

Portfolio Volume 1: Major Research Project

How Individuals Diagnosed with Borderline Personality Disorder Experience their 'Schema Modes' or other States of Self

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DEDICATIONS

For my precious daughter Melina

Never stop being you.

And dedicated to my father who I miss dearly.

*And to my brave and wonderful lifelong friend Marina, who sadly passed away while I was
conducting this research.*

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ABSTRACT

Schema therapy (ST) (Young, 1990; Young, Klosko & Weishaar, 2003) is an integrative therapy originally developed for individuals with Borderline Personality Disorder (BPD). As the model developed, the concept of ‘modes’ was introduced. Modes are thought of as ‘parts’ of the self that are expressed through one’s current predominant state and can change moment-by-moment (Young, Klosko & Weishaar, 2003). The authors proposed five central modes for BPD, namely ‘*Abandoned Child*’, ‘*Angry and Impulsive Child*’, ‘*Punitive Parent*’, ‘*Detached Protector*’ and ‘*Healthy Adult*’; although the latter was believed to be ‘weaker’ in this client group. There is a dearth of qualitative studies that explore schema modes in patients with BPD and mixed empirical evidence for the prominence of BPD modes, as measured by Young’s Schema Mode Inventory (SMI) (Young et al., 2007). However, such quantitative research can only examine the prevalence of the modes included within the measure and cannot identify whether modes occur outside of a ST context. Furthermore, the SMI cannot tap into an individual’s perspective. Due to gaps in the literature, this mixed-methods study aimed to explore whether modes or any other states of self could be identified in individuals with a diagnosis of BPD or Emotionally Unstable Personality Disorder (EUPD), and if so, how participants talked about them and to what extent they compared with Young et al.’s mode concept. To meet this aim, 7 working-age adults (women) with a diagnosis of EUPD were recruited from a single NHS Trust, and participated in a semi-structured interview incorporating mode vignettes and completed the SMI. Interviews were transcribed verbatim and analysed using deductive and inductive Thematic Analysis (TA). 5 superordinate deductive themes and 13 sub-themes were derived. The main themes were: *Vulnerable Distress*, *Explosive Anger and Rage*, *Closing Down*, *Self-Loathing*, and *Resilience*. A single inductive theme was identified: *Feeling like Myself is Subject to Change*. The deductive themes were then triangulated with the scored SMI ratings. The findings from the TA suggested that

participants broadly identified with four of the central modes and their experiences were in keeping with Young's theory. For the Healthy Adult mode however, there were high levels of resilience described, as well as challenges remaining within or connecting to that mode. All participants reported a sense of self that was in flux due to their modes and various disparities and similarities were highlighted between the SMI and interview transcripts. No other states of self were evident across the transcripts. The findings of this research have strong clinical implications for the way services engage women with EUPD or BPD and foster their resilience. Future research could focus more on understanding mode sequences, and nuances of the Healthy Adult mode.

Keywords and Interchangeable Terms

AC: Abandoned Child Mode; AIC: Angry & Impulsive Child Mode; BPD: Borderline Personality Disorder; CAT: Cognitive Analytic Therapy; CBT: Cognitive Behavioural Therapy; CMHT: Community Mental Health Team; DP: Detached Protector Mode; EBE: Expert by Experience; EMS: Early Maladaptive Schemas; EUPD: Emotionally Unstable Personality Disorder; HA: Healthy Adult Mode; HRA: Health and Research Authority; IRAS: Integrated Research Application System; NHS: National Health Service; PD: Personality Disorder; PIS: Participant Information Sheet; PP: Punitive Parent Mode; Research Team: Principal Investigator/s (Research Supervisor/s) / Field Supervisor and Researcher (Student); QoL: Quality of Life; RCT: Randomized Controlled Trial; R&D: Research and Development Department; SMI: Schema Mode Inventory; ST: Schema Therapy; States of self: Young's Modes / Self-states; SU: Service-user / Patients / Clients; TA: Thematic Analysis; TAU: Treatment as Usual; Trust: NHS Foundation Trust; Tx: Treatment / Therapy; UH: University of Hertfordshire

Please note, the terms BPD and EUPD are used interchangeably throughout this thesis.

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CHAPTER 1: INTRODUCTION

1.1 Introduction to Borderline Personality Disorder

When an individual is diagnosed with a ‘personality disorder’ it is understood that their personality traits can have a negative impact upon their social and occupational functioning or can otherwise lead to marked distress for the individual (Davidson, 2008). Such traits are believed to emanate from the adolescent period, later emerging in adulthood, and are considered to be enduring aspects of the person (Davidson, 2008).

Borderline Personality Disorder (BPD) is classified as a severe mental illness, characterised by significant distress and disrupted functioning, particularly in the work and education arenas (Arntz & Genderen, 2009). BPD is estimated to affect 1-3% of the general population (Lenzenweger et al., 2007; Trull et al., 2010), as compared with between 40% and 44% for psychiatric inpatients (Grilo et al., 1998; Marinangeli et al., 2000) and is frequently associated with suicidal and self-injurious inclinations, as well as aggressive reactivity (Leichsenring et al., 2011). Psychiatric comorbidity rates are also extremely high for individuals living with BPD, with depression, anxiety, Post Traumatic Stress Disorder (PTSD) and eating disorders (cited in Arntz & Genderen, 2009) highly prevalent.

Individuals who attract this diagnosis usually encounter difficulties in many areas of their lives as they frequently contend with rapid mood changes (including positive feelings, [Hooley & Masland, 2019]), rageful outbursts, impulsivity, and ‘crises’ (Arntz & Genderen, 2009). They also tend to struggle in their interpersonal relationships, experience low self-worth and a constantly shifting self-identity. They are at an increased risk of self-harm, substance misuse (Arntz & Genderen, 2009) and engage in parasuicidal behaviours (Young, Klosko and Weishaar, 2003). If this was not enough to contend with, the suicide rates amongst patients living with BPD have been found to be higher than the general population (Pompili et al.,

2005), with approximately 4% - 10% of patients completing suicide (Zanari et al., 2002; Paris, 2002).

Someone meeting diagnostic criteria for Borderline Personality Disorder would be characterised within the DSM-V (American Psychiatric Association [APA], 2013) as presenting with “a pervasive pattern of instability in interpersonal relationships, self-image, and emotion, as well as marked impulsivity beginning by early adulthood and presenting in a variety of contexts, as indicated by five (or more) of the following: (a) Chronic feelings of emptiness; (b) Emotional instability in reaction to day-to-day events (e.g., intense episodic sadness, irritability, or anxiety usually lasting a few hours and only rarely more than a few days); (c) Frantic efforts to avoid real or imagined abandonment; (d) Identity disturbance with markedly or persistently unstable self-image or sense of self; (e) Impulsive behaviour in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating); (f) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights); (g) Pattern of unstable and intense interpersonal relationships characterized by extremes between idealization and devaluation (also known as ‘splitting’); (h) Recurrent suicidal behaviour, gestures, threats, or self-harming behaviour, and (i) Transient, stress-related paranoid ideation or severe dissociative symptoms”.

This extensive list of characteristics can have many permutations where staggeringly but not surprisingly, BPD diagnoses are given within Western society twice as much to women than their male counterparts (Black et al., 2007). However, men presenting in similar ways tend to attract the similarly stigmatising diagnosis of Antisocial Personality Disorder (ASPD) (Skodol & Bender, 2003).

BPD is understood within a medical framework as “an illness marked by an ongoing

pattern of varying moods, self-image, and behaviour. These symptoms often result in impulsive actions and problems in relationships" (National Institute of Mental Health in England [NIMH(E)], 2021). However, such a frame of reference fails to consider an individual's internal world, and this arguably hampered view has been criticised for discounting the impact of developmental trauma in the origin of BPD. Moreover, referencing 'symptoms' within a model of personality is also problematic as difficulties associated with BPD could be more appropriately formulated as an understandable response to traumatic experiences, such as oppression and childhood sexual abuse (Shaw & Proctor, 2005).

The World Health Organization (WHO, 2019 / 2021) International Statistical Classification of Diseases and Related Health Problems, Eleventh Revision (ICD-11), comprises a dimensional model of personality disorder which incorporates a general PD diagnosis, with differing degrees of severity. For this classification system, the level of 'severity' is categorised according to the intensity and ubiquity of overall personality difficulties, as judged within two main areas: interpersonal and intrapersonal, with some acknowledgement of associated psychological distress. The dimensional model also encompasses a 'Borderline pattern qualifier' (Tyrer et al., 2019) and replaces the previous conceptualisation of 'Emotionally Unstable Personality Disorder' (EUPD) (International Classification of Diseases and Related Health Problems, Tenth Revision [ICD-10, 2016], World Health Organization [WHO]). Conceptually, the EUPD diagnosis is analogous to BPD and continues to be widely used within UK mental health services and various European Member States.

In spite of the challenging nature of the vocabulary and conceptual frameworks associated with diagnoses of BPD, EUPD and 'Personality Disorder', there is substantial agreement that individuals meeting these criteria often experience very challenging circumstances, whereby considered and effective interventions are of the utmost importance.

1.2 Therapeutic Interventions for Borderline Personality Disorder

The concept of ‘therapeutic nihilism’ remains prominent within mental health services in relation to the ‘treatment’ of people diagnosed with Borderline Personality Disorder (Winston, 2000). However, rather than being an untreatable condition, significant advances have been made in the therapeutic offerings and outcomes for this client group. For example, it is estimated that patients can overcome their personality disorder seven times faster after completing psychotherapy, when contrasted with “the natural course of their PD” (Perry et al., 1999).

The first treatment that was believed to contest the prevailing sense of therapeutic nihilism was Dialectical Behaviour Therapy (DBT) which is a form of CBT (Dimeff & Linehan, 2001) and was developed by a clinician who had struggled with Borderline Personality Disorder. DBT is a NICE recommended psychological therapy for BPD (National Institute for Clinical Excellence, 2009) and conceptualises the core difficulties of BPD as a continuous breakdown of patients’ cognitive, behavioural and emotion regulation systems when emotionally overwhelmed (Lynch et al., 2007). A number of studies have demonstrated the effectiveness of DBT, including substantial reductions in attempted suicide (e.g., Bohus et al., 2004) due to the utilisation of taught emotional coping skills.

Schema Therapy (ST), which is an integrative approach, has also produced promising outcomes for BPD (e.g., Farrell et al., 2009). Within this modality, BPD is formulated as regressing into early ‘maladaptive states’ that are linked to specific schemas and modes (states of self) and is based on the premise that aversive childhood experiences, such as insecure attachment, abuse and neglect can result in the development of dysfunctional schemas (mental representations of the self, others, and the world). For a review of ST treatments, please see Chapter 2.

In contrast with the longer-term interventions above, Cognitive Analytic Therapy (CAT) has been shown to be effective for a range of personality difficulties, including BPD (Kellett et al., 2013) and so-called Narcissistic Personality Disorder (NPD). CAT is a time-limited (typically 16 – 24 sessions), integrative psychotherapy that was specifically developed for personality disorders (Ryle & Kerr, 2020). CAT aims to obtain a shared understanding of individuals' problematic relationship patterns, cognitions, emotions, and behaviours that emanate from these. However, the evidence-base has been critiqued for its focus on practice-based studies and lack of comparison or control groups (Calvert, 2014). While this reduces the generalisability of findings, CAT remains a promising intervention for BPD.

Finally, Mentalisation-based Therapy (MBT) is a time-limited treatment that has also been shown to be effective for Borderline Personality Disorder (Bateman & Fonagy, 2010). Within this psychodynamically-oriented model, it is understood that there is a 'failure' for the 'BPD patient' to mentalise, in relation to both others' minds and their own. This inability to mentalise is believed to develop in response to childhood abuse or neglect and / or imperfect mirroring. MBT interventions aim to facilitate the development of mentalising capacities (Bateman & Fonagy, 2010) by supporting the patient to maintain a level of arousal that is within their window of tolerance. This is hoped to be achieved through the creation of a nurturing therapeutic space that is designed to be "not too intense, and (yet) not too detached" (Bateman & Fonagy, 2010).

1.3 Challenges Associated with Treating Borderline Personality Disorder

A substantial body of literature purports that conducting therapeutic work with individuals diagnosed with a personality disorder (PD) can be a challenging experience (e.g., Winship, 2010). Interacting with and 'treating' people with personality disorders is consistently associated with strong countertransference reactions (Markham & Trower, 2003), particularly

with ‘BPD clients’ (Bateman & Fonagy, 2004). The strong negative reactions towards this client group have been attributed to the marked difficulties they apparently show when relating to others, and how pervasive maladaptive behaviour patterns frequently rooted in childhood (Millar et al., 2012) get enacted within therapeutic relationships.

Some of the relational difficulties reported by clinicians include impoverished rapport, clients’ hypersensitivity to perceived criticism, intense dichotomised emotional reactions, and high therapy drop-out rates (Bouke et al., 2010). They have been unfairly described as ‘the patients psychiatrists dislike’ (NIMH[E], 2003) and mental health professionals more frequently associate ‘angry’ states of self with BPD clients (Young, Klosko & Weishaar, 2003). Such dominant discourse has led to much trepidation and hesitancy in those who are involved in the care of people living with BPD despite growing evidence (as above) that personality disorders are amenable to treatment (e.g., Verheul & Herbrink, 2007).

While many clients with a label of ‘Personality Disorder’ yearn for acceptance and a listening ear from service providers (Lester et al., 2020), when asked directly, service-users highlighted various relationship-interfering factors coming from the direction of those providing care. For example, service-users reported a sense that they were to blame for their difficulties (revealing a ‘what is wrong with you’, versus ‘what has happened to you’ mindset) and were referred to as time-wasters, manipulative, bed-blocking or attention-seeking (National Institute for Mental Health in England, [NIMH(E)], 2003).

As a positive therapeutic relationship is crucial for people with histories of disrupted attachments, such negative attitudes are likely to present a significant barrier to both engagement and treatment and is diametrically opposed to (NIMH[E]’s 2003) best practice guidance: ‘Personality Disorder: No Longer a Diagnosis of Exclusion’. This paper called for the necessary development of personality disorder interventions within NHS Trusts, stating:

“many clinicians have not seen personality disorder as a mental disorder that is treatable”, and was linked to a new funding initiative specifically identified for this purpose. NIMH(E)’s follow-up paper entitled: *Breaking the Cycle of Rejection: ‘The Personality Disorder Capabilities Framework’* (2004) recommended a further step in the development of specialist mental health services for people attracting the diagnosis of personality disorder, with the aim of creating “an understanding and more compassionate, responsive workforce”. The introduction of the Personality Disorder Pathway (National Institute for Health and Clinical Excellence [NIHCE], 2009) has gone some way in meeting this aim, whereby NHS Trusts are increasingly offering a range of evidence-based psychological therapies to meet the needs of service-users diagnosed with BPD.

1.4 My Position (written in the first person)

My position synthesises relational and cognitive-behavioural ideas while being mindful of languaging distress in ways that aim to privilege service-users’ lived experiences, as opposed to ‘symptoms’ within psychiatric classification systems. However, I acknowledge that this presents a challenge when describing the evidence-base as this is typically saturated with psychiatric terminology. Within this thesis I have referred to individuals as ‘diagnosed with’, ‘attracting the label of’ and also, ‘with Borderline Personality Disorder’ as short-hand for the reader. However, I do not personally believe that anyone ‘has’ a personality disorder, rather I consider that the difficulties associated with this label(s) developed in response to the individual being on the receiving end of power abuses, as opposed to being ‘blameworthy’, ‘weak’, ‘deficient’, or ‘mentally ill’ (Johnstone et al., 2018).

