuals to experiment with 'who they are' (McKenna & Bargh, 2000).

Research suggests that blogging appeals to people who feel isolated because of their own difficulties and the associated societal judgments (e.g., difficulties such as managing emotions and connecting with others in the offline world, consistent with a diagnosis of Borderline Personality Disorder, or 'BPD').Concerning the literature highlighting personality as a factor, the difficulties associated with a BPD

diagnosis include: problems making and maintaining relationships; feeling isolated or ‘different’; struggling to cope with strong emotions; struggling with a negative sense of self or having an unstable sense of identity; and dealing with receiving a diagnosis that can be stigmatizing (Hatloy, 2012).

It will be useful to further understand the experiences of people who blog and its effects, and potential links to wellbeing, in order to inform the availability of mental health services. For instance, Dialectical Behaviour Therapy (a National Institute of Clinical Excellence recommended therapy for people with a BPD diagnosis) includes email or phone contact between therapy sessions (Linehan, 1993). Introducing an element of blogging/ computer mediated communication may also be of benefit for service users, particularly in an age where internet communication is already prominent in many people’s lives.

Aims and Objectives

The current research asked the question, what is it like for people who write personal journal style blogs? The aims were to explore what the experience of blogging and why people might blog; the links/associations between personality and blogging; and how blogging might or might not be beneficial (including the impact on wellbeing).

Methodology

The design and analysis were based on the principles of Interpretative Phenomenological Analysis (IPA; Smith, Flowers, and Larkin, 2009). Thirteen participants who self-identified with a diagnosis of BPD were recruited via purposive sampling, in order to generate information-rich, rather than

representative and generalizable, data (Smith et al., 2009). The semi-structured interviews were conducted via sequential emailing rather than face-to-face verbal discussion (in order to remain with the online focus of the research). This involved the researcher emailing an open-ended question, allowing time for the participant to respond, then following up with prompts or further exploratory questions where required. Then, the next question was asked and so on. Each participant's interview transcript was analysed following guidelines outlined by Smith et al. (2009).

Findings and Conclusions

Five super-ordinate themes were interpreted from the data, including 'Writing Online as Emotional Regulation'; 'The Blog as Communication'; 'The Blog as a Living Document'; 'Online Empowerment'; and 'Problems Associated With Blogging'. In summary, the current participants described their blogs as a way to manage their thoughts and emotions; connect with others; record and narrate their life stories with a supportive audience; develop and integrate different aspects of their identity in dialogue with others; and challenge the stigma surrounding mental health. Some difficulties were outlined, such as fear of reader response, and others holding sensitive information about them; but all participants felt these issues could be managed, as the therapeutic benefits outweighed any problems.

Limitations

There are several limitations within the current research. Participants were approached via purposive sampling, which could have implications for findings,

e.g., the participant sample was not random and hence not representative of the wider population. However, the methodology intended to illuminate the specific experiences of a particular group of people, and so the research does not attempt to generalise findings to the wider population.

Additionally, participants were currently, or very recently, blogging (which is how they were identified for purposive sampling). This may indicate bias regarding the views of the people who chose to volunteer, in that they may have held strongly positive beliefs about blogging. The research, therefore, may have failed to capture the experiences of people who hold less favourable views, and had stopped writing online because of this. However, participants in the current study did identify drawbacks and difficulties, and so the themes represented do attempt to cover the limitations as well as the benefits of blogging.

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Volume 1 Appendices

Appendix A.

Quality Criteria Framework

Quality Criteria Developed from:

Kmet, L., Lee. R.C. and Cook, L.S. (2004). 'Standard quality assessment criteria for evaluating primary research papers from a variety of fields.' *Alberta Heritage Foundation for Medical Research*

Sale, J.E.M., and Brazil, K. (2004). 'A strategy to identify critical appraisal criteria for primary mixed-methods studies.' *Quality and Quantity* 38 351-365 – which draws on the framework by Lincoln and Gruba (1985, 1986).

Quality Criteria – Qualitative

Criteria	Key
Introduction/ Background/ Aims/ Rationale	
Question/ objective is not sufficiently described	A
Transferability: no sufficient statement of purpose	B
Transferability: no sufficient statement of research questions	C
Design	
Study design is not sufficiently evident/ described	D
Study design is not appropriate	E
Transferability: the context of the study is not sufficiently clear or described	F
Transferability: why the context of the study was chosen is not sufficiently clear or described	G
There is no sufficient connection to a theoretical framework/ wider body of knowledge or it is not described	H
There is no sufficient statement or discussion of the research paradigm	I
Transferability: the sampling strategy is not sufficiently described	J
Transferability: the sampling strategy is not relevant/ appropriate/ justified	K
Transferability: no sufficient description of participants	L
Transferability: no sufficient rationale for qualitative methods	M
Transferability: data collection methods are not sufficiently described	N
Transferability: data collection methods are not systematic/ appropriate	O

Transferability: (if appropriate) no sufficient description of audiotaping, transcribing, field note taking etc.	P
Credibility: informed consent not stated	Q
Credibility: consent procedures not stated or described	R
Credibility: confidentiality protection not stated	S
Credibility: ethical considerations not sufficiently stated or discussed	T
Analysis and Findings	
Transferability: data analysis is not sufficiently described	U
Transferability: (if appropriate) coding techniques not described	V
Transferability: (if appropriate) data saturation not stated	W
Transferability: (if appropriate) no sufficient description of raw data	X
Credibility: no sufficient triangulation of sources	Y
Credibility: no sufficient triangulation of methods	Z
Credibility: no sufficient triangulation of researchers	*AA*
Credibility: no sufficient triangulation of theory/ perspective	*AB*
Credibility: no sufficient peer debriefing	*AC*
Credibility: negative case analysis or searching for disconfirming evidence	*AD*
Credibility: no sufficient use of quotations	*AE*
Discussion/ Conclusion/ Reflexivity	
Conclusions drawn are not sufficiently supported by the findings	*AF*
Transferability: reflexivity is not sufficiently evident or described, e.g. through use of journals or logbooks etc.	*AG*
Consistency: no sufficient discussion of external audit of process	*AH*
Consistency: no sufficient discussion of external audit of data and reconstruction of data	*AI*
Consistency: no sufficient statement/ discussion of bracketing	*AJ*
Consistency: no sufficient statement/ discussion of researcher's assumptions	*AK*

Quality Criteria – Quantitative

Criteria	**Key**
Introduction/ Background/ Aims/ Rationale	
External validity: question/ objective is not sufficiently stated or described	1
External validity: no sufficient statement of purpose	2

External validity: no sufficient hypothesis stated	3
Design	
External validity: study design is not sufficiently evident/ described, e.g. case study, cross sectional, RCT etc.	4
Study design is not appropriate	5
External validity: data gathering procedures not sufficiently described	6
External validity: no sufficient description of data collection instruments or source of data not described	7
Method of participant selection or source of information selection is not sufficiently stated or described i.e., sampling frame not identified	8
Method of control/ comparison group selection or source of information selection is not sufficiently stated or described i.e., sampling frame not identified	9
Method of participant selection or source of information selection is not appropriate/ justified	10
Method of control/ comparison group selection or source of information selection is not appropriate/ justified	11
External validity: no sufficient discussion of inclusion/ exclusion criteria	12
External validity: sample size is not sufficiently defined or described	13
External validity: sample size is not appropriate	14
External validity: participant characteristics are not sufficiently described	15
External validity: control/comparison group characteristics are not sufficiently described	16
Internal validity: (If applicable) no statement about comparability of participant and control group at baseline	17
If interventional and random allocation was possible, this was not sufficiently stated or described	18
External validity: if interventional and blinding of researcher was possible, not reported or sufficiently stated or described	19
External validity: if interventional and blinding of participant was possible, not sufficiently stated or described	20
External validity: selection of control/ comparison group not described	21
Internal validity: Informed consent not stated	22
Confidentiality protection not stated	23
Internal validity: confounding/ extraneous variables not identified/ discussed	24
Internal validity: no controlling for confounding/ extraneous variables	25
Intervention (if applicable)	