As mentioned, my position is also mindful of power imbalances between researcher and participant, and clinician and service-user. I also hold in mind the wider social influences of power (Johnstone et al., 2018). As an integrative practitioner with a background in CBT, my

position encapsulates who I am as a clinician, colleague, and advocate of trauma-informed thinking within the National Health Service (NHS), as well as overlapping more broadly in other areas of my life. For example, some of the people whom I am closest to have experienced trauma and social disadvantage and have consequently struggled with their wellbeing.

I am aware that anyone, whether they are a healthcare professional or otherwise, can respond to threatening, adverse experiences in a whole manner of reasons and there is no shame in that, and no victim blaming where I am concerned. As a mental health clinician, I relate to the person not the diagnosis, and remain mindful not to get caught up in diagnostic overshadowing. At the same time, I also appreciate that diagnosis can be helpful for many service-users, where ‘having’ a diagnosis (or identifying as such) is often the only way to access mental health services or make sense of difficulties.

1.5 Personal Interest (written in the first person)

I arrived at the topic of ‘personality disorder’ for this thesis partly due to some previous experiences and struggles with mental health (Grice, Alcock, & Scior, 2018) which resulted in my becoming a service-user within a mental health service. Being on the other side of the therapist’s chair initially felt uncomfortable and it was not easy to assume the role of ‘patient’. Accepting this help was almost as daunting as the idea of completing this thesis; I would have to hold it very much in mind and dedicate a large proportion of my heart and soul to this research, relying on myself to push through while learning to accept support along the way. I admit to finding the latter especially hard.

Through having had personal therapy, I discovered that beginnings for me were equally as difficult as endings, and this appeared to be the case for many of the service-users I had worked with too; particularly those with a diagnosis of personality disorder. On several occasions I came perilously close to not beginning this thesis, which meant that I would not

complete my qualification. I therefore needed to move closer to the pain of ending by ‘beginning the beginning’, embarking upon a difficult labour of love, sweat, and fears. In addition, the area of personality disorder had always interested me, and I was keen to understand more about ‘feeling states’, and to give voice to those who are historically seen in services as a ‘treatment-resistant’ (Arntz, 1993; James & Cowman, 2007), ‘heart-sink’ (Lewis & Appleby, 1988; Chartonas et al., 2017) and homogenous group.

I was aware before embarking upon this project, that conducting research within the NHS would be a challenge, but I was determined not to take ‘the easy way out’. I previously worked as an NHS Researcher, both on clinical trials and within a (smaller) clinician collaboration so I had a sense of what could lie ahead, but the reality was very different, particularly due to Covid-19 landing and endless research bureaucracy. The process of securing ethical approval and subsequent amendments evoked a number of feeling states within me, including ‘angry child’ and ‘detached protector’ modes, whereby I became ever more frustrated and numb to the levels of bureaucracy that created barriers to carrying out research. As soon as I completed one required task, it would then impact upon other tasks and further processes and add to the ever-growing frustration; but this aspect of what I was getting into was previously outside my realm of experience. I did not heed the warning!

I can only compare this experience to renovation works on a house extension that had just been built. If it was found that some of the brick foundations were not completed to a specific standard, then, if doing the repairs yourself, you would initially need to get back down into the foundations to rectify them and in doing so you would undoubtedly damage some of the work that had already been done. You would also need to factor in further repairs to what lies above the foundations (for example, plastering and cosmetic works), and this would be costly both in time and effort. Further sign-offs would be needed, and additional snagging work required before the house is deemed safe enough and secure. Indeed, the ethical processes were

messy, tiring, painful and frustrating and no doubt has influenced whether I would consider carrying out research within the NHS in the foreseeable future.

Crucially, I also had several changes in Research Supervisor during the process of securing ethical approval, which left me feeling (at times) as if I was extending the house on my own without a project manager. While I admit to grappling with perfectionist and procrastination tendencies, the changes in research supervision certainly added to the reduced motivation and sense of helplessness I (sometimes) felt.

1.6 Background: Schema Therapy and Borderline Personality Disorder

Schema therapy (Young, 1990; Young, Klosko and Weishaar, 2003) can be conceptualised as a form of third-wave Cognitive Behaviour Therapy (CBT) (Kahl et al., 2012) that synthesises CBT, Psychodynamic, Gestalt and Attachment perspectives. Schema Therapy was developed originally for service users for whom standard CBT was less effective for addressing more complex interpersonal difficulties (Kellogg & Young, 2006). Such individuals were found to show fluctuating or persistent negative patterns in their interpersonal styles and often reported an intense range of ‘symptoms’ that were in keeping with diagnostic criteria for Borderline Personality Disorder (Arntz & Jacob, 2013).

Delivering CBT for people with personality disorders was found to be problematic due to difficulties with achieving positive therapeutic outcomes or risk of relapse (Arntz, 1993). However, Young, Klosko and Weishaar (2003) considered that the duration of intervention(s) was crucial, particularly when working with individuals’ difficult attachment histories. Young subsequently increased the intervention period while explicitly addressing key developmental experiences. This focus on childhood themes was not dissimilar to psychodynamic ideas implemented by object relations or attachment therapists. In a similar vein, Young, Klosko and Weishaar (2003) further emphasised the importance of the therapeutic process, including the

nature and resilience of the therapeutic relationship. Indeed, this has been shown to be a consistent success factor across therapeutic modalities (Luborsky, 1995). Studies examining the limitations of CBT in treating complex interpersonal presentations revealed that such patients typically experienced lifelong psychological difficulties and adapted to their environments through the development of less helpful, deeply entrenched belief systems (Kellogg & Young, 2006). These patients were found to be less amenable to CBT and so Schema Therapy was developed.

Within Schema Therapy, Young, Klosko and Weishaar (2003) hypothesised that people with personality disorders have in common several ‘Early Maladaptive Schemas’ (EMS) within their psychic apparatus. They proposed that EMS are “a broad pervasive theme or pattern regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree” (Young, Klosko & Weishaar [2003], p. 7). EMS are also linked to the enactment of maladaptive coping responses.

It is acknowledged that Early Maladaptive Schemas tend to originate from negative developmental experiences (Kellogg & Young, 2006). While it is recognised that all individuals develop schemas, in the case of individuals coping with BPD, they become maladaptive as a consequence of unmet core emotional needs, such as growing up in toxic and invalidating environments (Young, Klosko & Weishaar, 2003). EMS were also linked with early coping and survival behaviours in response to abuse or neglect (Kellogg & Young, 2006), with some behaviours continuing into the present (see Appendix 1 for list of Early Maladaptive Schemas).

For an individual that has been exposed to repeated negative emotional experiences (such as being abused by a parent), he or she might develop a Mistrust / Abuse schema. A

person who grew up with a neglecting parent(s) might develop an Emotional Deprivation schema. A child's temperament can also significantly influence schema development and crystallisation as the response or feedback from caregivers to a more temperamental child may be less than ideal. When considering caregivers' own (potentially unhelpful) schema organisation, this is likely to contribute to less attunement to the child. Taking these factors into account it is therefore not surprising that an individual coping with a personality disorder would develop a number of EMS.

According to Kellogg and Young (2006), patients with Borderline Personality Disorder “presented unique challenges to the original Schema Therapy model” (p. 446). They suggested that while most patients living with BPD could respond to schema work in the face of (often) rigid cognitive styles, they were frequently observed to be in a state of ‘flux’. Moreover, such swift emotional changes, e.g., flipping from adoration to hatred, presented additional challenges for therapists (Kellogg & Young, 2006) who themselves could be on the receiving end of ‘splitting’.

The aim of Schema work is to address the inter-relationships between clients' thoughts, feelings, and behaviours as well as the impact of developmental experiences through interventions such as ‘limited reparenting’ and chair work. Concurrently, it aims to facilitate emotional literacy and relational risk-taking within the therapeutic relationship. The ST model has since been extended for use with other personality disorders and continues to demonstrate increasing evidence for its effectiveness (Arntz & Jacob, 2013).

The ‘mode’ concept was first described by Young, Klosko and Weishaar (2003) and was further elaborated by Bernstein et al. (2007), Arntz and Jacob (2013), and others (e.g., Farrell & Shaw, 2012) as the model evolved. Young and colleagues (2003) defined modes as the set of schemas or responses (adaptive, healthy or maladaptive) that are currently active for

an individual, i.e., the global emotional, cognitive, motivational, and behavioural 'state' of a person. Modes can also be conceptualised as a particular mindset that a person might find themselves in temporarily. Kellogg and Young (2006, p. 447) noted that "the inner world of the Borderline patient" is characterized by five central modes, or states of self, that interact in unhelpful ways.

Kellogg and Young (2006) asserted that gaining an understanding of the way that modes operate can help to explain the apparently "irrational behaviour of these patients" (Kellogg & Young 2006, p.447). Three groups, or clusters of modes have been identified in the literature: 'Child', 'Parent' (now referred to as 'Critic', [Fassbinder & Arntz, 2018]), and 'Coping' modes (Kellogg & Young, 2006). Modes are hypothesised to explain many of the abrupt changes in thoughts, feelings and behaviours observed clinically in service-users coping with BPD (Young, Klosko & Weishaar, 2003; Lobbestael, van Vreeswijk, & Arntz, 2007). For example, rapidly switching from one way of feeling and behaving (such as being calm and relaxed) to another extreme state, such as crying inconsolably in response to specific internal or external triggers. As with schemas, innate temperament combined with difficult developmental experiences may enhance the expression or sequence of modes.

Previous studies, such as those conducted by Young and colleagues have shown that service-users living with BPD would typically display three or four central modes; these were labelled 'Vulnerable Child'; 'Punitive / Critical Parent'; 'Detached Protector'; and 'Surrenderer'. However, they then identified the presence of a different cluster of modes for this client group (see Appendix 2), namely Abandoned Child; Angry & Impulsive Child; Punitive Parent; Detached Protector, and (a weaker) Healthy Adult (Young, Klosko & Weishaar, 2003). Later research attempted to reclarify the mode concept (Lobbestael et al., 2007) and associated further modes with BPD (Lobbestael, van Vreeswijk, & Arntz, 2008). The researchers also identified an overlap of modes between various personality disorders,

particularly BPD and Antisocial Personality Disorder (APD). They concluded that there was an abundance of modes expressed for people living with BPD and questioned the value or specificity of the mode concept for this client group. However, the clinical usefulness of modes has been demonstrated for BPD (Nordahl & Nysæter, 2005; Giesen-Bloo et al., 2006) and other so-called personality disorders (Arntz & Jacob, 2013).

At the core of Schema Therapy is the argument that clients need to learn how these modes or states operate so that negative ones can be avoided and replaced with states that are more healthy or benign (Young, Klosko & Weishaar, 2003). Similarly, other therapies such as Transactional Analysis (TA) (Berne, 1961), Cognitive Analytic Therapy (CAT) (Ryle & Kerr, 2020) and Internal Family Systems Therapy (IFST) (Schwartz, 1995) have also suggested that people can encompass many diverse states, though these therapies use different terminology (e.g., ‘parts’) to describe these states of self.

Within the existing literature, the evidence-base shows that there is limited evidence which illustrates the efficacy of Schema Therapy for mental health difficulties such as agoraphobia, eating disorders and chronic depression (Taylor et al., 2017) as well as anxiety disorders, Obsessive Compulsive Disorder (OCD), and Post Traumatic Stress Disorder (PTSD) (e.g., Peeters van Passel & Krans, 2022). With regards to BPD, there appears to be a relatively greater but (still) small, growing evidence-base for Schema Therapy effectiveness, and a dearth of evidence concerning Emotionally Unstable Personality Disorder. Considering these apparent literature gaps, this study performed a systematic review of the literature in order to gather the available quantitative evidence that assesses the efficacy and effectiveness of Schema Therapy interventions (including individual ST and / or group ST) for the treatment of BPD and EUPD.

CHAPTER 2: SYSTEMATIC REVIEW, RATIONALE, AIMS, AND RESEARCH QUESTIONS

The following systematic literature review explored the available evidence base relating to Schema Therapy for individuals with a diagnosis of Borderline Personality Disorder and Emotionally Unstable Personality Disorder. The decision to carry out this review was due to 1) Schema Therapy being a NICE recommended treatment for Borderline Personality Disorder (National Institute for Clinical Excellence [NICE], 2009), 2) Bringing together the aforementioned limited research evidence, 3) ST being a relatively new and unresearched intervention (compared with CBT) and, 4) Reflecting the recommendations made by the University of Hertfordshire (UH) Senior Research Team. As there were limited (exclusively) qualitative studies available (e.g., Puri et al., 2021), the review focused on empirical *quantitative* outcomes of Schema Therapy, namely the efficacy and effectiveness for this client group.

2.1 Search Strategy

Published studies were identified through searches of the following electronic databases and Journals: PsycArticles, PsycInfo, Scopus, PubMed, Behavioural and Cognitive Psychotherapy, Journal of Consulting and Clinical Psychology and Google Scholar. The PICO (Patient, Intervention, Comparison intervention and Outcome measures) strategy informed the research question regarding the search and systematic review. This approach has been shown to be useful for safeguarding “the correct definition of which information (evidence) is needed to solve the clinical research question, maximizes the recovery of evidence in the database, focuses on the scope of the research, and avoids unnecessary searching” (Santos et al., 2007).

Table 1. PICO Strategy

Participant Population:	Borderline Personality Disorder (BPD) and Emotionally Unstable Personality Disorder (EUPD).
Intervention(s):	Schema Therapy (ST): 1-1, Group or Combined (including with any other intervention).
Comparison:	Control, Treatment as Usual (TAU), other psychological interventions or alternate format of ST delivery (e.g., Group / Individual Therapy / Combined).
Primary Outcome:	Reduction in BPD / EUPD symptomatology and / or recovery.

2.2 Systematic Review Question

The research question that helped to guide the review as per PICO guidelines was as follows: ‘What is the empirical evidence (efficacy and effectiveness) for Schema Therapy in people with a diagnosis of Borderline Personality Disorder and Emotionally Unstable Personality Disorder?’ Or in other words, do participants with a diagnosis of BPD or EUPD benefit from Schema Therapy, as evidenced by their reduction of ‘symptoms’ or level of recovery? Please note, as the review also included data from uncontrolled trials (see below), effectiveness evidence was included.

2.3 Review Inclusion and Exclusion Criteria

The date range for the initial search was 1 January 2003 – 31 December 2020 and this was conducted in April 2021. The 2003 baseline was selected due to the seminal publication of Young’s Schema Therapy guide (Young, Klosko & Weishaar, 2003) as well as the emergence of the mode concept in 2003. As the search produced only a small number of eligible articles (N=4) the search terms were then widened to include uncontrolled studies, following a discussion with the Research and Field Supervisors (applying inclusion criterion

a – d; f – h, and exclusion criterion a – g). Please see below to find the inclusion and exclusion criteria a-h, and a-g respectively. This search was carried out in August 2021 and yielded a further two papers of acceptable quality, so the number of reviewed studies (at this stage) was N=6.

Following further discussions with the Research Supervisor, as the overall study was taking longer to complete than anticipated, a further search using the original search terms was repeated in March 2022, for the date range of January 2021 - January 2022. One additional eligible article (RCT) was identified, and no further searches were conducted. This meant that the total number of reviewed studies were N=7.

The search(es) necessitated that the studies / articles in the review must be: a) published in peer-reviewed journals; b) include participants aged 18 or above and fall within the currently recognised UK working-age bracket (18-65); drawn from community mental health (outpatient) or inpatient mental health settings; c) include participants with a diagnosis of BPD or EUPD (not PD traits) with or without comorbid personality disorder diagnoses. Also, d) allow BPD or EUPD diagnosis comorbid with an anxiety disorder and / or depression; e) should be randomized controlled (explanatory) or pragmatic trials for 1-1 or group / combined therapy; f) must be published in Europe or the USA; g) be in the English language and; h) have their full text available. Articles that did not conform to the inclusion criteria were excluded.