External validity: (if appropriate) no sufficient description of intervention	26
Internal validity: (If applicable) no statement about comparison group being treated equally apart from intervention	27
Reliability: no sufficient statement or discussion of standardization of observers	28
External Validity: no statement about non-respondents/ attrition rates	29
Analysis and Findings	
External validity: missing data not sufficiently addressed	30
Method of analysis is not sufficiently described	31
Method of analysis is not appropriate/ justified	32
External validity: outcome and (if applicable) exposure measure(s) are not well defined/ described	33
Outcome and (if applicable) exposure measure(s) are not robust to measurement/ misclassification bias	34
Some estimate of variance is not reported sufficiently/ correctly	35
External validity: no power calculation to determine adequacy of sample size	36
External Validity: statistical procedures are not sufficiently stated/ described	37
External validity: *p* value not stated	38
External validity: confidence intervals not provided	39
Discussion/ Conclusion/ Reflexivity	
Results are not reported in sufficient detail	40
Conclusions drawn are not sufficiently supported by the results	41
External validity: both statistical and clinical significance together are not sufficiently acknowledged or discussed	42

Quality Criteria – Case Study

Yin (1993) makes a distinction between three key types – 'exploratory', 'explanatory', and 'descriptive'. Exploratory cases are considered as an introduction to social research in areas where little is known about a certain topic. Explanatory case studies may be used for doing causal investigations. Descriptive cases require a descriptive theory to be developed before starting a project. Stake (1995) offers three further types: the 'intrinsic case', when the researcher has an interest in the case; the 'instrumental case', when the case is used to understand more than what is obvious to the observer; and the 'collective case', when a group of cases is studied.

Criteria	Key

No rationale provided for why the particular person for the case study was chosen	43
Not clarified if it is a single or multiple case study	44
No discussion of aims/objectives	44a
No sufficient discussion of when and where the case study data was collected	45
No sufficient discussion of the method/ procedure used to gather the data (e.g. assessments, clinical interviews etc) and no rationale for these methods	46
No valid interpretation of the assessment data offered	47
No discussion of bias/ personal reflections on these interpretations	48
If there is a formulation, not supported by assessment data or not linked to wider theory/ literature	49
If there is an intervention, no clear description of this (including rationale, aims, etc) or not suitable/ appropriate	50
No valid evaluation	51
If appropriate, no discussion of data analysis	52
If data analysis has been carried out, utilize qualitative or quantitative criteria above for relevant sections.	
No practical suggestions offered as a result of the conclusions drawn	53
No sufficient evidence of clear and credible reflective practice	54
No sufficient evidence of critical thinking	55
Anonymity/ confidentiality not explicitly discussed	56

Quality Traffic Light System:

RED (Poor Quality) : Major flaws with methodology, e.g., no description of how measures or questions were generated and no discussion of their reliability, validity or credibility such as links to the wider literature. AND/OR major flaws with the results, e.g. inappropriate or insufficient data analysis (such as a lack of robust statistical analysis or discussion of credibility of analysis etc) which would then impact on any conclusions drawn.

Amber (Moderate Quality): Some, to many, minor issues highlighted by the quality criteria which are not addressed by the authors, but no major flaws with the method or analysis.

Green (High Quality): Very few minor flaws which are addressed by the authors, but overall scoring highly on the quality criteria with no major limitations.

Appendix B:

Study Characteristics Table

Paper Num-ber	Authors	Title	Journal Details	Coherent Epistemol ogical Position	Sample	Method of Data Collection	Method of Data Analysis	Reflexivity (re: self as researcher & research as process)	Quality Issues (in reference to quality criteria framework – see Appendix A)
1	Black, D.W., Pfohl, B., Blum, N., McCormick, B., Allen, J., North, C.S., Phillips, KA., Robins, C,. Siever, L,. Silk, K.R,. Williams, J.B., and Zimmerman, M.	Attitudes Toward Borderline Personality Disorder: A Survey of 706 Mental Health Clinicians	CNS Spectrums Vol. 16 (3). 2011 pp 67-74 DOI: 10.1017/S1092852912000020X	Quantitativ e – survey design.	706 mental health clinicians (227 psychiatrist s, 126 psychiatry residents, 98 social workers, 97 nurses, and 89 psychologi sts, 17 nurse practitioner / physician assistants, and 52 other clinicians)	31 item Self report questionnaire with a Likert style scale (1= strongly agree, 7= strongly disagree). Administered at 9 academic centres (USA). 15 items concerned clinician attitudes towards BPD. Demographic info also collected. (Survey response rate was less than 50%.)	An ordinal logistical regressio n model; and an analysis of covarian ce (ANCOV A).	None	**1:** The 'introduction' dos not define BPD. Rationales for exploring clinician attitudes are stated but not sufficiently discussed. **4:** Not explicitly discussed. **7**: The 'Method' only states what 15 items were, does not state what the other 16 are. Does not discuss how the survey was developed or who by or its validity/ reliability. No example questions provided (some can be seen in the results tables later on though) and it does not discuss what constitutes a 'caring attitude' or how empathy or treatment optimism will be assessed for. Hence, this limits how results can be linked back to the goals of the study (goal to examine attitudes, but attitudes are not defined, discussed, or deconstructed); and causes validity and reliability problems. **8**: Does not state why or how the chosen participants were selected (e.g., if it was random or purposive sampling etc.) **12**

									15: ’52 other clinicians’ completed the survey – does not state what this includes. **22, 23, 24, 25, 30** **31:** does not describe what the statistical test is or why it was chosen in sufficient detail. **36, 37, 39** Overall, the results section is confusing to read and is not presented clearly, nor does it flow coherently. **41, 42** The ‘Discussion’ does not sufficiently discuss the findings. The ‘Conclusion’ does adequately discuss some limitations of the study, e.g., non-despondence possibly skewing findings and the survey not being standardised. My opinion: an average paper with a lot of limitations/ quality issues. In the discussion the authors mention a training programme they are running to educate staff regarding BPD called STEPPS (systems training for emotional predictably and problem solving). This should have been discussed/ declared more clearly at the introduction.

									Traffic light rating: **Red**
2	Bodner, E., Cohen-Fridel, S., and Iancu, I.	Staff attitudes toward patients with borderline personality disorder.	Comprehensive Psychiatry. 2011 Vol.52 (5) pp. 548-555. DOI: 10.1016/j.comppsych.2010.10.004	Quantitative – survey design.	57 clinicians (25 nurses, 13 psychologists, and 19 psychiatrists).	Self-report questionnaire using a Likert style rating scale (1= strongly disagree, 5= strongly agree) administered to clinicians who had worked in mental health settings for over 1 year, across several psychiatric institutions. 47 items regarded cognitive attitude (required treatment, suicidal tendencies, and antagonistic judgment); and 20 items regarded emotional attitude (negative emotions, experienced difficulties in	Regression Stepwise Analysis; and multivariate analysis of variance (MANOVA)	None	Good introduction and clear rationale. However, as the research cited is from a variety of countries, and the current research was conducted in Israel, it would have been good to have some discussion of research conducted cross-culturally and cross-cultural validity. **3:** No hypothesis stated (but aims/goals are clearly stated). Good method – clearly describes development of the measures and how reliability/validity issues were addressed; and all questions are available to see. **4:** Not explicitly discussed. **24, 25, 29, 36, 39** Limitations discussed by the authors include having a rather small non-random sample, collected from central hospitals only in a small country. My opinion: Overall a good paper, well written, clear, and of good quality.

						treatment, and empathy). Demographic data also collected.			Traffic light rating: **Green**
3	Bourke, M. E., and Grenyer, B. F. S.	Therapists' accounts of psychotherapy process associated with treating patients with borderline personality disorder.	Journal of Personality Disorders. Vol.27(6), Dec 2013, pp. 735-745.	Mixed Methods: survey design, but responses were then analysed for themes.	20 therapists (17 doctoral level and 3 masters level clinical psychologists). The therapists were to draw from 2 clients they were each working with who were primarily diagnosed with BPD, and also 2 clients primarily diagnosed with major depressive disorder. They were surveyed	The psychotherapy Relationships Questionnaire was utilised (an already established measure). This is 90 item self-report measure, which looks at relational patterns consistently expressed by the client towards the therapist in order to look at transference issues. Items are rated on a Likert style scale (1 = not true, 5 = very true). There are 6 factors: hostile, narcissistic, compliant/ anxious, positive working alliance, avoidant/	Multi Level Modelling (MLM); and Content Analysis (computer software programme underpinned by statistical processes)	None	Good introduction, summary of previous research, and rationale. Method: good description of the sample. **S/ 23,** ***AE:*** No quotations, This was content analysis so can be understood, but it would help to see more of the context of the responses to fully understand. **36** ***AF/ 41:*** although I can see why the authors are drawing the conclusions they are, the content analysis felt much more quantitative than qualitative although it was supposed to be mixed methods. It would have benefitted from being much more embedded within the raw data, and incorporating more quotations. The authors suggest some of their own limitations: snowball sampling not being representative of a wider population.

					using a snowball sampling technique, in order to compare therapist's emotional responses to working with these 2 client groups. The sample was recruited from community health facilities.	dismissing, and sexualised.			My opinion: overall a well written paper of good quality. However, it lacked elements to make a good qualitative paper, and felt more like a quantitative paper than a mixed methods paper. Traffic light rating: **Amber** (no/ limited quotes to support the conclusions)
4	Bourke, M. E., and Grenyer, B. F. S.	Psychotherapists' response to borderline personality disorder: A core conflictual relationship theme analysis.	Psychotherapy Research. Vol.20(6), Nov 2010, pp. 680-691.	Quantitative – survey design.	20 therapists were recruited from community healthcare facilities via snowball sampling. This consisted of males and females	Semi-structured interview. The core conflictual relationship themes (CCRT) method was utilised to record participants' responses. This is designed to measure pervasive and problematic relationship themes. This	Multi level modelling (MLM)	None	Good introduction to BPD, and rationale for why they are exploring transference in BPD **4** – Not explicitly discussed. **23** **24/25:** Not discussed **36, 37, 39** **41:** When discussing reasons for findings, seems to put most of the difficulty as originating from the client

					who were doctorate level (n = 17), and masters level (n = 3) clinical psychologists. 14 practiced CBT and 6 interpersonal-dynamic therapy. Each therapist was working with both 2 clients diagnosed with BPD (n = 40) and 2 diagnosed with MDD (n = 40).	includes exploring what the therapist wanted to do in the interaction (intent), how the therapists experienced the client (their perceptions), and what the therapists actually did and felt (responses to the client).Responses were transcribed for analysis, and patterns found in personal narratives are coded and converted to standardised categories that could then be statistically analysed.			(transference and countertransference) but this feels quite blaming, and seems to miss what might be brought to the interaction by the therapist. Additionally, it feels like it is generalising about what a 'BPD client' and an 'MDD client' are like and how they respond interpersonally – this is very dubious in my opinion, as a diagnosis does not account for the whole person, e.g., someone with a diagnosis of MDD does not necessarily have very easy interpersonal interactions just because they do not have a 'personality disorder'. The discussion introduces a few extracts from participants' - although the paper is quantitative this feels late to introduce this, rather than presenting this alongside the results. Hence, it would have been helpful to see some of the quotations from participants', to contextualise the findings more and thus lend more support to the conclusions drawn. The author's highlight their own limitations: snowball sampling may not be representative of a population and thus limits generalizability; and self-report data may be biased e.g., to avoid judgment (here mentions this as a confounding variable, but this was not discussed earlier on).

									Traffic light rating: **Amber** (no/limited quotes to support the conclusions)
5	Cambanis, E. V. A	Treating borderline personality disorder as a trainee psychologist: Issues of resistance, inexperience and countertransference.	Journal of Child and Adolescent Mental Health. Vol.24(1), Jul 2012, pp. 99-109. DOI: 10.2989/17280583.2011.639075	Case study	1 trainee clinical psychologist writing a case study regarding a client they worked with who was diagnosed with BPD.	The case study is drawn from clinical work over 8 sessions.	N/A	Shows lots of reflection regarding the therapeutic work with the client.	**Qualitative quality Criteria:** **F:** the setting where the case study occurred is not descried. **Q, R, S, T** (although pseudonyms have been used) In my opinion, a good case study. **Case Study Criteria:** **45** **56 (**Not explicitly discussed, although pseudonyms have been used) Traffic light rating: **Green**
7	Colli, A., Tanzilli, A ., Dimaggio, G., and Lingiardi, V.	Patient Personality and Therapist Response: An Empirical Investigation	American Journal of Psychiatry Vol. 171 (1) 2014 pp 102-108	Quantitative – survey design	A random national sample of psychiatrists (35%) and clinical psychologists (65%) (n = 203) who worked in centres specialising in treating personality disorders recruited by email.	The Shedler-Weston Assessment Procedure-200 was utilised to assess the personality disorder diagnosis of the clients. The Therapist Response Questionnaire was utilised, to identify patterns of therapists' emotional	SPSS partial correlations.		Good definition of what they mean by emotional response. **23** **35, 36, 39:**. Results section is very brief. Authors discuss their own limitations: the same therapist provided info regarding the client's personality disorder and their own responses to this (bias); there were more axis II disorders in the client group than axis I; and it was self-report (bias, e.g., fearing judgment).

					Theoretical approaches were either cognitive-behavioural (n = 100) or psychodynamic (n = 103). Each therapist completed the measures regarding one of their clients (n = 203).	responses to their clients diagnosed with personality disorder (not BPD specific). The measure consists of 79 items measuring thoughts, feelings, and behaviours expressed by therapists' towards their clients. Eight countertransference responses are derived by factor analysis: overwhelmed/ disorganised, helpless/ inadequate, positive, special/ overinvolved, sexualised, disengaged, parental// protective, and criticised/ mistreated. Demographic information also collected.			My opinion: a well written paper with few quality issues. However, the discussion could have provided some more hypotheses as to why they found what they did. Traffic light rating: **Green**

11	Draper, M. R., and Faulkner, G. E.	Counseling a student presenting borderline personality disorder in the small college context: Case study and implications	Journal of College Counseling. Vol.12(1), 2009, pp. 85-96. DOI: 10.1002/j.2161-1882.2009.tb00042.x	Case study. The therapist identifies working from an interpersonal and object relations theoretical framework; and her supervisor works from a dialogic perspective, which focuses on the meaning and perspective people take on relationships and their world. The formulation is from an object relations perspective.	1 counselor's (1st year doctoral student in counselling psychology) work with a 19 year old female client diagnosed with BPD, in a Catholic women's college.	Data collected from 3 months of therapy sessions.	N/A	None	**Qualitative Quality Criteria:** **I** **N:** no overview of the assessment process **Q, R, T, *AF, AG,*** ***AK:*** The overview of the client comes across as quite judgmental, using words such as "promiscuity" (although there is a very good overview of the therapist and even their supervisor, there is no declaration of the author's assumptions and biases, e.g., if they chose to work at a catholic college due to reasons of spirituality and may hold beliefs about sex outside of marriage). My opinion: I get a negative vibe from this case study, from the language used and the way the client is described – it seems that the therapist held negative attitudes towards the client but fails to explicitly address this, such as anger, frustration, helplessness, rejection etc. Considering the orientation of the therapist, I would have expected more discussion of transference and countertransference and what the therapist was bringing to the interaction.