The following studies were not deemed eligible: a) studies in forensic or addiction settings; b) studies with participants diagnosed with learning disabilities, neurodevelopmental conditions, psychotic disorder / symptoms; c) eating disorders; d) single case studies; e) studies that primarily focused on cost-effectiveness; f) studies in papers written in languages other than English; and g) unpublished and grey literature.

The keywords for the database searches were: “Borderline Personality Disorder” OR

“Emotionally Unstable Personality Disorder” OR “Cluster C Personality Disorder” AND “Schema Therapy” AND “Randomized Control Trial” OR “Clinical trials”. The widened search term included AND “Uncontrolled trials”. When selecting studies, the inclusion criteria was followed, and the duplicates, foreign language and abstract-only papers from the initial search results were removed. Following this, the remaining set of studies were screened (N=246). The shortlisting process then consisted of the following two stages: 1) a cursory reading of the abstracts and, 2) a more in-depth review of the articles to determine eligibility. Full text articles were then retrieved for those that appeared to meet the review’s inclusion criteria (N=33), and the reference lists were examined via secondary screening. This yielded a further four papers for review. A final cull of 30 papers then took place. This left a total of seven papers that were included in the literature review.

The results of the searches are presented in the flow diagram below (Figure 1), which is based upon the Prisma format, as proposed by Page et al. (2021).

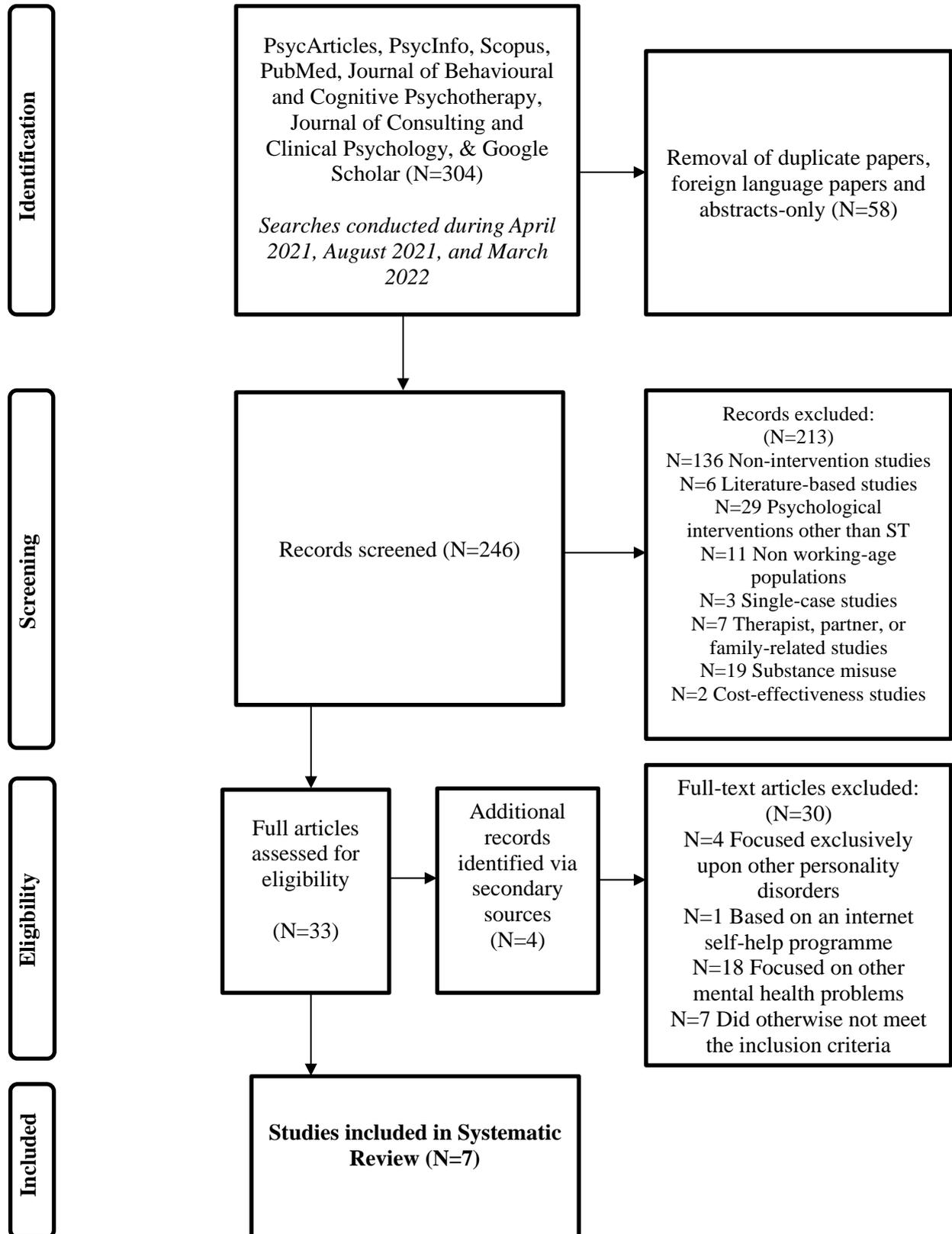


Figure 1. Study Selection Flow Diagram

2.4 Quality Appraisal

Due to the small evidence base, a quality appraisal tool was not employed for both the controlled and uncontrolled studies. Although quality appraisal tools were considered (due to their role in determining methodological quality and differentiating between strong and weak evidence), the researcher was concerned that the low number of shortlisted papers would be reduced even further, thus jeopardising a comprehensive review of the available evidence. In view of this dilemma, the respective journals' published impact factors were scrutinized. An impact factor (IF) is recognised within the academic community as an indicator of journal quality and is defined as "an index based on the frequency with which a journal's articles are cited in scientific publications" (Saha et al., 2003). For the selected studies (N=7), their corresponding journals' IFs were found to range from 2.2 (Journal of Behavior Therapy and Experimental Psychiatry) to 5.3 (Behaviour Research and Therapy). Journals with impact factors above 1.0 are generally considered to have a higher average impact, with IFs of 2.0 indicating twice the average impact (*Journal Citation Reports*, Clarivate, 2021). None of the journals IFs were reported as falling below the average. Furthermore, all studies were subject to a peer-review process, which was paramount for their inclusion in the review. However, it is acknowledged that methodical assessment of quality is a key task within systematic literature reviews, and this limitation will have likely impacted on rigour.

2.5 Narrative Synthesis Approach

The reviewed studies were analysed and reported using elements of narrative synthesis. Narrative synthesis has been conceptualised as "an approach to the systematic review and synthesis of findings from multiple studies that rely primarily on the use of words and text to summarise and explain the findings of the synthesis" (Popay et al., 2006). It is a process of 'story telling' that aims to merge and present research findings in an interesting way. Two main

tools of narrative synthesis were selected for this review, namely: textual descriptions of shortlisted studies and tabulation (see Table 2). The tools are contained within ‘element 2’ of the narrative synthesis approach (Popay et al., 2006).

Textual analysis is the basic component of narrative synthesis and is largely used to achieve a descriptive analysis of selected studies. Tabulation serves the function of concisely summarising the research design and findings. In this regard, Table 2 was used to present reference information, data concerning the research methods and approach, and summarising the resultant data and research findings in accordance with the review question. These narrative synthesis techniques helped to highlight patterns (in this case, themes) within the dataset as well as presenting a break-down of the data.

2.6 Summary of Paper Characteristics

The review sample (N=7) included N=5 randomized controlled trials (RCTs) and N=2 uncontrolled studies. All studies recruited working-age mental health / community outpatients with Borderline Personality Disorder and no studies researched Emotionally Unstable Personality Disorder. All but one (Leppanen et al., 2015) used female participants only and total sample sizes ranged from 10 to 88. The majority of studies were conducted in Europe with none taking place in the UK. Three were carried out in The Netherlands (Dickhaut & Arntz, 2014; Giesen-Bloo et al., 2006; Nadort et al., 2009), two in Finland (Hilden et al., 2021; Leppanen et al., 2015), one in Germany (Fassbinder et al., 2016), and one in the USA (Farrell et al., 2009).

All studies empirically assessed the effectiveness of Schema Therapy on ‘recovery’ rates and secondary outcomes, delivered via a combination of individual and group ST (N=3), individual ST (N=2), and group-based ST (N=2). However, three of the studies delivered the ST treatment(s) while combined with some other form of intervention including individual

psychotherapy (N=1). All studies reported effectiveness as opposed to efficacy, although it can be argued that by being carried out in routine health settings the RCTs were striving to demonstrate efficacy.

The primary outcome measures used were structured clinical interview (DIB-R, Zanarini et al., 2002) (N=1, Farrell et al., 2009) or semi-structured clinical interview (BPDSI-IV, Arntz et al., 2003) (N=5) as the measure of recovery (e.g., Dickhaut & Arntz, 2014) which were denoted by a reduction in BPD ‘symptoms’ or ‘manifestations’ following interventions. The remaining RCT study (Hilden et al., 2021) used the Borderline Symptom List (BSL-23, Kleindienst et al., 2020) which is a self-rating instrument that measures decline in BPD symptomatology.

Secondary outcomes for patients diagnosed with BPD were investigated in all studies, including indices of quality of life (QoL) (e.g., Leppanen et al., 2015), schema change (e.g., Fassbinder et al., 2016), schema mode change (e.g., Hilden et al., 2021) and ratings of ‘happiness’ (Dickhaut & Arntz, 2014; Fassbinder et al., 2016) over the intervention phases.

In terms of comparing the effectiveness of interventions, the ST treatment(s) were compared to another therapeutic modality in one RCT study (Giesen-Bloo, van Dyck, & Spinhoven, et al., 2006) and to variable Treatment as Usual alone (TAU) in another (Leppanen, et al., 2015). In two other RCTs the researchers combined ST with TAU, and compared to TAU alone (Farrell, Shaw, & Webber 2009; Hilden et al., 2021). Another study augmented ST with telephone crisis support versus ST alone (Nadort et al., 2009) and no control groups were used for the remaining studies (N=2) (Dickhaut & Arntz 2014; Fassbinder, Schuetze, & Kranich, et al., 2016). However, it should be noted that the uncontrolled trials ‘optimised’ the ST intervention in different ways.

2.7 Study Methodologies

The studies employed a range of methodological designs and varying intervention periods, from five months to up to three years in duration. For the RCTs (N=5), one comprised a single-centre 2-group design, and another was a single-centre randomized, parallel-arm intervention study, with 4 treatment groups and 2 parallel groups. The remaining three RCTs used multisite randomized 2-group designs.

For example, Giesen-Bloo, van Dyck and Spinhoven, et al. (2006) used a multicentre, randomized 2-cohort design (N=88) to compare the effectiveness of individual ST versus Transference Focused Psychotherapy (TFP) for patients diagnosed with BPD. Both interventions were delivered twice-weekly in 50-minute hours over the study's duration (3 years), with primary outcome measures administered at 3-monthly intervals. Secondary outcome measures were obtained every six months. Treatment integrity tests were also incorporated into the design. The strengths of this study included the thorough evaluation process, standardised assessment tools and frequent quality checks. The observed changes and differences were evaluated using Survival and Analysis of Covariance (ANCOVA) statistical analyses.

Nadort et al.'s (2009) study also utilised a multicentre, randomized 2-group design (N=62) to evaluate the addition of telephone out of hours crisis support to twice-weekly ST in 45-minute hours for BPD (versus ST alone). It was a more unique design in that it was set up as an 'implementation study' to also determine whether the findings from Giesen-Bloo, et al.'s (2006) study could be replicated within a clinical setting, and the scholars compared their findings with the aforementioned RCT. Assessments were carried out at 6-month intervals over an 18-month intervention period. One-sample t-tests, parametric ANCOVA's and Chi-squared tests were computed to identify statistical differences between the groups. As well as being

applicable to real-world clinical settings, another strength of the design was the incorporation of a qualitative element (making it a mixed-methods study).

For the uncontrolled studies (N=2), one included a feasibility study in patients with high hospitalisation rates in an outpatient ST-treatment programme, and the second focused upon the training effects of group ST specialists, as well as treatment outcomes. Both studies were carried out in clinical settings using both group and individual ST, and the interventions were bolstered by either psychotropic medication or further ST, if deemed necessary by the researchers.

In Dickhaut and Arntz's (2014) uncontrolled study, two groups of BPD patients (N=18) participated in combined weekly group ST (in 90-minute hours) and individual (1-1) ST (in 60 minute-hours) over a period of two years, with the second cohort of patients receiving the specialist group intervention much earlier on. This cohort was treated by therapists specifically trained by group ST specialists, with one aim of the study exploring training effects. Prior to this all patients received pre-therapeutic interventions ranging from 2 - 12 sessions. An additional six months of individual ST was tagged onto the research design (where indicated), with primary assessments utilising BPDSI-IV criterion (Giesen-Bloo, Wachers, Schouten, et al., 2010) to establish recovery rates. Assessments to evaluate 'manifestations' of BPD were conducted every six months over a course of two and a half years (Dickhaut & Arntz, 2014). Differences between the groups were assessed using mixed regression analysis, based upon the intention to treat principle. Strengths of the study included its treatment integrity, use of standardised assessment tools, and evaluating the additional effects of specialist group ST training.

Fassbinder, Schuetze and Kranich, et al.'s (2016) study recruited a relatively smaller sample of BPD outpatients (N=10) with "a high severity of symptoms", and a "history of

multiple hospitalisations and outpatient episodes” (Fassbinder et al., 2016). All patients received individual and Group ST + optimisation of psychotropic medication over the course of one year (in 60 and 100-minute hours respectively). Primary assessments were made at six, twelve, and thirty-six-month intervals using the BPDSI-IV to ascertain BPD severity. As with the aforementioned study, changes in BPD symptomatology were computed using mixed regression analysis, based upon an intention to treat. Strengths of the study included the therapists’ extensive training and supervision, and interventions were carried out within a clinical setting.

2.8 Review Findings: Effectiveness of Interventions

The findings of the review are described below and were structured into the following five themes in accordance with the range of comparisons made. The themes comprised: 1) ‘*Comparison of ST to TF Psychotherapy*’, 2) ‘*Comparison of ST and TAU with TAU*’, 3) ‘*Comparison of ST with Variable TAU*’, 4) ‘*Comparison of ST and Crisis Telephone Support with ST*’, and 5) ‘*Uncontrolled Study Interventions*’. For a summary of the review findings, please refer to Table 2.

2.8.1 Comparison of Schema Therapy to Transference Focused Psychotherapy

Giesen-Bloo, van Dyck and Spinhoven et al. (2006), compared Schema Therapy (N=45) to Transference Focused Psychotherapy (TFP) (N=43) in their RCT, and found that recovery rates for ST were superior to TFP at three year-follow-up, with statistically and clinically significant effects constant for both treatments on all measures at 1, 2, and 3-year assessment intervals. The treatment effect size for ST was also large. Only QoL was not superior to TFP by the end of treatment. The attrition rate for ST was also reported to be significantly lower than for TFP which suggests that ST may have been more engaging as an

intervention. For example, ST's explicit approach of 'limited reparenting' incorporates techniques such as nurturing, praise, limit-setting, and validation of client's unmet needs (Byrne & Egan, 2018). In contrast, the frame of TFP (a psychoanalytic therapeutic modality specifically designed for 'severe' personality disorders) is based on technical neutrality, process over content, and working in the transference (Kernberg et al., 2008). It is possible that the lack of overt structure or explicit techniques within the TFP condition may have negatively influenced attendance rates in these participants.