									Case Study Quality Criteria: **46, 48,** **51** (client stopped attending) **54, 55, 56,** Traffic light rating: **Amber**
12	EL-Adl, M., and Hassan, S.	The borderline patient: Mental health clinicians' experience and views.	Arab Journal of Psychiatry. Vol.20(2), 2009, pp. 135-146.	Quantitative – survey design	185 mental health personnel (40 psychiatrists, 100 nurses, 25 social workers, 14 occupational therapists, and 6 psychologists)	A cross-sectional survey was sent to all clinicians working in an adult mental health service (response rate 69%)..	Just percentages are reported but analysis is not directly addressed.	None.	**7:** no description of what the survey was or how it was developed (reliability and validity not discussed) **12, 15,** **31:** Doesn't state how data was analysed at all, just provides percentages in the results section, linking to **32:** no justification for why stats have not been used, so **35, 36, 37, 38, 39** **40:** results section is very brief and very poor, just providing overall percentages, it doesn't even break it down according to professional group and make any comparisons. **42** My opinion:: very brief and without sufficient detail. More like a very small service evaluation than research.

									Traffic light rating: **Red**
13	Jimenez, Xavier F	Patients with borderline personality disorder who are chronically suicidal: Therapeutic alliance and therapeutic limits	American Journal of Psychotherapy. Vol.67(2), 2013, pp. 185-201	Case study	1 therapist's (4th year psychiatry resident) experiences of working with 1 female client in her late 30's diagnosed with BPD, utilising DBT. The setting was a women's intensive outpatient program.	Data was collected from 16 weeks of 35-40 minute weekly individual sessions and weekly phone calls.	N/A	Evidence of reflecting as part of the therapeutic work.	**Qualitative Quality Criteria:** **I** **N:** no description of the assessment phase **Q, R, S, T, *AG*** ***AK:*** A better description of the therapist was needed. My opinion: a long case study that includes a lot of material. Quite interesting to read. **Case Study Quality Criteria:** **46, 55, 56** Traffic light rating: **Amber**
14	Krawitz, R., and Batcheler, M.	Borderline personality disorder: a pilot survey about clinician views on defensive practice.	Australasian Psychiatry. (2006). 14 (3). pp 320-322	Quantitative – survey design	29 mental health staff (inpatient and community, consisting of 14 nurses, 6 psychologists, and 4 psychiatrists)	Survey asking about beliefs and behaviour towards this client group, rated on a likert style scale.	Descriptive data was generated.	None	**6** **7:** more depth required, does not address reliability or validity etc. **8, 12** **14:** too small **15, 22, 24, 25** **31, 32:** no justification for why statistics were not used, hence **35, 36, 37, 38, 39.** Results were too brief, with no discussion of the different

									responses from different professional groups. **40, 42** My opinion: too small a sample, no statistics, so again feels more like small scale service evaluation rather than research. Traffic light rating: **Red**
15	Liebman, R. E., and Burnette, M.	It's not you, it's me: An examination of clinician- and client-level influences on countertransference toward borderline personality disorder.	American Journal of Orthopsychiatry. Vol.83(1), Jan 2013, pp. 115-125.	Quantitative – survey design	560 clinicians currently providing treatment (257 psychologists, 81 psychiatrists, and 231 psychotherapists/ social workers)	Anonymous online survey – participants read case information describing a client with either a male typical (alcohol use) or female typical (MDD) diagnosis. The 4 vignettes were identical except for age and gender of client. Following this, participants then answered questions to assess their reactions to the client across 7 domains regarding the person in the vignette: if it was	2x2 between subjects design (age and gender). SPSS: Chi Square and logistic regression.	None	Very thorough intro/ background/ rationale. **24, 25, 36** My opinion: very good paper with solid grounding in the literature and robust methodology and data analysis. Traffic light rating**: Green**

						a behavioural problem vs mental illness; distrust; interpersonal efficacy; empathy; chronicity; dangerousness and conduct problems. Answers were rated a 4-point Likert style scale. The scale was developed from versions of existing surveys, and piloted for validation with a student sample. Demographic info was also collected.			
16	Mcintyre, S.M., and Schwart, R.C.	Therapists' differential countertransference reactions toward clients with major depression or borderline	Journal of Clinical Psychology. Vol. 54, (7), 1998 pp. 923–931 DOI: 10.1002/(SICI)1097-	Quantitative – survey design	155 psychotherapists from a variety of theoretical orientations.	Participants listened to a typical diagnostic interview session (BPD or MDD). Following this, the Impact Message Inventory (assesses personal response, to	SPSS: ANOVAS		Good explanation of countertransference. **12, 24, 25, 36, 39** My opinion: A good, thought through paper grounded in literature with a robust method and analysis. Traffic light rating: **Green**

		personality disorder.	4679(199811)54:7<923::AID-JCLP6>3.0.CO;2-F			include dominant, hostile, submissive, friendly); and the Stress Appraisal Scale (to include caring, consequences, demands, perception, skill, and success) to evaluate direct feelings, action tendencies, cognitive attributions, and perceived anxiety were completed in response to the recording. Both use likert style scales. Demographic info was also collected.			
17	Millar, H., Gillanders, D., and Saleem, J.	Trying to make sense of the chaos: Clinical psychologists' experiences and perceptions of clients with	Personality and Mental Health. Vol.6(2), May 2012, pp. 111-125. DOI: 10.1002/pmh.1178	Qualitative – IPA. The authors discuss phenomenology	16 female clinical psychologists (9 trainees and 7 qualified staff) working within one clinical psychology	Four focus groups, using semi-structured interviews, were conducted.	IPA	Some, but limited, i.e. this is mentioned but not discussed in any depth.	Discusses the theoretical concept of attachment as the basis for understanding relationships between staff and clients in the introduction. **L:** Participants are described according to their job role and how they were accessed etc., but there's no table representing who the participants were with a bit more background story and pseudonyms (participants are referred to as simply