However, the results are encouraging and suggest that an extended period of ST treatment is beneficial for women with BPD. The authors concluded that *both* treatments impacted the "level of personality" at a deeper, as opposed to surface level (Giesen-Bloo, van Dyck & Spinhoven et al., 2006). This may offer some hope for people coping with BPD, as well as for service-providers. However, the authors cautioned against extrapolating the findings to clinical practice on the basis that further replication would be necessary.

2.8.2 Comparison of Schema Therapy and Treatment as Usual with Treatment as Usual

Farrell, Shaw and Weber (2009) provided compelling evidence for the effectiveness of Group ST + TAU (Eclectic Psychotherapy) versus TAU alone for treating women with BPD. It is of note that the authors did not elaborate on the form/s of eclecticism that were used, of which there are at least three variations, and practitioners understanding of eclecticism can vary (Rimaioli & Faccio, 2012). The study therapists were also comprised from a wide range of disciplines, namely clinical social workers, psychologists, and psychiatrists, and patients were treated in diverse community settings including mental health services, university 'outpatients', and within private practice. The sheer number of variables would have been challenging to control, and therefore therapeutic practice (study interventions) would have differed widely.

In spite of these issues, the study's results were encouraging, demonstrating statistically significant reductions in BPD symptomatology and enhanced global functioning for those who underwent ST + TAU (94%), when compared to TAU alone (16%) by the end of the intervention. The treatment effect size was large, and the Group ST intervention also had a 100% retention rate (versus 75% for TAU). The authors concluded that the lack of change in the TAU condition supported the powerful impact of the ST Group intervention, however this could have been more convincing as an argument, had the TAU condition *not* been added to ST. It would therefore be of benefit to repeat this study with a larger sample and more rigid experimental and control groups.

Hilden et al.'s RCT (2021) adopted a similar design, however the TAU condition was psychiatric input, and the primary outcome measure utilised a self-report measure (BSL-23). In contrast to Farrell, Shaw and Webber's study (2009), the results showed that there was no statistically significant difference between Group ST + TAU (N=28) and TAU alone (control) (N=14) for reducing symptoms of BPD and secondary outcomes (including depression and general functioning). Interestingly the authors noted a decline in 3 out of 4 dysfunctional schema modes, however, this related to clinical significance only.

While treatment validity was reported as 'good' or 'very good' for treating female outpatients diagnosed with BPD, Group ST was deemed to be no more effective than TAU for both primary and secondary measures. The authors therefore concluded that although Group ST was a viable intervention, the treatment period was relatively brief (only 5 months in duration). This suggests that there may have been inadequate time for the ST intervention to be internalised; for example, the development and crystallisation of participants' 'healthy adult' mode (Young, Klosko & Weishaar, 2003). The use of a self-report measure may have also negatively influenced the results due to 'self-report bias' which is defined as "the deviation between the self-reported and true values of the same measure. The bias is a type of

measurement error that may be random or systematic and constant or variable” (Bauhoff, 2014).

The results of the two studies went some way in determining the impact of (additional) Group ST vs TAU but did not go far enough. What is apparent, is that combining ST with different forms of TAU (and comparing to such) and then measuring the impact of interventions in differing ways (objective versus subjective measures) introduces lots of confounding variables. Further investigation incorporating increased experimental rigour is needed in order to reduce complexity.

2.8.3 Comparison of Schema Therapy with Variable Treatment as Usual

Leppanen et al.’s (2015) RCT compared a Community Treatment by Experts (CTBE) ST Group + Individual ST (N=24) to a variable range of TAU interventions (consisting of individual psychotherapy, medical appointments, or home rehabilitation) (N=47). Notably, this study recruited both male and female participants. The CTBE element pertained to the trial therapists’ (Community Treatment Experts) work being scrutinised by a consultation group on a frequent basis. The Community Treatment Experts were selected due to their enthusiasm in treating people with BPD, irrespective of the duration or content of their therapeutic education. None of the Community Experts received formal ST training and the Group ST material was manualised. Of note was the flexibility given for the therapist and patient to collaboratively decide upon the content of the individual ST sessions, as was the emphasis on homework completion. There were no details provided about the Psychotherapy TAU condition, other than it being “supportive” (Leppanen et al., 2015). Retention rates for the interventions were 83% for the CTBE patients and 68% for the variable TAU group.

Following a longer length of treatment (one year), patients’ mean BPDSI-IV scores were found to be lower in the CTBE (ST) condition than variable TAU, but the difference

between the two groups was not statistically significant. For health-related QoL, the CTBE (ST) group was superior to TAU, but in clinical significance only. While there is relevance in comparing against TAU interventions for real-world clinical settings, arguably this variable mix of treatments may have ‘diluted’ the control intervention(s) to the point that they were no longer meaningful as a comparison.

The authors concluded that although the results were not statistically meaningful, they were inspiring as the CTBE (ST) patients showed a clinically significant reduction in both a wide range of BPD manifestations and improved QoL, compared to TAU patients.

2.8.4 Comparison of Schema Therapy and Crisis Telephone Support with Schema Therapy

Nadort et al., (2009) achieved reasonably good results for their RCT implementation study. The scholars compared 32 BPD patients randomized to individual ST + access to therapeutic telephone crisis support, to 30 patients with ST *without* telephone support over the course of 1.5 years. The results were then compared to the previous findings of Gieson-Bloo et al. (2006). All study therapists agreed to provide patients with out of hours support if randomized to the experimental condition. Patients were also randomized to a therapist who may or may not have provided them with telephone crisis support. Assessments were made by research assistants who were not involved in delivering the interventions.

The qualitative phase of the study was a methodological strength and involved a process evaluation which aimed to ascertain the impact of the implementation interventions (i.e., provision of information on the study, clarifying the time-investment on the delivery of ST and telephone support, supervision commitments, and financial arrangements) on the therapists, managers, and research assistants of the various study sites. Data was captured during monthly project and therapist supervision meetings and analysed using Thematic Analysis (TA).

In terms of participant retention, 79% completed treatment and the study encompassed broadly similar attrition rates (N=7 for the experimental group and N=6 for controls). However, the authors reported that one participant in the telephone support group sadly completed suicide prior to receiving their therapist's phone number. While the authors could not go into detail for reasons of confidentiality, it was disheartening to read that the participant was not especially acknowledged in the paper, apart from a cursory mention. Regarding the quantitative outcomes, 42% of patients were considered to have recovered from BPD after 1.5 years of treatment, but with no added benefit from receiving the therapeutic crisis intervention. Moreover, only two patients were reported as making use of the intervention, albeit in a limited way. The authors hypothesised that this finding may be attributed to good mental healthcare in The Netherlands, whereby patients can easily access a GP or the emergency department of the local hospital. Crucially, this kind of crisis support does not require training in a therapeutic model. The authors also postulated that the positive results were due to views on BPD and its treatment changing for the better, as well as ST gaining momentum. The translation of ST and BPD literature into Dutch was also highlighted as enabling the therapists to learn more about the model, leading to the delivery of a more effective treatment. Medication effects and reduced baseline severity were also noted as contributing factors to the study's success. However, it is notable that the findings were compared to a study that was carried out three years previously.

Following qualitative analysis (TA) a small number of process-oriented themes were derived from the monthly project and supervision meetings. These included the pressing issue of 'no-shows' for both the treatment and evaluation sessions, with the researchers concluding that the assessments may have been "too confronting" (Nadort et al., 2009). A further theme pointed to the telephone support element of the study being too onerous, particularly when patients were in crisis or were otherwise influenced by psychoactive substances. Interestingly, no themes were reported regarding the completed suicide case.

Overall, this RCT appeared to be well-designed and provided compelling evidence for the implementation of individual ST to enable women with BPD to recover from their difficulties. The study also highlighted the risk of ‘scaring patients off’ with challenging assessment measures and the need to be mindful of therapist burn-out.

2.8.5 Uncontrolled Study Interventions

In Dickhaut and Arntz’s (2014) uncontrolled study, ST was found to reduce the manifestation of BPD symptoms significantly, with large effect sizes. This study compared two cohorts of BPD patients (N=8) + (N=10), who each received a combination of weekly group and individual ST for twenty-four months, with a further six months individual ST if indicated. One cohort received the interventions by therapists experienced in individual (not group) ST and the second group of patients received the interventions by therapists who were additionally trained in *group* ST by “specialists” (Dickhaut & Arntz, 2014) using Farrell and Shaw’s training format (Farrell et al., 2009). No statistically significant difference was found in attrition rates between the two groups, although it was mentioned that some patients attended fewer group sessions. Notably, the authors did not report on the gender of the group therapists, whereby gender differences may have had a negative impact on the women’s attendance.

The rate of recovery from BPD was reported as a robust 77% for the total sample at thirty months. However, not all patients received the additional 6-month intervention, nor were they offered the same number of pre-treatment sessions which may have skewed the findings. Additionally, the rationale for extending ST input was not clarified in the paper. The authors also found evidence of improvements in schema measure outcomes and psychopathological symptoms as measured by the SCL-90 (Derogatis & Savitz, 1999), with indices of QoL and happiness ratings strongly suggestive of improvement in the women’s wellbeing. The addition of a specialist Group ST intervention was inferred to have ‘sped up’ recovery from Borderline

Personality Disorder (Dickhaut & Arntz, 2014). However, no statistically significant difference was found between the specialist and non-specialist groups, long-term.

The authors concluded that while it is feasible to treat BPD female outpatients with combined group and individual ST, the risk of drop-out is greater in group as opposed to individual treatment. This appears to reflect what is found in routine clinical practice and is an ongoing concern. On the other hand, the group ST format by Farrell and Shaw (2009) was shown to augment the results of 1-1 work, and they proposed that with further replication, Group ST had the potential to treat more patients with BPD, as well as provide crucial cost-savings for services. The scholars also determined that patients reaching a 'normative' level of happiness was evidence that the women had developed a "satisfying life", as well as reducing BPD symptomology (Dickhaut & Arntz, 2014). Although an uncontrolled study with low participant numbers, this showed great potential for positive outcomes in women with BPD.

Fassbinder, Schuetze and Kranich, et al., (2016) reported similarly impressive results. The researchers combined Individual ST with Group ST + optimisation of psychotropic medication for a small sample of female patients (N=10). The researchers reported a large treatment effect size on a variety of measures including ST specific measures, with mean scores evidencing a decrease in maladaptive schema modes and scores on Young's Schema Questionnaire (YSQ) (Young & Brown, 2003). Significant improvements were also found in patients' functional mode outcomes. Reduction in severity of BPD symptoms was evidenced too, with 7 out of 9 DSM-IV symptoms decreasing substantially. However, self-reported evaluation of health and QoL, as assessed by the EuroQoL measure (Rabin & Charro, 2001) did not yield positive results.

A further statistically significant finding was a dramatic reduction in hospitalisation admissions (incorporating a high effect size), reducing from an average of 93 days in the

previous year, to just 4 days in the 2nd follow-up year. Although an incredible finding, providing much hope to people with BPD, without a control group it is difficult to determine what the change mechanisms were, e.g., the results could have been mediated by modifications in psychotropic medication. Despite the findings, the authors cautioned against the generalisability of their findings due to the small sample size, lack of control group and a possible therapist allegiance effect (Luborsky et al., 1999).

The results of the uncontrolled studies show great potential for Group + Individual ST in promoting recovery for women with BPD (as evaluated by the BPDSI-IV), in addition to reducing hospital admission rates and increasing levels of happiness. However, the role of (optimised) psychotropic medication is unclear and semi-structured interviewing (for non-blinded treatment conditions) may have introduced bias. Specialist ST group training appeared to hasten patients' rate of recovery but not long term. Further research is required, utilising more rigorous methodology including the use of control groups and male participants.

2.9 Critique of Reviewed Studies

In spite of the relatively higher number of RCTs (N=5) relative to uncontrolled studies (N=2), and the lack of quality control in this review, several methodological difficulties were noted. These limitations included some dependence on (secondary) self-reported outcomes and smaller sample sizes (in 3 of the reviewed studies), which suggests the possibility of Type II errors (Pallant, 2016). Semi-structured interviewing (used in N=5 of the studies) relies on some element of subjectivity and as mentioned (above) may have been subject to bias. Only one study used a structured interview (Farrell, Shaw & Webber, 2009).

In Hilden et al.'s (2021) study, despite the randomisation process, the TAU (control) group (N=14) encompassed higher BSL-23 baseline scores than the treatment group (N=28), which could have had a negative impact on the results. The authors hypothesised that bias may

have been present in the former condition due to patients' "disappointment" (Hilden et al., 2021) at being allocated to the TAU group, although this could have been due to some other confounding variable(s). This issue could have been anticipated by offering the ST intervention to *all* trial participants (at the end of the study), which would have also been ethical and fair. The study therapists also appeared relatively naïve to the ST approach, having only received less than a week's ST training; albeit they underwent > 40 hours of ST supervision. The study also lacked statistical power.

Farrell, Shaw, and Webber's (2009) study found that Group ST was an effective intervention for women diagnosed with BPD after demonstrating statistically and clinically significant results for both primary and secondary outcome measures. This was following a relatively short duration of treatment (eight months). The authors showed that 94% of the patients in the ST condition no longer met criteria for BPD. However, it would have been interesting to compare Group ST versus TAU as opposed to Group ST + TAU to TAU, as the patients in the experimental condition received two forms of psychological therapy, where it could be argued that the ST element may not have influenced the results and could have (instead) been augmented by the TAU condition. It is also puzzling why the patients received two forms of therapy at the same time as this is otherwise known to be contraindicating and is not routinely recommended (or indeed funded) in real-world clinical settings. This study was also low-powered due to the smaller number of participants in each group (N=16 [x2]).

There were also disruptions to the study interventions; for example, one therapist in the Nadort et al. (2009) study had a prolonged period of absence and other colleagues needed to step in. N=2 patients were reported to have dropped out of the study for this reason, although 79% did complete treatment, which was noted to be a relatively high percentage. However, a lack of therapist consistency during treatment could have impacted on the (reasonable) recovery rate of 42%. It is well documented that disruptions or ruptures in the therapeutic

relationship are problematic if not worked through (Safran, et al., 1990); particularly for individuals with attachment difficulties, where the absence of the therapist may have been experienced by the patients as an ‘absent’, ‘inconsistent’ or ‘withholding parent’, and therefore influenced the results. Systemic factors were also likely to have influenced the outcomes too. Notably, significant organisational changes had taken place during the implementation of interventions, which subsequently may have (also) had a bearing on therapist retention and the experience of patients.

The Leppanen et al. (2015) RCT was the only study in the sample to treat both male and female patients (to the study’s credit). However, the findings may have been influenced by gender differences. For example, men with a diagnosis of BPD have been shown to have an increased prevalence of comorbid substance-misuse disorders, schizotypal, antisocial, or narcissistic personality disorders, and women with BPD are more likely to present with post-traumatic stress disorder (PTSD), eating disorders and ‘identity disturbance’ (Johnson et al., 2003). Such differences may have impacted on patients’ reported mode repertoires and how they were formulated and treated. Gender differences could have also affected group dynamics. Although exclusion criteria for Leppanen et al.’s (2015) study included ‘severe substance misuse problems’ it was interesting that none of the other gender-specific variables appeared to have been accounted for or controlled.

Only two of the reviewed studies delivered the intervention over two years or more (Dickhaut & Arntz, 2014 and Giesen-Bloo, van Dyck & Spinhoven et al., 2006). Schema Therapy for BPD is recommended to be carried out for at least two years (National Institute for Clinical Excellence [NICE], 2009) due to the central aim of internalising the therapist as the ‘healthy adult’, with a view to patients occupying this mode for themselves (Kellogg & Young, 2006). The lower number of ST sessions may therefore have had a negative impact on the recovery rates of the remaining five studies due to this crucial process variable being

overlooked.

Studies with enhanced ecological validity also encompassed limitations. Dickhaut and Arntz's and Fassbinder, Schuetze and Kranich et al.'s (2014 and 2016, respectively) studies were uncontrolled, which implied that the findings were less generalisable to other people living with BPD. In addition, the sample sizes were small (N=18 + N=10 respectively), thereby undermining the confidence intervals of the results.

Dickhaut and Arntz's (2014) study was also limited by the fact that the impact of the 'specialist' Group ST training was evaluated in a convoluted way. Arguably, the design did not lend itself to dismantling the anticipated treatment effects, and the authors suggested that the training effects may have been "non-specific". It was also unclear as to what criteria led to some of the participants receiving an additional six months of individual ST, with no statistical adjustment made for this adjunct practice. However, this may have been due to the small sample size/s. When compared with Giesen-Bloo, van Dyck and Spinhoven et al. (2006), the authors demonstrated a higher rate of recovery on the BPDSI-IV, although Dickhaut and Arntz conducted their study over a shorter duration (2 years, compared to Giesen-Bloo et al.'s 3 years). Furthermore, the emergence of "antisocial and narcissistic traits" in Dickhaut and Arntz's (2014) study were hypothesised to be therapy-interfering within their (smaller) treatment groups, although these traits could have presented in any of the review sample's groups. Cohort effects were also highlighted as confounding variables, with the authors stating that the first group of participants were "more difficult patients".

Such reported observations were puzzling for a study of this nature. Crucially the ST stance focuses upon modelling the Healthy Adult to clients, with particular attention paid to attunement and meeting unmet needs. If certain patients were deemed problematic by those delivering and / or evaluating the interventions, this suggests that attunement was low and could

have impacted on the quality of the interventions or therapeutic relationship(s). In addition, the identification of a ‘problematic cohort’ may have been due to the research team becoming caught up in splitting and / or due to possible burnout. Nonetheless, the recovery rate of 77% was impressive in spite of the difficulties reported, although it would have also been interesting to ascertain if the reported gains continued beyond the 6-month (post treatment) period.

Limitations in Fassbinder, Schuetze and Kranich et al.’s (2016) study included the Group ST intervention delivered within a closed group format. The authors noted that a semi-closed (‘rolling’) group could offer greater flexibility in applying the ST techniques and encourage newer group members to feel confident in attending the sessions. On the other hand, this poses the risk of compromising ‘safety’ and attachment amongst group members and may negatively influence the effects of Group ST (Fassbinder et al., 2016). However, this would be a helpful hypothesis to test in future controlled studies.

Finally, as the majority of reviewed studies were RCTs (N=5), it can be argued that such practices deviate from how therapeutic interventions are delivered in reality. The RCT research findings may not mirror applications in routine clinical practice, and so encompass reduced ecological validity. This suggests that there is room for further studies to add to the (small) body of literature by investigating the impact of ST on BPD outcomes within less controlled contexts.

2.9.1 Challenges with Comparing Different Types of Study Interventions

The review studies were significantly different from one another, with a range of interventions that included psychotherapy, psychiatry input, or medication. Interventions were also combined with ST in some cases. There were also varying formats of ST (e.g., Individual ST, Group ST, Group + Individual ST, Psychoeducational ST, and manualised ST), and differing methods of assessment. These study differences meant that ‘like for like’ comparisons

were not possible and is important to acknowledge.

2.10 Synthesis and Review Conclusion

A systematic review of the European and American body of research was performed to evaluate and synthesise the available empirical evidence regarding the efficacy and effectiveness of Schema Therapy for the treatment of BPD and EUPD. The search(es) yielded seven shortlisted studies, five of which were randomized control trials and two were uncontrolled studies. No (exclusively) qualitative studies were included within the review as this focused primarily on quantitative outcomes of efficacy and effectiveness, which in hindsight was a limitation as the findings failed to capture the richness of patients' experiences. None of the review studies reported efficacy data.

A range of research methods were employed in the sample and included semi-structured and structured interviews and self-report measures, with one study incorporating a mixed-methods design that explored process variables in relation to the trial professionals. As ST effectiveness is an under-researched area, this presents an important opportunity for further research to be carried out in similarly imaginative ways. This could include evaluating the potential impact of outcome or retention-oriented process interventions, such as the inclusion of pre-treatment sessions as implemented in the Dickhaut and Arntz (2014) study. Crucially, carrying out qualitative research in this area would further address gaps in the evidence base as highlighted previously.

Only one study (Giesen-Bloo van Dyck and Spinhoven et al., 2006) compared ST alone to another therapeutic intervention (TFP). Following the intervention, the results were in favour of ST on both primary and secondary measures as well as yielding a reduced attrition rate, although the authors noted that both ST and TFP were effective in promoting recovery of BPD. This appeared to be a well-designed study and was conducted over a substantial period of three

years. However, the authors warned against generalising the findings without further replication, whereby the onus is on researchers to fund further studies of this nature. This message should be directed towards the UK research community in particular, as ST is a NICE recommended treatment (National Institute for Clinical Excellence [NICE], 2009) and the majority of studies were carried out in other parts of Europe. For ST to be taken more seriously as an intervention it is important that ST research is funded in the same way as Cognitive Behavioural Therapy.

Two of the studies compared ST against itself (Dickhaut & Arntz, 2014; Nadort et al., 2009). In the case of Dickhaut and Arntz's (2014) uncontrolled study, it was concerned with the impact of specialist group ST training on BPD manifestations and reported an impressive recovery rate of 77%. Whilst understanding the training element was an important aim, this further underscores the need for more studies comparing ST against other forms of psychotherapy and with larger sample sizes.

When combined with other interventions the impact of ST was difficult to determine. Three of the studies (43%) combined ST with either Eclectic Psychotherapy (Farrell, Shaw & Webber, 2009), psychiatric input (Hilden et al., 2021) or optimisation of psychotropic medication (Fassbinder, Schuetze & Kranich et al., 2016). The challenge remains in discerning the 'active ingredient/s' of change, although the Hilden et al. study reported clinical significance only, and the interventions were delivered over a relatively shorter period.

Recovery rates or reduction in BPD symptoms were substantial, ranging from 42% (Nadort et al., 2009) to 94% (Farrell, Shaw & Webber, 2009) for patients receiving ST. However, the studies used different methods of evaluation and sample sizes varied. As well as measuring recovery from BPD, all short-listed studies investigated additional outcomes including QoL, general 'psychopathologic' function, schema / mode changes and 'happiness'

ratings, with secondary improvements found in all seven studies, comprising both statistical and clinical significance. While encouraging, the diverse ways in which the studies were conducted presents a challenge in interpreting them as a body of evidence.

Evidence for the effectiveness of ST was weaker in the Leppanen et al. (2015) study compared to variable TAU. The latter consisted of individual psychotherapy, medical appointments, or home rehabilitation. The study was carried out over the course of a year. Although BPD symptomatology was found to be lower than TAU, the varied nature of the control interventions (including psychotherapy) may have introduced confounders into the study so may have artificially reduced the impact of ST. It is crucial that studies are well designed while encompassing ecological validity, although it is of note that this review did not carry out a quality appraisal of the papers.

The results from the total sample suggested that patients dropped out of group ST at a greater rate than individual ST (e.g., Dickhaut & Arntz, 2014), however combining group with individual ST was noted to ‘speed up’ the rate of recovery (Dickhaut & Arntz 2014) and adding (a different) Psychotherapy resulted in substantial recovery from BPD (Farrell, Shaw & Webber, 2009). These are interesting findings and may suggest a need to ‘front-load’ or ‘concentrate’ therapeutic efforts, however this would have significant cost-implications attached. Furthermore, Farrell et al.’s (2009) results occurred despite the study delivering two therapies concurrently and appears to challenge the commonly held view that duplicity of (therapeutic) work is unhelpful.

As mentioned, this review is limited in various ways; thus, the findings must be contextualised. First, the sample of studies is relatively small and cannot be generalised to encapsulate the wider literature, e.g., studies written in other languages were not sampled, nor were studies carried out in other parts of the world. In addition, the shortlisted studies were not

quality appraised. By focusing only on studies conducted in Europe and the USA, the potential outcomes of ST within non-Western regions were not taken into consideration, and therefore the results may be viewed as ethnocentrically biased and lacking in important nuance, e.g., cultural differences. Intriguingly, there were links noted between several of the study researchers who were either co-author in at least one other study (e.g., Arntz & Giesen-Bloo, respectively); had used a peer's data as comparison (Nadort et al., 2009); or utilised study materials (Dickhaut & Arntz, 2014). This suggests that the reviewed body of research may be subject to increased bias. Finally, since the reviewed studies overwhelmingly focused on BPD, the findings cannot necessarily be extrapolated to EUPD; although the diagnostic criteria for both classification systems are qualitatively similar.

The findings of this systematic review suggest that Schema Therapy (in its various guises and permutations) might be an effective treatment for reducing the symptomatology of (mainly) women with BPD, with encouraging results emanating from both the controlled and uncontrolled trials. The addition of group ST may enhance the therapeutic effects but may also have a negative impact on retention. It was not clear how duration of treatment affected the results. Further RCTs are needed comparing ST alone with other therapies, in addition to increasing numbers within uncontrolled studies, thereby increasing confidence in the ST model and its generalisation to clinical settings. Qualitative and mixed-method studies would enrich the evidence-base in relation to lived experience of recovery from BPD following ST. The review however could not determine whether ST might be effective in men due to only a single study including men. This speaks to the wider literature which highlights that fewer males participate in psychological research studies (Knox et al., 2022). Future research concerning ST outcomes would therefore need to pay close attention to engaging and increasing men's participation.

Table 2. Summary of Systematic Review Findings (N=7 papers)

Research Study	Design	Sample / Intervention	Main Research Findings
<p>Dickhaut, V. & Arntz, A. (2014). Combined Group and Individual Schema Therapy for Borderline Personality Disorder: A Pilot Study. <i>Journal of Behaviour Therapy and Experimental Psychiatry</i>, 45(2), 242-251.</p>	<p>Uncontrolled Study. Combined Individual + Group Schema Therapy. Additional Individual ST if indicated. Study primarily focused upon ascertaining training effects of the therapists (Experienced in Individual ST vs Individual + Specialist Training in Group ST). Assessments were made at 6 month intervals up to 2.5 years. Primary measure: BPDSI-IV (Semi-structured interview).</p>	<p>Two cohorts of working-age female patients diagnosed with BPD (N=8, N=10) participated in a combination of group ST + individual ST over the course of 2 years; bi-weekly, for 90 minutes (group intervention); and 60 minutes (individual therapy).</p>	<p>Manifestations of BPD reduced significantly. The effect size was large and recovery at 30 months was 77%. The researchers also identified improvements in general psychopathologic function, schema mode measures, QoL and happiness. The researchers found that overall, combined group ST as well as individual ST, are effective for the treatment of BPD although the attrition rate was higher for group therapy in the first year (33%) as compared to individual ST. Attrition was 6% in year 2. No significant differences were found long-term between the groups.</p>
<p>Farrell, J.M., Shaw, I.A., & Webber, M.A. (2009). A Schema-Focused Approach to Group Psychotherapy for Outpatients with Borderline Personality Disorder: A Randomized Controlled Trial. <i>Journal of Behaviour Therapy and Experimental Psychiatry</i>, 40(2), 317-328.</p>	<p>RCT. Single-centre randomized 2-group design. Combined Schema Focused Group + TAU (Individual Psychotherapy) vs TAU alone. Primary measures: Structured Interview (DIB-R) and BSI. Assessments were made at 8 months and at 6 month follow-up.</p>	<p>Two groups of working-age female patients diagnosed with BPD (N=16, N=16) were randomized to either a 90-minute Group ST + TAU (Individual Psychotherapy for BPD) or TAU over a period of 8 months (30 sessions).</p>	<p>The researchers found evidence of significant reductions in BPD symptoms: 94% of ST + TAU, compared to 16% of TAU no longer met diagnostic criteria for BPD. There were also reductions in global severity of psychiatric symptoms in the ST + TAU group. The effect size was large. Attrition rates were 0% for the experimental group and 25% for controls.</p>

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

Research Study	Design	Sample / Intervention	Main Research Findings
<p>Fassbinder, E., Schuetze, M., Kranich, A., Sipos, V., Hohagen, F., Shaw, I., Farrell, J., Arntz, A., & Schweiger, U. (2016).</p> <p>Feasibility of Group Schema Therapy for Outpatients with Severe Borderline Personality Disorder in Germany: A Pilot Study with Three Year Follow-up.</p> <p><i>Frontiers in Psychology, 7 (1851), 1-9.</i></p>	<p>Uncontrolled study.</p> <p>Combined Individual Schema Therapy and Group Schema Therapy + Optimisation of Psychotropic Medication.</p> <p>Primary measure: BPDSI-IV.</p> <p>Assessments were made at 6, 12, and 36 month intervals.</p>	<p>One group of female working-age patients (frequent hospital attenders, N=10) diagnosed with BPD participated in group ST and individual ST + optimisation of psychotropic medication over the course of one year, weekly, delivered in 60 and 100-minute appointments (respectively).</p>	<p>The researchers identified significant decreases in severity of BPD symptoms, general symptom severity, dysfunctional BPD-specific schema modes and EMS and reduction in days of hospitalisation. Functional modes, QoL and happiness were also improved. There were high effect sizes for the improved ST specific measures.</p> <p>N=1 patient was counted as dropping out of the study.</p>
<p>Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt, T., & Arntz, A. (2006).</p> <p>Outpatient Psychotherapy for Borderline Personality Disorder: Randomized trial of Schema-Focused Therapy vs Transference-Focused Psychotherapy.</p> <p><i>Archives of General Psychiatry, 63(6), 649-658.</i></p>	<p>RCT.</p> <p>Multisite randomized, 2-group design.</p> <p>Individual Schema Therapy vs Transference Focused Therapy.</p> <p>Primary measure: BPDSI-IV.</p> <p>Assessments were made at 3-monthly intervals for the primary outcome measure, and at 6 month periods for the secondary measures.</p>	<p>Working-age female patients diagnosed with BPD were randomized to three years of ST (N=45) or TFP (N=43) which took place twice a week in 50-minute appointments.</p>	<p>The researchers found that three years of ST or TFP was effective for reducing BPD symptoms, general psychopathologic function, measures of ST / TFP concepts and QoL. Both forms of therapy were also effective for reducing psychopathologic dysfunction. ST was found to be significantly more effective when compared to TFP for all measures.</p> <p>ST was shown to have better treatment retention with a higher attrition rate for TFP patients.</p>