		'borderline personality disorder'.			department in NHS Scotland (so they already knew each other).				'participant 1' etc.). It would have felt richer to have a sense of who the participants were. Good description of methodology and how analysis was carried out. **Q, R, S, T –** these all relate to no mention of consent, confidentiality etc. ***AA, AC:*** no discussion of how themes were reflected on, e.g., with other researchers, no information on who the researchers were etc. ***AG, AH, AJ, AK:*** no discussion of reflexivity or reflecting on themes with others etc. The discussion is quite short. The authors point out the limitation of using a focus group with colleagues (e.g., participants may be more selective about what they say). My opinion overall: A good paper, clear ad well written, that seems to have carefully planned, carried out, and understood the research process. However, for an IPA paper it would have been good to have more information about the researchers, the participants, and more evidence of reflexivity – these issues are mentioned but not fully explored or

									discussed. However, this may have been for word limit reasons. Traffic light rating: **Green**
18	Miller, G. D., Iverson, K. M., Kemmelmeier, M., MacLane, C., Pistorello, J., Fruzzetti, A. E., Crenshaw, K. Y., Erikson, K. M., Katrichak, B. M., Oser, M., Pruitt, L. D., and Watkins, M. M.	A Pilot Study of Psychotherapist Trainees' Alpha-Amylase and Cortisol Levels During Treatment of Recently Suicidal Clients With Borderline Traits	Professional Psychology: Research and Practice. Volume 41(3), 2010, p 228–235 DOI: 10.1037/a0019118	Mixed Methods Quantitative – cross sectional. stress hormone analysis and survey too.	6 therapists in training (a psychiatry resident, a post-doctoral therapist, 1 masters level counselling and educational psychology student, and 3 clinical psychology trainees) who were working with a pool of 18 clients using either DBT or psychodynamic therapy.	Participants provided salivary samples immediately before and after 2 selected sessions (mostly from work with the same client over the period of 1 year) to be analysed for levels of alpha-amylase (AA) and Cortisol (C). Participants also completed a working alliance questionnaire (12 items, with subscales of therapeutic bond; agreement between client and therapist on tasks, and agreement on therapy goals); and rated perceived session difficulty	Linear mixed models.	None	**14:** only 6 people is small, but it is over a year long period. **23, 24, 25, 31** (not enough detail, I wouldn't be able to replicate it), **36, 37, 39** My opinion: A good paper, but issues with sample size and not a detailed enough analysis section. Traffic light rating: **Amber**

						after each selected session.			
19	Perseius, K.I., Kaver, A;.,Ekdahl, S., Asberg, M., Samuelsson, M.	Stress and burnout in psychiatric professionals when starting to use dialectical behavioural therapy in the work with young self-harming women showing borderline personality symptoms.	Journal of Psychiatric and Mental Health Nursing. Vol.14(7), Oct 2007, pp. 635-643.	Mixed methods	22 participants (2 physicians, 2 psychologists 8 nurses, 8 mental health care assistants, and 1 occupational therapist). All had extensive experience of working with BPD.	Participants completed the Maslach burnout inventory general survey (MBI-GS) was administered at the start, twice during, and once at the end of the intervention programme. This consists of 16 items concerning exhaustion, cynicism, and personal efficacy, A free format questionnaires was provided at the end of the intervention; and group interviews were conducted 2 months after the end o the intervention. Questions addressed feelings towards the work before and after the intervention, and experiences of stress.	For the inventory, descriptive statistics and t-tests and chi-square tests. Content analysis on questionnaire's. This then guided the development of the questions for the interviews. The interviews were again analysed using content analysis.	Authors did discuss reflecting on the content analysis, but not much evidence of seeing the research as process.	Very thorough introduction and design section. Might have been helpful to have a more detailed overview of participants, but some relevant information was provided. **14:** only 22 participants for the quantitative analysis is quite small. **36, 39.** ***AJ, AK*** My opinion: Overall a very good paper, easy to read, no major limitations and minor limitations are addressed. Traffic light rating: **Green**

20	Rossberga,J.I., Karteruda, S., Pedersenc, G., and Friis, S.	An empirical study of countertransference reactions toward patients with personality disorders.	Comprehensive Psychiatry. Vol 48 (3), 2007, pp. 225–230	Quantitative - Survey	11 participants working in the department for personality psychiatry at a hospital in Oslo (1 psychiatrist, 1 resident, 1 psychologist, 1 art therapist, 1 physiotherapist, 1 social worker, and 5 nurses).	Participants filled out the Feeling Word Checklist-58 (FWC-58) 2 weeks after admission and 2 weeks before discharge concerning 71 clients in a day programme (71 regarding the checklist on admission; 54 including the checklist on discharge too). The checklist consists of 58 feeling words, across 7 dimensions: important, e.g., empathic, caring; confident, e.g., relaxed, calm; rejected, e.g., disliked, disparaged; on guard, e.g., anxious cautious; bored, e.g., aloof, indifferent; overwhelmed, e.g., surprised, confused; and inadequate, e.g., sad, helpless.	Independent samples t-test. Levenes test.	None	**14:** 11 participants for a quantitative study is quite small. **15:** a bit more detail about participants would have been helpful, but they were described a bit. **22, 23, 24, 25, 36, 39** My opinion: overall a well written paper, but nothing that stands out (it feels quite 'average'). For a paper exploring countertransference, it would have been good to add a qualitative element. Traffic light rating: **Green**

21	Ruggiero, I.	The unreachable object? Difficulties and paradoxes in the analytical relationship with borderline patients.	The International Journal of Psychoanalysis. Vol.93(3), Jun 2012, pp. 341-362. DOI: 10.1111/j.1745	Case study	The author, regarding a client she worked with.	Data taken from the first few months of therapy.	N/A		**43, 44, 45, 46, 56** My opinion: some issues with 'setting the scene' but the main contents were very reflective and interesting to read. It is a case study written from a psychoanalytic perspective so it may not fit the mould of a traditional case study, hence quality issues are highlighted but I think overall it's a very insightful piece of work bearing in mind the theoretical orientation it was written from. Traffic light rating: **Green**
22	Servais, L. M., and Saunders, S. M.	Clinical psychologists' perceptions of persons with mental illness.	Professional Psychology: Research and Practice. 2007 Vol 38 (2), pp 214-219. DOI: 10.1037/0735-7028.38.2.214	Quantitative – survey (cross sectional correlational)	1000 Clinical Psychologists were randomly selected for the APA directory and sent postal information. 306 responded.	Two surveys were provided by post (a professional characteristics questionnaire and an attitude measure) Participants were asked to rate either themselves, a member of the public, or people with a diagnosis of either moderate depression, borderline features, or schizophrenia. on six semantic	One-way within-subjects analyses of variance (ANOVA's) and paired samples t-tests; and regression analyses.	No reflection on research as process	**24, 25, 39** My opinion: a very good paper, draws on wider theory and literature, is clear and reflective, with very minimal quality issues. Traffic light rating: **Green**

						differential scales (like a continuum) comprising of: effective – ineffective; understandable – incomprehensible ; safe – dangerous; worthy – unworthy; desirable to be with – undesirable to be with; and similar to me – dissimilar to me. The ratings were on a 7 point scale, with 1 indicating the most positive end of the scale. Demographic information was also collected.			
24	Egan, S.J., Haley, S., and Rees, C.S. (2014)	Attitudes of Clinical Psychologists towards clients with personality disorders	Australian Journal of Psychology. 66 175-180 DOI: 10.1111/ajpy.12068	Quantitative - survey	81 clinical psychologists were recruited via professional bodies.	The Australian Survey of practicing Clinical Psychologists was completed online. Questions included “what percentage of clients do you have that are diagnosed with a	Bivariate correlations; and hierarchical regression analysis.	No reflection on research as process	**8, 24, 25, 28,** power calculation is discussed, but 85 was needed for a medium effect size and so the sample of 81 falls short of this. My opinion: Good intro, background, and rationale. However, throughout, more clarification about what ‘personality disorders’ encompasses might have been helpful, rather than lumping the different diagnoses