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

Research Study	Design	Sample / Intervention	Main Research Findings
<p>Hilden, H. M., Rosenström, T., Karila, I., Elokorpi, A., Torpo, M., Arajärvi, R., & Isometsä, E. (2021).</p> <p>Effectiveness of Brief Schema Group Therapy for Borderline Personality Disorder Symptoms: A Randomized Pilot Study.</p> <p><i>Nordic Journal of Psychiatry</i>, 75(3), 176-185.</p>	<p>RCT (pilot study).</p> <p>4 Treatment (Tx) groups and 2 parallel control groups.</p> <p>Single site randomized 2:1.</p> <p>Combined Group Schema Therapy + TAU (Psychiatric Treatment) vs TAU alone.</p> <p>Primary measure: BSL-23 (self-rating instrument).</p> <p>Post Tx assessments were made at 5 months.</p>	<p>N=42 working-age female patients with a BPD diagnosis were randomized to either a 20-session weekly 90-minute Group ST + TAU (psychiatric treatment) (N=28) or control group that consisted of TAU alone (N=14).</p>	<p>The researchers did not find significant differences between the treatment and control groups with respect to the primary outcome mean (BSL-23 decline) and in the secondary outcome measures (PHQ-9, AUDIT score and SDS for general functioning). The decline in 3 out of 4 dysfunctional schema modes was not found to be statistically significant.</p> <p>The researchers concluded that although Group ST was feasible for psychiatric outpatients with BPD, it was no more effective than TAU alone.</p> <p>82% of Group ST patients and 86% of controls completed treatment.</p>
<p>Leppanen, V., Hakko, H., Sintonen, H., & Lindeman, S. (2015).</p> <p>Comparing Effectiveness of Treatments for Borderline Personality Disorder in Communal Mental Health Care: The OULU BPD Study.</p> <p><i>Community Mental Health Journal</i>, 52, 216-227.</p>	<p>RCT.</p> <p>Multisite randomized 2-group design.</p> <p>Group + Individual Schema Therapy vs variable TAU (Individual Therapy, Medical Appointments or 'Home Rehabilitation'). The ST Group intervention element was more psychoeducational in nature.</p> <p>Individual therapists attended consultation group sessions every fortnight x20 sessions.</p> <p>Primary measure: BPDSI-IV (interviews were blinded).</p> <p>Post Tx assessments at 1 year.</p>	<p>N=71 working-age male and female patients were randomized to either the Group ST intervention (N=24) or (variable) TAU (N=47), consisting of 40 weekly sessions for 45-60 minutes, delivered over the course of 1 year. The group intervention was delivered by Community Treatment Experts (CTEs) (Study Therapists).</p>	<p>The researchers found that after 1 year, ST patients showed a significant reduction in a "wider range" of BPD symptoms and improved QoL than TAU patients.</p> <p>The researchers concluded that ST delivered by CTBEs appeared more effective in increasing distress tolerance and decreasing dysfunctional behaviours such as parasuicide and impulsivity, compared to TAU.</p> <p>N=51 patients completed the study. Of the N=10 that dropped out, N=1 was lost to completed suicide.</p>

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

Research Study	Design	Sample / Intervention	Main Research Findings
<p>Nadort, M., Arntz, A., Smit, J. H., Giesen-Bloo, J., Eikelenboom, M., Spinhoven, P., & van Dyck, R. (2009). Implementation of Outpatient Schema Therapy for Borderline Personality Disorder with, versus without Crisis Support by the Therapist Outside Office Hours: A Randomized Trial. <i>Behaviour Research and Therapy</i> 47(11), 961-973.</p>	<p>RCT. Multisite randomized 2-group design, studying the added value of crisis telephone support. Clinical evaluation of Schema Therapy + Crisis Telephone support vs ST without Telephone support. Incorporated a mixed-methods approach (small qualitative element). Primary measure: BPDSI-IV. Assessments made at 6 monthly intervals over 1.5 years by independent Research Assistants.</p>	<p>N=62 working age female patients diagnosed with BPD were randomized to ST twice a week for 45-minute appointments + access to therapist telephone availability out of hours, when in crisis (N=32), vs ST without additional telephone support (N=30). The study was delivered over the course of 18 months.</p>	<p>The researchers concluded that ST for BPD can be successfully incorporated into mental healthcare as the results showed high effectiveness and limited dropout results, which were comparable to previous clinical studies. 42% of patients ‘recovered’ from BPD. However, no added value of therapist availability after hours, nor any other measure (e.g., QoL, Psychopathology) following 1.5 years of ST was found. 79% completed treatment. Of the 21% who dropped out, N=1 patient was lost to completed suicide.</p>

2.11 Study Rationale and Aims

Within the existing literature, there is mixed empirical evidence that suggests the prominence of particular schema modes for BPD and several reports of the clinical usefulness of the mode concept (Nordahl & Nysæter, 2005; Giesen-Bloo van Dyck & Spinhoven et al., 2006). Despite this, there is a relatively small number of quantitative studies in which groups of service-users diagnosed with different personality disorders have been given the Young Schema questionnaire (Young & Brown, 2003) and the Young Schema Mode Inventory (Young, Arntz & Atkinson et al., 2007). While valuable in showing the possible distribution or prominence of types of modes in different client groups (e.g., 'Obsessive-compulsive' and 'Narcissistic Personality Disorder', Lobbestael, van Vreeswijk, & Arntz, 2008), such research can only examine the prevalence of the modes included within the questionnaire. It cannot identify whether modes occur outside of a schema context or whether there might be other typologies of modes / states at play. Furthermore, it cannot tap into the service-users' own perspective.

When perusing the empirical qualitative literature, only one study explored patients' perspectives of Schema Therapy, for example, Klerk et al. (2016) but the sample included individuals with Avoidant, Dependent, Obsessive Compulsive, Paranoid, and Narcissistic Personality Disorders. Sari and Gençöz (2019) explored the experience of a combined Compassion-focused Therapy (CFT) (Gilbert, 2010) and Schema Therapy (Group) intervention with a particular focus on the soothing system (Gilbert, 2009). However, the women in the group were diagnosed with depression. The same number of studies evaluated Young et al.'s schema modes, namely Puri et al. (2021) who used a mixed methods approach to evaluate schema modes and cognitive distortions within Borderline Personality Disorder. Edwards (2017) derived phenomenological accounts of schema modes, but from a person with lived experience of Anorexia Nervosa. Moreover, there did not appear to be any qualitative

studies that investigated participants' view of their modes nor were open to capturing any other states of self. Such deficiency of qualitative literature is likely to reflect (and influence) the reduced power and lack of 'voice' that people with BPD report and in turn, impact directly on the nuance and richness of the evidence-base.

Due to the gaps in the qualitative literature, this research project aimed to explore whether 'modes' or other 'states of self' can be identified in those who attract the diagnosis of Borderline or Emotionally Unstable Personality Disorder, and if so, how participants talked about them (in other words how modes or states were subjectively experienced) and to what extent they compared with Young et al.'s mode concept (i.e., how the modes manifested with respect to theory). Through investigating participants' perspectives, this may lead to greater insights into states of self for BPD and EUPD and would enable their voices to be heard; potentially bringing to life the abstract concept of modes, thus enriching the evidence-base and making modes more accessible to people with BPD and the clinicians they work with. The dissemination of findings to service-user groups and clinicians will support this undertaking, as will aiming to publish the findings in a peer-reviewed journal. Finally, this research might highlight further avenues of investigation.

The five modes that were selected for this study were what Young and colleagues (2003) hypothesised as being the 'Primary' or 'Central' Schema Modes for this client group, namely **'Abandoned Child'**, **'Angry & Impulsive Child'**, **'Punitive Parent'**, **'Detached Protector'** and **'Healthy Adult'**.

Specifically, the researcher intended to explore the patterns of experience of participants, including what participants made of the mode concept. However, in conducting this research it was not assumed that any one theory of modes was 'correct', be that Schema Therapy or any of the other therapies using apparently similar concepts. To this end, what

emerged from the data might indeed look exactly like or similar to a ‘schema mode’, but the researcher was mindful to keep an open mind as these phenomena were explored.

2.11.1 Research Questions

The main objective of the study was to explore the possible presence of Young et al.’s schema modes for BPD or other states of self in individuals (NHS service-users) with a diagnosis of Borderline Personality Disorder or Emotionally Unstable Personality Disorder.

The following primary research question was concerned with the extent that participants’ comments made during the interviews were representative of Young’s BPD mode concept.

Primary Research Question:

- To what extent do participants’ responses compare to Young et al.’s (2003) modes for BPD, namely Abandoned Child, Angry & Impulsive Child, Punitive Parent, Detached Protector and Healthy Adult modes?

The first secondary research question (below) was interested in whether participants’ responses in the interview could be considered to ‘fall outside’ of Young’s mode concept and be otherwise coherent with other theoretical states of self, such as Internal Family Systems Therapy (IFST) (Schwartz, 1995) and Cognitive Analytic Therapy (CAT) (Ryle & Kerr, 2020) or suggest the possibility of new modes or self-states.

Secondary Research Question 1:

- Do the participants’ responses in the interviews suggest alternative theoretical or novel states of self?

The final secondary research question took a meta-perspective and explored what the participants thought about their modes following the main discussion in the interview.

Secondary Research Question 2:

- How do the participants view their modes or states of self?

The study also triangulated the interview findings with participants' (amended) SMI scores.

2.11.2 Relevance for Clinical Practice

If modes or self-states are understood from the client's perspective, these may better scaffold assessment and psychological formulation processes and potentially influence clinical decision-making. For example, one therapeutic approach might be a better fit than another, thereby meeting NIMH(E)'s aim of creating 'an understanding and more compassionate, responsive (therapeutic) workforce' (National Institute for Mental Health in England (NIMH[E], 2003 & 2004). Additionally, if modes specific to EUPD / BPD are identified or variations of existing ST modes described, then schema mode work could be modified to more accurately reflect service-users' lived experience.

CHAPTER 3: METHODOLOGY

3.1 Epistemological Stance

The epistemological stance adopted was critical realist, which maintains that ‘reality exists independently of the researcher’s mind and that there is an external reality’ (Ritchie et al., 2003; Madill et al., 2000). The critical realist stance is not in favour of total rejection of empiricist methodology; but rather it emphasises the importance of exploring deep-seated causal processes that operate in the world. It also posits that societal ideas may be socially constructed through discourse (Burr, 2015). The critical realist position can therefore be argued as located between social constructionist and realist positions, where the idea of different interpretations of reality is accepted and is similar to constructionist thinking (Joffe, 2012).

For the present study, it was envisaged that the adoption of a critical realist stance would be well suited to the theoretical understanding of Young, Klosko and Weishaar’s (2003) schema modes (2003), while also considering how states of self may otherwise be regarded by the participants. As critical realism is methodologically pluralistic (Wynn & Williams, 2020), it was felt that a mixed-methods approach was ideal. This would allow for both retroductive exploration of phenomena through semi-structured interviews and triangulation of research findings (McEvoy & Richards, 2006; Denzin, 2012) through the administration of an amended version (see Appendix 3) of Young, Arntz and Atkinson et al.’s (2007) Schema Mode Inventory (SMI).

3.2 Study Design

When considering the most appropriate design for the study, it was important to weigh up the relative merits and limitations of various methodological procedures employed within psychological research. A mixed methodology approach employing a qualitative and

comparative cross-sectional quantitative research design (using descriptive statistics) was utilised to explore the extent that participants' comments compared to the concept of Young, Klosko and Weishaar's (2003) central modes for Borderline and Emotionally Unstable Personality Disorder or other states of self. Semi-structured interview methodology was decided as the overarching method to explore participants' modes as posited within Schema Therapy; to identify any other states of self, as well as explore how participants view their self-states. It was anticipated that semi-structured interviews would allow participants the opportunity to "think, speak and be heard" (Layder, 1993) whilst enabling the researcher to reflexively identify, probe and interpret topic-related themes as they emerged. As this was a mixed methods approach, participants' experiences were later coded and compared to their responses on the amended SMI.

The cross-sectional design allowed for a range of service-users' experiences of modes (or states of self) to be captured at a single time point across two adult community mental health teams (CMHTs), located within a single NHS Trust. Therefore, each participant completed the interview and questionnaire (sequentially) on the day their interview was arranged. All seven interviews took place from January to November (2020). This type of design is important when using questionnaires, as it permits multiple variables (schema modes) to be investigated concurrently. The qualitative aspect of the design enabled in-depth exploration of participants' experience of modes or otherwise-identified states of self.

The study aimed for a minimum sample size of 10 as proposed by Braun and Clarke (2013) for medium-sized research projects. It is of note that for Thematic Analysis, a sample size of 6 - 15 participants is an acceptable range for professional doctorate programmes (Braun & Clarke, 2006). Bearing this in mind, the study aimed for a maximum of 15 in the event of participant attrition. However, due to the unforeseen effects of the pandemic, only 7 participants were recruited.

Recruitment of participants was affected in the following ways:

1. How mental health services were delivered in England during the height of the pandemic, which led to emergency business continuity plans being implemented and services reconfigured / streamlined.
2. During the early part of the pandemic, the Trust R&D Lead specified that research activities must cease.
3. There was a substantial shortage of NHS clinicians due to self-isolation, shielding, ill health, burn-out or Covid-related bereavement. This meant that fewer referrals to the study were made. Although it was not possible to estimate the loss on recruitment numbers, research showed that for global (including UK) clinical trials, recruitment was affected year on year by -80% to -100% between the months of March 2020 and May 2020 (Sathian et al., 2020).
4. Many NHS clinicians (mainly community nurses [care co-ordinators]) were redeployed to other parts of the trust that were in greater need, such as inpatient wards. This was in response to anticipated high levels of Covid-19-related absence where the Trust moved into the 'surge phase' of business continuity.
5. Those who remained within the teams were largely working from home (including the researcher), thereby reducing day to day interactions, resulting in fewer opportunities to discuss potential referrals to the study.
6. Government restrictions dictated that service-users would be unlikely to receive a face-to-face service, which was how the interviews were designed to be delivered.
7. Many service-users were self-isolating, shielding, coping with Covid-19 symptoms,

bereavements and / or struggling with social, psychological, financial and ‘treatment’ implications of pandemic measures. This further impacted upon study recruitment.

8. Finally, the pandemic held similar restrictions for the researcher (including personally), which not only impacted upon recruitment, but carrying out the study within the estimated time frame.

In addition to the above, the researcher was not based at the Colne House recruitment site which resulted in a weaker working relationship with much of the multidisciplinary (MDT) team and consequently the study received fewer referrals from this site. The researcher later came to understand that the low accrual rate was likely attributed to the team’s heavier caseloads as well as the researcher not being a visible-enough presence in the team, particularly when Covid restrictions were implemented. All the aforementioned factors pointed towards the study being lower down on the Colne House team’s list of priorities. Only one participant was recruited from the site, compared to six at Cygnet House which was (also) the researcher’s place of work.

For the qualitative analysis, Thematic Analysis was utilised as it is a highly flexible approach that can be used across the epistemological and ontological spectrum and is applicable to a wide range of research questions. Thematic Analysis primarily encompasses encoding qualitative information through generating codes, followed by commensurate themes and sub-themes. TA has been conceptualised as “a method for identifying and analysing patterns of meaning in a dataset and illustrates which themes are important in the description of the phenomenon under study...the end result of a Thematic Analysis should highlight the most salient constellations of meanings present in the dataset. Such constellations include affective, cognitive, and symbolic dimensions” (Joffe, 2012, p.209).

Alternatively, TA can be understood as a method for “systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set” (Braun & Clarke, 2006). Through this process, TA afforded the researcher the opportunity “to see and make sense of collective or shared meanings and experiences” (Braun & Clarke, 2012, p.57). A theme, as defined by Boyatzis (1998, p.4) is “a pattern found in the information that at minimum, describes and organises the possible observation, and at maximum, interprets the aspects of the phenomenon”.

With respect to working from theory, a TA approach can be sympathetic to this when analysing data (Braun & Clarke, 2006). Consequently, a Thematic Analysis rather than any other qualitative method, was chosen in line with the study’s aims and research questions. Furthermore, TA proposes that exploration of a phenomenon, in this case schema modes or states of self, can produce rich and detailed data, resulting in the generation of descriptive themes (Braun & Clarke, 2006). Although Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) may generate similarly rich and meaningful themes, this idiographic approach was viewed as incompatible with the premise of working from a theoretical standpoint due to IPA’s premise to explore shared experience *without* the imposition of prior knowledge or assumptions. Grounded theory (GA) (Glaser & Strauss, 1967; Strauss & Corbin, 1998) was also discounted on the basis that GA is used for the *development* of theory, rather than evaluating whether preexisting theory (i.e., Young et al.’s [2003]) main schema modes resonated for participants.