						PD? When was the last time you attended specialist professional development for treating PD?". The Attitude to Personality Disorder Questionnaire was also completed (assesses 5 factors on a likert style scale). Demographics were also collected.			together under the one heading. Very good methodology section. Traffic light Rating: **Green**
25	Rizq, R. (2011)	'There's always this sense of failure': an interpretative phenomenological analysis of primary care counsellors' experiences of working with the borderline client.	Journal of social work practice: psychotherapeutic approaches in health, welfare, and the community. 26 (1) 31-54 DOI: 10.1080/02650533.2011.579695	Qualitative - IPA	5 primary care counsellors.	IPA interview schedule.	IPA analysis.	Yes.	***AA, AH*** (a lone author, and no discussion of talking over themes with other researchers/ supervisors etc. However, did check out themes with the participants) ***AE***(more quotes would have been good) ***AJ*** My opinion: the interview schedule asked relevant questions but needed a bit more work – some questions felt very slightly leading. Good intro, good discussion of IPA, good methodology section. Traffic light rating: **Green**

Appendix C:

Participant Information Sheet and Consent Form

UNIVERSITY OF BIRMINGHAM

Participant Information Sheet

Study Title

Blogging, wellbeing, and personality: An exploration of mental health blogging

Introduction

You are being invited to take part in a research study conducted at the University of Birmingham. Before you decide if you'd like to take part, it is important for you to understand why the research is being done and what it would involve. Please take time to read this information and discuss it, if you wish, with friends or family, and don't rush to decide whether or not you wish to take part. Feel free to get in touch with the study researcher (Laura Dennick) via the researcher's email address (available in the 'researchers details' section) if there is anything that is not clear, or if you would like more information.

What is the purpose of the study?

The purpose of the study is to understand more about people's experiences of keeping a blog that involves talking about their mental health. In particular, why some people might maintain blogs, and what they might get out of it.

Why have I been chosen?

We placed an advert on the websites that host blogs about mental health, or contacted you directly, after finding you through an internet search engine. Search terms included mental health blogging.

Am I eligible to take part?

We want people to take part who identify with a diagnosis of Borderline Personality Disorder (sometimes also referred to as Emotionally Unstable Personality Disorder) or who experience anxiety/ and or depression, and who write blogs focusing on their thoughts, emotions, and experiences (a 'personal journal' style blog). The other eligibility criterion for this part is that you are aged 18-65, live or are permanently based in the UK, and are happy to discuss your experiences with a researcher.

If you are unsure if you are eligible please feel free to contact the study researcher, Laura Dennick, on the email address provided and she would be happy to answer any questions you may have.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to participate you will be given this information sheet and you will be asked to provide written consent via email. If you do decide to be involved, you are free to withhold any personal information or to withdraw at any time, without giving a reason. After participating you can also decide to withdraw any information you have submitted for up to 2 weeks afterwards.

What would taking part involve?

The research will involve having some discussions with the researcher (Laura Dennick) via email. The discussions are over email, and so you can respond at a time and in a location that is convenient to you, and it should take up no more than an hour of your time in total.

Where would I have to go?

The discussion is all online, and so you would not have to go anywhere you would not normally go to access a computer.

What are the advantages and disadvantages of taking part?

One advantage of participating in this research is that you will have an opportunity to express your viewpoints and experiences of writing a personal journal style blog. This may be interesting to do, and for others to hear about. A disadvantage could be taking the time out of your day to be involved. However, the discussions will take no longer than one hour.

Additionally, this research is planned to be published in an international journal, which means that other people can read about the findings. Although no participants will be identified in this research, it would be entirely up to the individuals involved if they choose to share this published research with others.

What if I don't want to carry on with the study?

You may withdraw from the study at any point during the interview and for any reason. Once the interview is complete, you may ask to withdraw any information you provided for up to 2 weeks afterwards.

Confidentiality

All information that is recorded during the course of the interview would be kept anonymous and stored securely. Only members of the research team would have access to these records (see researchers details section). The discussions would be analysed by the researcher to identify what themes come out of the conversations. When discussions are being analysed, participants would be allocated a name different to their own so that it remains anonymous, but the details of what has been said would not be altered, except where it explicitly reveals a participant's identity. The study complies with data protection laws.

What will happen to the results of the study?

The results of this study will be written-up and submitted to an international psychology journal. You could receive feedback on the results of the study if you wanted to. No-one will be explicitly identified in any part of the write-up or article, however quotes will be used to illustrate and explain points. Any quotes used will be allocated to a pseudonym. It would then be up to participants if they wanted to share with others that they had been involved in this research, and share the published findings if they wanted to.

Who has reviewed the study?

The study has been reviewed and approved by the University of Birmingham Research Ethics Committee.

Contact for further information

If you have any questions or concerns about this study, you are welcome to discuss them with the researcher:

Laura Dennick
Trainee Clinical Psychologist
Email: L

The study does not intend to touch upon any potentially sensitive or emotive aspects of participant's lives. If you feel you have been harmed by taking part in this research study, there are no special compensation arrangements. However, if you are harmed by someone's negligence, then you may have grounds for a legal action, but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal University complaints mechanisms should be available to you.

Thank you for taking the time to read this information sheet. If you decide to participate in the study you will be given a copy of this information sheet to keep.

If you have read the information sheet and would like to participate in the study, please email the researcher (Laura Dennick) on the above email, stating:

I have read the information sheet, including the purpose of the study and my role if I am involved; and my right to withdraw at any point during, and for 2 weeks after, my interview. I am aware of how my interview data will be used, and who to contact if I have any queries, complaints, or need support with my mental health. I consent to participate in the study.

Appendix D:

Interview Schedule

Interview Questions

I will introduce how I will ask 4 questions, each with 3 pointers to consider whilst answering, and I will encourage participants to share extracts of their blogs to help illustrate their answers.

1) Can you tell me about your experiences of writing a 'personal journal style' blog, bearing in mind the following pointers, and sharing any extracts from your blog which help to illustrate your answer?
   - How would you describe what you do to someone who is new to this idea?
   - What prompted you to start? What keeps you blogging now?
   - Have you ever taken a break from it, or considered stopping? For what reasons?