Within TA there are various ways of deriving codes. For example, through the inductive or bottom-up method, whereby coding is derived from the raw data set. This data-led method was viewed to lend itself well to the potential identification of otherwise-unidentified states of self, as well as identifying how participants viewed their modes. Another method of coding is deductive, or top-down / theory-driven, whereby existing constructs (e.g., schema modes) are

the starting point on which to derive codes. This method of coding is based upon the premise that there are laws that can be applied to data (Guest et al., 2012). Therefore, the inductive approach begins from the transcripts, and the codes derived, describe the data. The deductive method originates from theoretical ideas and interrogates the transcripts for evidence in support of the theory (Boyatzis, 1998).

The study used a combination of inductive and deductive approaches, with an emphasis on reflexivity (Elliott et al., 1999). Reflexivity comprises “an honest examination of the values and interests of the researcher that may impinge upon research tasks” (Primeau, 2003). It is acknowledged that both quantitative and qualitative research are susceptible to the preconceptions of the researcher and subsequently how they influence the interpretation of data (Strauss & Corbin, 1998; Creswell & Millar, 2000). It is through the process of bracketing (Ahern, 1999; Chan et al., 2013) that biases resulting from the researcher’s own experiences can be mitigated. Indeed, much has been written about the processes by which researchers “put aside their repertoires of knowledge, beliefs, values and experiences, in order to accurately describe participants’ life experiences” (Chan et al., 2013). The researcher attempted as much as possible to suspend judgement and remain curious about (her) pre-determined views and ideas. This was facilitated through keeping a reflexive diary (Darawsheh, 2014; Wall et al., 2004) during the pilot, interview, and analytic processes; noting and reflecting upon personal thoughts, feelings, perceptions, and ideas, so that the derived themes could remain as close to the raw data as possible.

Where the data did not appear to fit with Young et al.’s (2003) modes, the identified states of self were coded in accordance with other theoretically derived self-states (e.g., Cognitive Analytic Therapy [Ryle & Kerr, 2020]) as well as keeping in mind any potential novel modes. Participants’ views of modes or states of self were analysed inductively, and

anonymised self-memos were also noted in the diary to record reflections and ideas as they came to mind.

For the Quantitative Analysis, participants completed an amended version of Young, Arntz and Atkinson et al.'s (2007) 124-item SMI following the semi-structured interview. The three amendments (items 15, 60 and 123, see Table 5) were rephrased at the request of the Cambridge Research Ethics Committee (REC) and one of the Service-User Consultants (items 60 and 123) to reduce the potential for participant distress.

The original SMI (2007) is designed to capture the full spectrum of Young et al.'s schema modes (14 in total), including the five (BPD) central modes of interest. Please refer to Appendix 2 for a description of the BPD modes and associated schemas. Participant responses on the amended questionnaire (see Appendix 3) were then scored and 'profiled' in terms of the total modes identified (out of a maximum of 14) and aggregated to the level of the participant and the sample as a whole. Please see Appendix 4 for the modes of interest. The central mode 'profiles' were then compared to the themes that were derived from the corresponding interviews. All participant scores were reported using simple descriptive statistics. For the remaining mode profiles relating to the total sample that were scored from the amended SMI (which fell outside the scope of this study), please see Appendix 5.

While it is recognised that quantitative designs are typically associated with realist positions (Maxwell & Mittapalli, 2010, p.145), it was felt that the inclusion of the SMI added further empirical merit; further strengthening and triangulating the conclusions that were drawn from the participants' lived experiences.

3.2.1 Reliability of Study Design: Qualitative Phase

For the qualitative phase, reliability guidelines as put forward by Elliott et al. (1999) were followed. These are listed in Table 3, below.

Table 3. Evolving Guidelines for Qualitative Research

Guideline	Procedure Undertaken
Own One's Perspective	Specify theoretical position and epistemology.
Situate the Sample	Provide sociodemographic data.
Ground in Examples	Give examples of data to illuminate themes.
Provide Credibility checks	Pilot procedures and quality check codes / themes.
Coherence	Present findings in a coherent, integrated fashion.
Accomplish General vs. Specific Research Tasks	Acknowledge limitations and generalisability of findings.
Resonate with Readers	Present an accurate and honest representation of findings.

Table adapted from Elliott et al., 1999

3.2.2 Reliability of Study Design: Quantitative Phase

According to Sürücü and Maslakçı (2020) the reliability and validity of a measuring instrument are two indispensable features for gaining optimum results in a quantitative study. Validity in this context, refers to whether the instrument (in this case, the amended SMI) is measuring what it purports to measure, and is a strong indicator of the extent that the measuring instrument is performing its given function (Anastasi & Urbina, 1997).

The reliability of an instrument points toward the stability of the quantified values captured in repeated measures using the same measuring tool, under the same conditions. Not only is reliability a key characteristic of the measuring instrument, it is also a characteristic of the results of the measuring instrument (Sürücü & Maslakçı, 2020).

The scholars emphasised that if a study uses a measuring tool that falls short of encompassing either or both of these qualities (validity and reliability), it will be unlikely to

produce beneficial results. It is of note that as the three rephrased items did not undergo any form of psychometric evaluation, the amended instrument cannot be expected to retain its (modest) psychometric claims. However, as mentioned previously, the rephrased items did not correspond to four of the five modes of interest, only the impulsive subscale, which links with the impulsive element of the Angry & Impulsive Child mode. It is therefore reasonable to assume that the majority of the central sub-scales / modes are likely to have produced theoretically sound data. For the two sub-scales that were compromised psychometrically (see Appendix 3), these results should be interpreted with caution.

It is also notable that owing to the small sample size (N=7) the study lacked statistical power (Pallant, 2016) and the quantitative results should be interpreted with this important limitation in mind.

3.3 Expert by Experience Consultants

Three Expert by Experience (EBE) Consultants (referred to elsewhere in the thesis as ‘Service-user and Carer Consultants’) were recruited to the study to provide input and feedback to the study’s piloting (Wendy, Millie & Janine, personal communication, 1 & 29 March 2019; Appendix 6), documentation, results (Appendix 7), and dissemination (Wendy, personal communication, 18 February 2024). The Consultants were recruited following Dr Emma Karwatzki’s (Senior Lecturer and Clinical Tutor, UH) email to the University of Hertfordshire’s Service User and Carer Committee with a summary of the study (written by the researcher) and a request for consultation support. One of the Consultants got in touch (a carer) with an offer of help and enlisted the support of two other people with personal experience of Emotionally Unstable Personality Disorder. All of the Consultants were women. The Consultants generously volunteered their time, wisdom, refreshments, and an excellent community venue, and understood that they would not receive financial remuneration for their

input. No EBE Stakeholders were recruited from the Community Mental Health Teams (HPFT) which could have added further value to the study.

3.4 Reflexivity

In striving for authenticity and validity throughout the study, the researcher paid close attention to reflexivity. Myerhoff and Ruby (1992), cited in Ahern (1999), defined reflexivity as “the capacity of any system of signification to turn back upon itself, to make itself its own object by referring to itself”. While it is recognised that qualitative researchers cannot be completely objective (Shultz, 1994, cited in Ahern, 1999), it was important that the researcher upheld a reflexive standing from an early stage. This involved repeated examination of the researcher’s assumptions, biases, values, motivations, and behaviours so that these could be placed aside (or ‘bracketed’) (Ahern, 1999; Chan et al., 2013) in order that the participants’ experiences remained as ‘true’ as possible to the reported findings.

The researcher first learned of the study after the UH course team shared a list of Major Research Projects (MRPs) for students to consider and was especially drawn to an outline of a mixed-methods project that was focused upon feeling states in individuals with BPD or EUPD. A particular aspiration of the researcher was to work therapeutically with service-users experiencing personality difficulties, and a personal value of promoting compassion and understanding of such individuals within multidisciplinary teams. These factors largely influenced the researcher to express an interest in the study; whereby she abandoned an earlier MRP idea in favour of this project. Through reflexive exploration, the researcher became aware that in committing to this research, she would be highly motivated to complete a thoughtful and clinically meaningful study, however, it risked being ‘contaminated’ with bias without continued acknowledgment of the researcher’s subjectivity (Ahern, 1999). To mitigate this, the researcher kept a reflexive diary that included examination of the moods and feelings that arose

within her when piloting the interviews (see Appendix 6), collecting and analysing data, encountering personal resonance, and navigating various research bureaucracies (see section 1.5).

In terms of the latter consideration, the researcher became more aware of her powerlessness in relation to ever-increasing ethical processes, while this increased her understanding of participants' *reduced* power in juxtaposition to the researcher and the NHS. These powerful insights enabled a reframing of ethical processes as in the best and necessary interests of both participants' and the populations they represented, as well as providing an important opportunity for the researcher to ride a steep learning curve.

As the Field Supervisor (Mr John Rhodes) was an experienced Schema practitioner / Clinical Psychologist and held expertise in understanding different states of self (e.g., Rhodes 2022, pp.90-111) it was assumed that Mr Rhodes' beliefs and assumptions would have a significant impact upon the way the researcher thought about modes. It is of note that at various points in the study the researcher deferred to the Field Supervisor having had relatively less training in Schema Therapy, which is likely to have reduced neutrality within the study.

Research decision making was also scaffolded by reflexivity, including the recognition of taken-for-granted assumptions such as counting on the support of familiar (but busy) colleagues to identify potential participants. This assumption was associated with guilty feelings within the researcher, and it was important to act on this information. This led the researcher to focus increasingly on those who were deemed more invested in the study by way of reducing role conflicts (Hanson, 1994, cited in Ayhern, 1999), power differentials, and staff burden.

Regarding the data collection process, the researcher noted a (later stage) interview did not arouse as much interest within her as others did and was exceeding the usual time frame.

With this realisation, the researcher was able to refocus the conversation once she connected with the possibility that her tiredness at this stage was being projected into the participant (Ayhern, 1999), and as a result the interview ‘picked up the pace’.

3.5 Participant Recruitment

The recruitment process differed slightly according to whether participants were identified via clinician referral or from Dialectical Behaviour Therapy-informed (DBT) groups, as outlined in Figure 2 and described below.

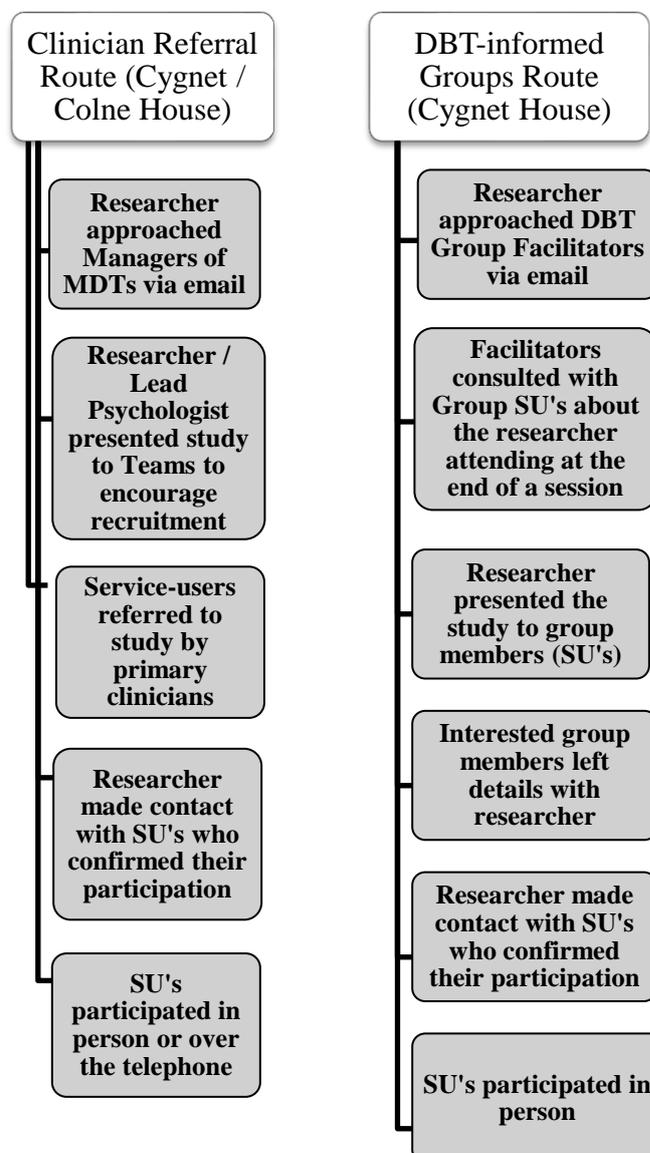


Figure 2. Recruitment Pathways

Seven working age (adult) service-users with a confirmed diagnosis of Borderline or Emotionally Unstable Personality Disorder were purposively sampled via two community mental health teams (Colne House in the South-West Quadrant and Cygnet House in the East) within Hertfordshire Partnership NHS Foundation Trust, in keeping with the study's inclusion and exclusion criteria. The Colne House recruitment site was chosen as the researcher's previous specialist personality disorder placement was within this team and was where the researcher had developed positive working relationships. Cygnet House was also selected as this was the researcher's place of work. The researcher anticipated that she would be better able to facilitate referrals to the study by virtue of being a consistent and familiar presence within the team.

The two teams were approached verbally and via email to introduce the study, and meetings were then arranged by the researcher to present it to teams (see Appendix 8 for the PowerPoint presentation). At the Cygnet House site, the presentation was delivered at an agreed MDT meeting slot and during a Psychological Therapies meeting. Due to scheduling constraints, it was not possible to deliver the presentation at Colne House and therefore one of the Lead Psychologists discussed the project with the MDT. Recruitment efforts at this site were facilitated mainly through email and telephone correspondence due to the researcher being based elsewhere, and the predominance of remote working at the time.

Service-users who were potentially eligible to participate were initially identified by their respective Care Co-ordinators and primary clinicians. Potential eligibility to take part was based upon the clinical judgement of the referrers, including service-users being deemed not to be in an acute state of distress (or 'in crisis'). Clinicians then approached the service-users during routine clinical contact to inform them about the study, provide the Participant Information Sheet (PIS) (see Appendix 9) and flyer (Appendix 10), and to gauge any initial interest. For participants recruited during the pandemic (N=3), this was done in a similar way,

with study materials emailed to service-users directly (for version 2 of the flyer, also see Appendix 10). Where service-users did express an interest, they were asked if their contact details, ethnic origin and gender, confirmation of EUPD / BPD diagnosis and information pertaining to the inclusion and exclusion criteria could be passed onto the researcher. These details were then noted down onto the study's data-capture form (see Appendix 11) and emailed to the researcher via her secure NHS email address. The researcher was not made aware of any service-users that declined to take part.

A second path of recruitment involved the researcher presenting the study at the end of a Dialectical Behaviour Therapy-informed (DBT) group session within the South-East and providing the written information (PIS) and flyer. The date of attendance was agreed in advance and potential participants within the group were identified by the Group Facilitators (Psychological Therapists). This recruitment path was included within the study protocol as DBT is a NICE recommended intervention for people who attract the diagnosis of EUPD (National Institute for Health and Clinical Excellence, 2009), thereby meeting the purposive sampling aim. However, not all service-users attending DBT-informed groups meet full criteria for EUPD.

Following the group session, the researcher verbally introduced the study, explained its purpose, the expectations of participation, the inclusion and exclusion criteria, restrictions to confidentiality, remuneration for travel, and the likely benefits of taking part for patient and clinical communities. The group members were advised by the researcher to read the PIS in their own time and encouraged any initial questions.

All potential participants (clinician-referred and DBT group members) were contacted by the researcher within two weeks to confirm if they wished to take part. During these discussions the PIS was explained further. The researcher also checked if the inclusion and

exclusion criteria were met and explained the restrictions to confidentiality. Where contact was unsuccessful, the researcher called again within a further two weeks to arrange a time to discuss the study further. Eight potential participants reached the stage of providing verbal consent, however, only seven were eligible to proceed as the remaining service-user did not meet full criteria for the study. It was therefore agreed with the referrer not to proceed any further and the researcher sensitively informed the service-user that they had been withdrawn from the process.