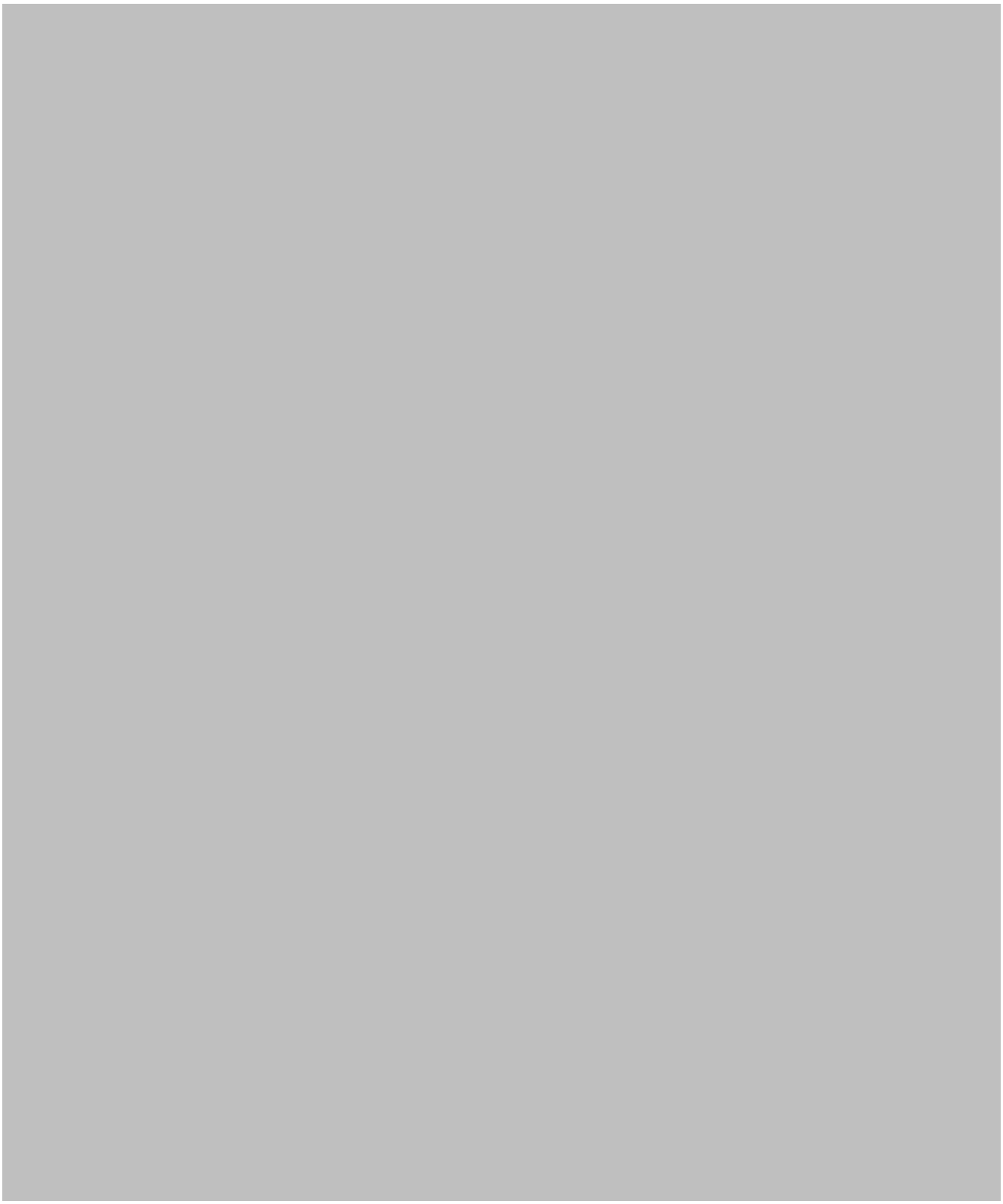
2) Can you tell me a little bit about how you came to be diagnosed with/ identify with the term 'Borderline Personality Disorder' (BPD), bearing in mind the following pointers, and sharing any extracts from your blog which help to illustrate your answer?
   - What do you think or feel about the term BPD?
   - Are your experiences, thoughts, feelings, understandings etc. of BPD, represented in your blog? How?
   - Do you think any of your experiences of writing would be different if BPD wasn't part of the picture? Do you think you'd still have been drawn to blogging?

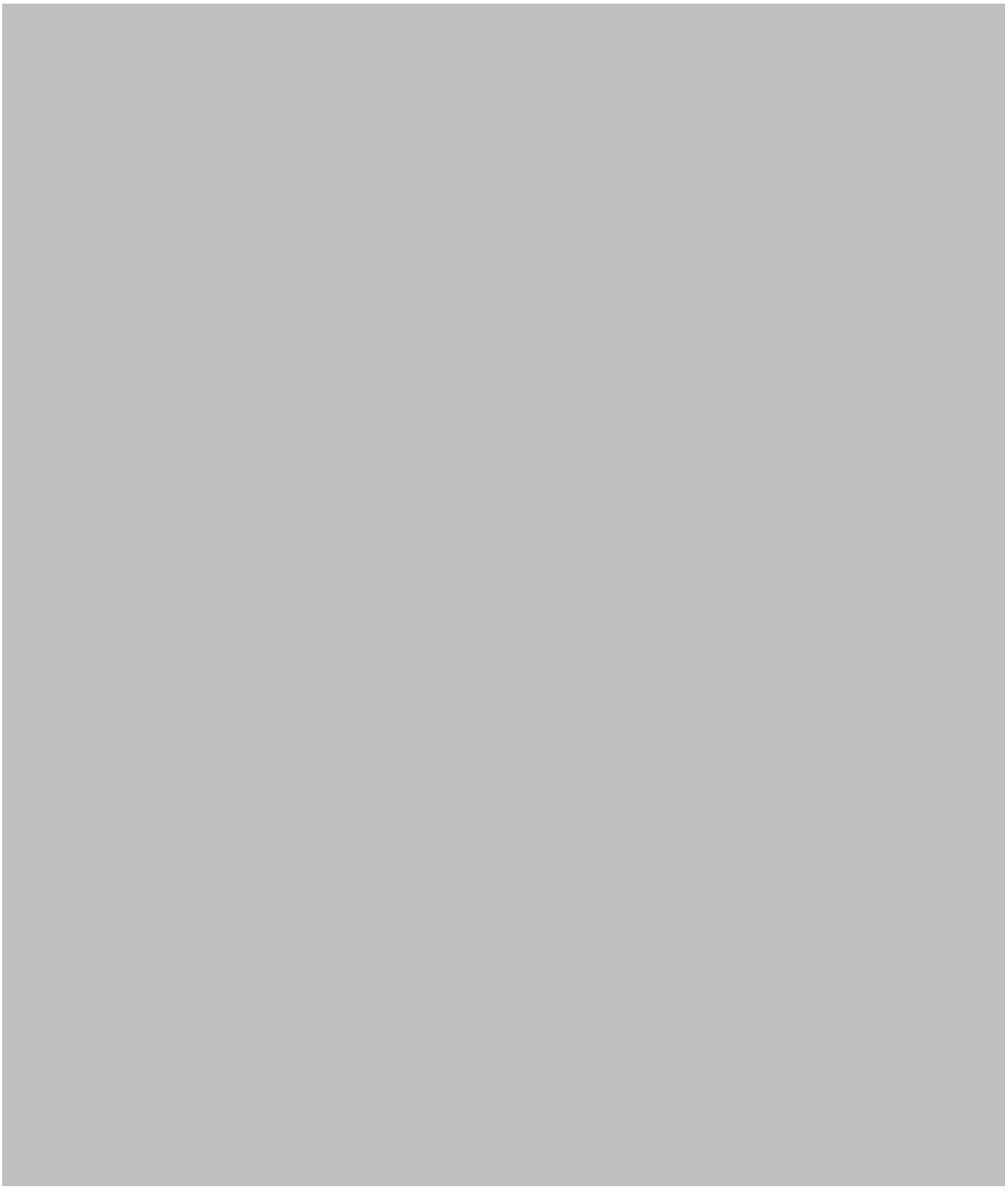
3) What does the term 'wellbeing' mean to you? Does blogging, and your experiences of it, have any impact on your wellbeing, bearing in mind the following pointers, and sharing any extracts from your blog which help to illustrate your answer?
   - Does blogging impact on any other areas of your life when you are offline?
   - Has your life changed in any way since you have been blogging?
   - What would be different for you if you were no longer blogging?

4) What's it like writing about yourself knowing an 'audience' will read it, bearing in mind the following pointers, and sharing any extracts from your blog which help to illustrate your answer?
   - Who is your 'audience' and do you feel any connection with them? Does your 'audience' respond to what you write? What's that like? Is this different in any way to the relationships you may have offline?
   - Do you get anything different from having other people read and/or respond to your writing than if you wrote the same things in a private journal instead?
   - Is it different conveying your experiences over the internet rather than discussing them verbally in person?

Appendix E.

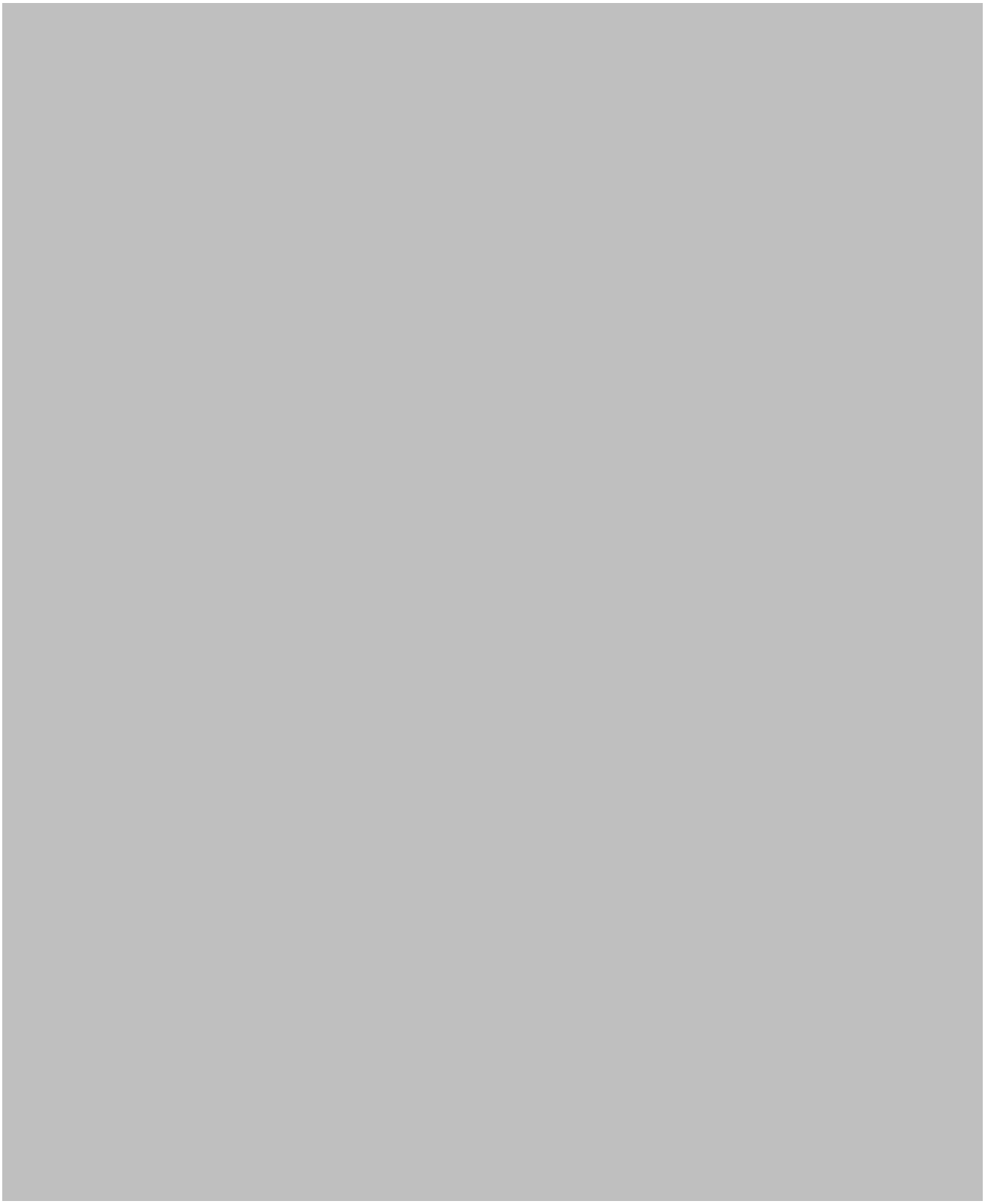
Research Ethics Committee Approval Letter

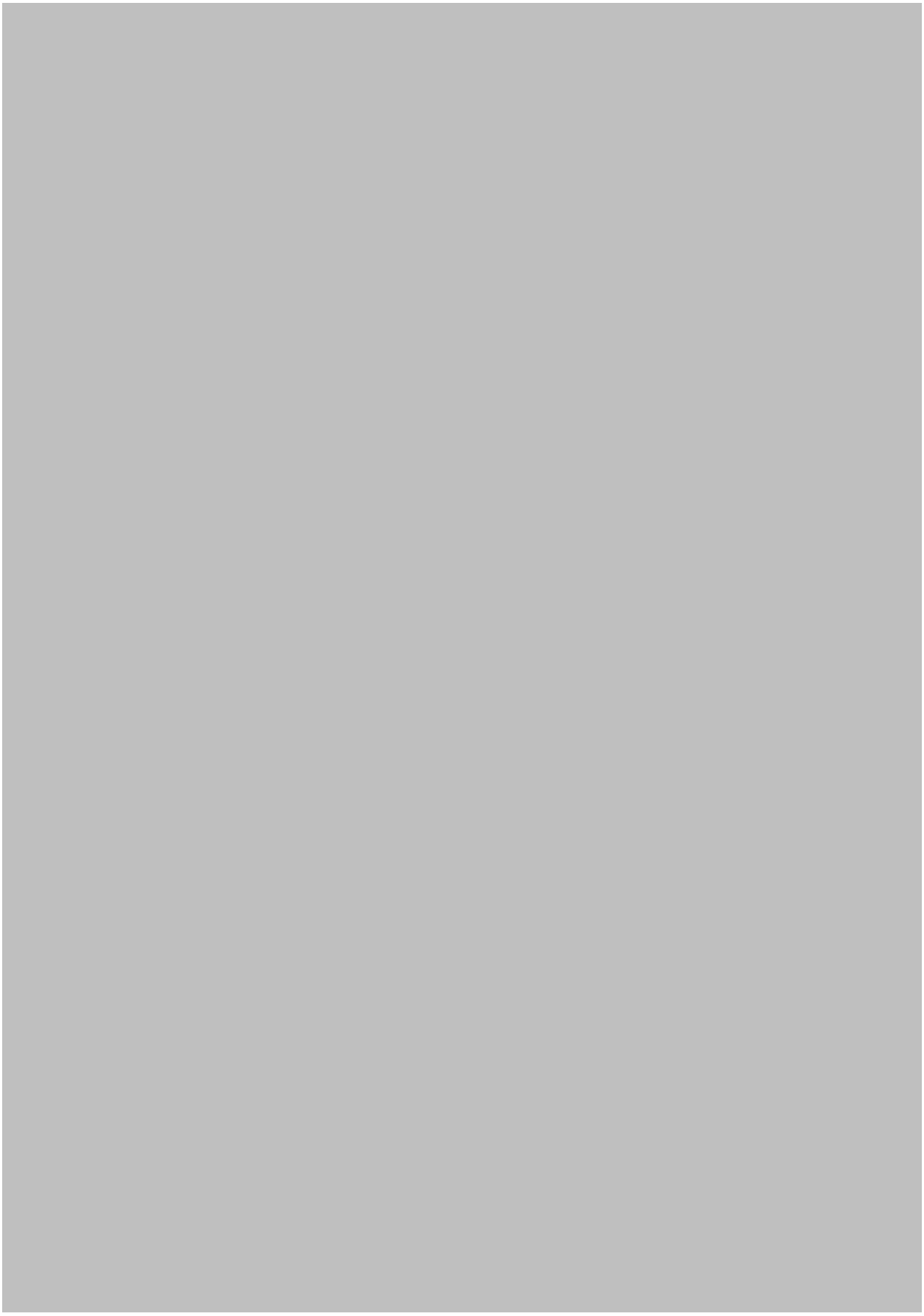




Appendix F.

Instructions for Authors for Nominated Journal







Appendix G.

Example of email response to interview questions