Where potential participants were happy to proceed, a mutually convenient date and time to meet for the purpose of taking written informed consent and participating in the research was arranged. No participant required further time to consider their involvement and none of the participants were known to the researcher prior to taking part.

The participants were initially interviewed face-to-face (N=4), and during Covid-19 restrictions, over the telephone (N=3).

3.5.1 Inclusion and Exclusion Criteria

Table 4 details the inclusion and exclusion criteria for the service-users who were recruited for the study. Given that this was an exploratory study there was no theoretical basis for adopting homogeneity of participant characteristics other than the criteria set out below.

Table 4. Participant Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
Diagnosed with EUPD or BPD.	Comorbid major psychiatric, personality disorders and neurodevelopmental diagnoses excluding anxiety disorders and depression.
Aware of diagnosis and has had an opportunity to explore it.	In current distress or crisis.
18 or above and working-age (18-65).	Are aged below 18 or above 65.
Reads, understands, and speaks English.	English is not a first language.
Actively engaged with care team.	Significant risk of harm to self, others, or the researcher.
Willing to participate.	Current or recent substance misuse.
Able to give informed consent and to withdraw consent.	No capacity to give informed consent or to withdraw consent.
Deemed to have capacity.	
No restriction on gender.	

Individuals with a first language other than English were not approached as the researcher was only able to communicate in English and rudimentary BSL and the study did not have a budget for interpreters. It was important that the participants had a confirmed diagnosis of BPD or EUPD and explored their diagnosis so that the material discussed in the interviews did not cause distress. Comorbid personality disorders and other major mental health

diagnoses were excluded from the study as it focused on Young's hypothesised BPD mode formation as opposed to configurations of modes for other personality disorders or significant mental health difficulties (Lobbestael, van Vreeswijk & Arntz, 2008). Current or recent substance misuse was excluded as this may have influenced participants' capacity to consent or the quality of responses given in the interviews. Participants were required to be actively engaging with their care team so that their service had a greater awareness of current mental health and capacity needs.

3.6 Study Measures

3.6.1 Semi-structured Interview Schedule

A semi-structured interview schedule was developed in accordance with the critical realist stance and was informed by reviewing literature on Young et al.'s (2003) schema modes and other therapeutic states of self. The schedule was not designed to enquire about developmental experiences as this may have caused participants' undue distress. The structure of the interview included the use of 'How' questions that were designed to elicit causal data that went beyond "mere empirical experiences" (Wynn & Williams, 2012) and encouraged a "logical flow of questions" (Millar et al., 2012) to allow themes to spontaneously emerge. The following stages were employed in the development of the schedule.

3.6.2 Stage 1: Reviewing Literature on Young's Schema Modes

This stage entailed reviewing key literature on Young's Schema Therapy and schema modes. This included the researcher familiarising herself with how schema mode therapy is delivered so that the study could be as close to the theory as possible. The researcher had also undertaken various trainings in Schema Therapy approaches, including participating in an experiential ST role-play within clinical training.

3.6.3 Stage 2: Inclusion of Theory-based and Meta Content

The semi-structured interview schedule was informed by the predominant research question, namely, to what extent do Young, Klosko and Weishaar (2003) et al.'s (five) central Schema modes for Borderline Personality or Emotionally Unstable Personality Disorder compare to participants' reported states of self? Therefore, the researcher homed in on the modes of interest. The schedule also enquired as to participants' *views* of their states of self (a meta component). Adhering to a deductive thematic approach enabled Young et al.'s theory (and potentially any other theoretical self-state orientation) to remain present, while the inductive aspect also allowed for participants' views about their states of self to be explored in the latter part of the interview.

3.6.4 Stage 3: Review of other Theoretical Orientations of Self-States

In order to consider the possibility that other theoretical states of self could be derived from the interviews, it was important for the researcher to familiarise herself with the constructs and terminology within the literature for other therapeutic orientations, e.g., Transactional Analysis (TA) (Berne, 1961), Internal Family Systems Therapy (IFST) (Schwartz, 1995) and Cognitive Analytic Therapy (CAT) (Ryle & Kerr, 2020). The researcher also met regularly with the Field Supervisor who discussed TA and IFST constructs in greater depth.

3.6.5 Stage 4: Generating Interview Questions

The study's field supervisor, Mr John Rhodes (an experienced Schema Therapy practitioner) provided input to the schedule, where it was agreed that the schedule would need to incorporate the following parts to meet the study's aims.

Part one aimed to capture participants' emotional experience of the world through asking open-ended, exploratory questions. Within part two, participants were presented with

mode cards summarising each of the five modes of interest along with accompanying brief vignettes (two for each scenario). The mode cards sought to highlight what each mode might 'look like' when one is inhabiting them. Similar cards are used in ST work.

When developing the fictitious scenarios for the mode cards it was important that they represented Young et al.'s (2003) main modes for Borderline Personality Disorder. Young's Schema Therapy Practitioner's Guide (Young, Klosko & Weishaar, 2003), The Schema Therapy Institute website (The Schema Therapy Institute, 2017), Schema Therapy South Africa website (Schema Therapy Institute, South Africa, 2017), and a Cognitive Behaviour Therapy self-help website (Get.gg - Getselfhelp.co.uk, 2017) were perused for ideas when developing the mode card scenarios. The mode cards (in Appendix 12) were then checked for relevance by the Field Supervisor prior to them being finalised. During the interviews, additional laminated cards were provided to the participants so that they could be referred to after the researcher initially read the scenarios aloud.

Exploratory questions corresponding with each mode and scenario were included in the schedule (see Appendix 12) in relation to participants' own experiences of (potentially) occupying any or all of the five central modes or other states of self. The third part of the interview took a meta-perspective and invited participants to reflect upon what was discussed in the interview in relation to their view of their 'modes' or 'states of self'. As well as the theoretical-based questions, various follow-up questions were included to provide a series of prompts and to help maintain conversation flow between questions.

3.6.6 Stage 5: Checking the Reliability of the Schedule (Piloting)

The schedule was then piloted with two of the Service-user and Carer Consultants to ascertain reliability and acceptability. This was determined by in-person correspondence (Wendy, Millie & Janine, personal communication, 1 & 29 March 2019). The effectiveness of semi-structured interviews is known to rely on both the structuring of the questions (Clough &

Nutbrown, 2007) as well as the ability for the researcher to build rapport (Opie, 2004); both of which were evaluated during pilot testing, in addition to ascertaining content acceptability. The Cambridge REC also reviewed the schedule and ratified it during the REC meeting.

3.6.7 Stage 6: Review and Revise Schedule

Following the pilot of the semi-structured interview with two Service-user Consultants, (Wendy, Millie & Janine, personal communication, 1st & 29 March 2019) the schedule was revised in terms of the phrasing and timing of questions. For example, the use of the term ‘state’ was better understood than ‘mode’ as the latter was reported to be a more ambiguous term. It was subsequently decided to use both terms within the interviews as Schema Therapy specifically refers to modes. The use of diagnostic acronyms (e.g., EUPD) was also found to be less acceptable than stating the full diagnostic label, which the researcher remained mindful of during the participant interviews.

Process issues that were revised following Service-user Consultant feedback (e.g., see Appendix 7) included the need to slow down the timing of questions to allow for thought-gathering and emotion-regulation (if needed), and reminding participants to take a break, offering more than one opportunity to do so in case this was needed. Having the mode cards to hand as well as the researcher reading them aloud was found to help with processing what was being explored during this part of the interview. No pilot data was included within the analysis. Figure 3 (below) summarises the process of developing the interview schedule.

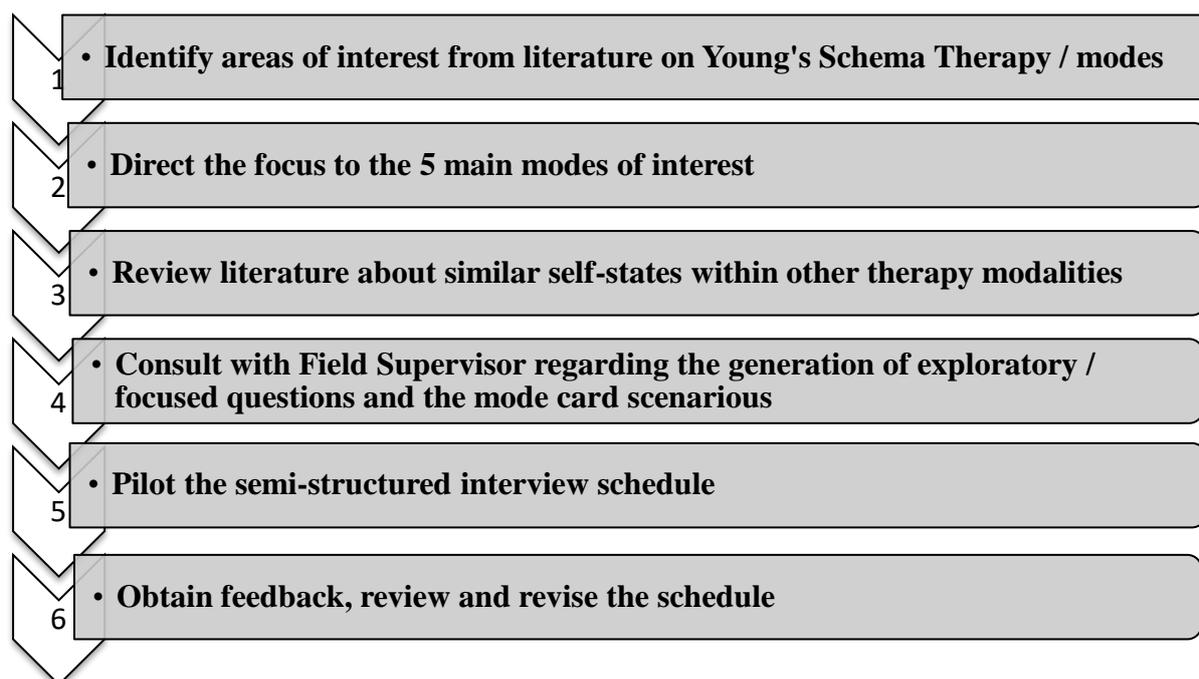


Figure 3. Summary of Process for Developing the Semi-Structured Interview

3.6.8 Amended Schema Mode Inventory (SMI)

Young's SMI (Young, Arntz & Atkinson et al., 2007) was piloted with all three service-user and Carer Consultants, prior to its revision. Items 60 and 123 were left deliberately unanswered by one of the Consultants, who stated that they evoked strong emotions and recommended their removal (Wendy, Millie & Janine, personal communication, 1 & 29 March 2019). This was also highlighted by the REC, who proposed the revision of items 60 and 123, as well as item 15 (see Table 5). A further 22 items were left blank by this respondent as the SMI was reported as being too lengthy (124 items) to maintain focus. For the remaining Consultants, one respondent missed two of the items, and the other completed the measure in its entirety. Further in-person feedback made mention of the SMI's length and small font size and suggested offering a comfort break prior to its completion. This feedback was taken on board by the researcher and implemented.

The revised Schema Mode Inventory was given to participants following the interview (Appendix 3). This 124-item measure captures a total of 14 schema modes (including the five modes of interest), using a Likert-type scale. There are five categories of modes (sub-scales) including 2 Parent modes, 1 Healthy Adult mode, 3 Avoidant modes, 2 Overcompensating modes, and 6 Child modes. Two of the subscales were reverse-scored, namely the Healthy Adult and Contented Child modes. For all the modes captured by the SMI, please refer to Appendix 13, which lists them in full.

The original SMI (Young, Arntz & Atkinson et al., 2007) is a psychometrically evaluated instrument which encompasses adequate test-retest reliability, acceptable internal consistency, and good construct validity for the 14 modes, with Cronbach's α ranging from 0.76 to 0.96. It is judged overall to be a "valuable measure of mode assessment" (Lobbestael et al, 2010). However, as mentioned in section 3.2.2 it is acknowledged that the substitution of the three (rephrased) items will no doubt have impacted upon the measure's psychometric robustness. All revisions to the SMI were undertaken in consultation with the Field Supervisor and the format was not changed apart from using a different font / size for ease of completion.

Each mode within the SMI is categorised from the resultant scores as being *Very Low* or *Average (shown in a non-clinical population)*, *Moderate (shown in people with Axis I Disorders)*, *High (shown in those with at least one personality disorder)*, *Very High*, and *Severe occupancy or expression (shown in people with 'severe' personality disorder/s or psychopathology)*. The mode configurations can be plotted onto a graph to give an overall picture of an individual's modes. Please refer to Appendix 14 for an anonymised example of Participant 1's SMI scores and accompanying profile graphs (Appendices 15 and 16). According to Young et al. (2007) a 'high' score indicates higher clinical severity of the mode and individuals profiling from 'high' to 'severe' are considered clinically significant. For the reversed items (Healthy Adult and Contented Child modes), higher scores indicate weaker

occupation within those modes (Lobbestael et al., 2010). Mode ‘caseness’ for the total sample was reported using simple statistics.

Notably, two of the SMI subscales differed slightly from the modes of interest, namely the Abandoned Child Mode and the Angry and Impulsive Child Mode. As the SMI does not incorporate an Abandoned Child subscale, the Vulnerable Child subscale was accepted as the closest match. Crucially, Young, Klosko and Weishaar (2003) highlighted that the Abandoned Child state is incorporated within the Vulnerable Child mode, and the modes appear qualitatively similar. This subscale will therefore be reported as the Vulnerable (Abandoned) Child mode. The SMI also separates the Angry Child and Impulsive Child subscales, so these will be reported separately within the results.

Table 5. Amended Items Within the Schema Mode Inventory

Item no.	Original phrasing	Amended phrasing	Mode
15 ^[a]	I act impulsively or express emotions that get me into trouble or hurt other people.	<i>I act impulsively or express emotions that get me into difficulties and distress other people.</i>	Impulsive child
60	I have been so angry that I have hurt someone or killed someone.	<i>I have been so angry that I've hurt someone.</i>	Enraged child
123	I can become so angry that I feel capable of killing someone.	<i>I can become so angry that I feel capable of harming someone.</i>	Enraged child

^[a] Amendment affected the Impulsive subscale (1 item), which for the purpose of this study impacted on the ‘Angry and Impulsive’ mode.

3.7 Data Collection Process

Initially the participants were interviewed face-to-face (N=4), and following Covid-19 restrictions, over the telephone (N=3) with participants at their homes. Adaptations to the interview process for the telephone participants included advising them to attend the interview alone or in a room where they would be less likely to be overheard or disturbed. In addition, the researcher checked if the participants were able to print off the study materials in advance and were also informed that the researcher would be taking notes during the interviews. Finally, the participants agreed to be called back immediately in the event of a disruption in line connectivity.

Once the participants had given informed consent (e.g., Appendix 17), the interview consisted of capturing participants' emotional experience of the world through asking open-ended, exploratory questions. These covered the key aims of the study, relating to both inductive and deductive content. Participants were also presented with five mode cards that depicted each mode of interest including accompanying brief fictitious vignettes (in Appendix 12). For the telephone participants, the mode cards (and SMI measure) were sent by email prior to interview. Exploratory questions relating to each mode were then asked in relation to participants' lived experiences.

The final part of the interview required each participant to reflect upon what was discussed in the interview regarding their view of their 'modes' or 'states of self'.

The wording of interview questions and follow-up questions differed slightly at times in accordance with participants' responses. This was in keeping with the semi-structured, more flexible format. All interviews were audio recorded and the duration of interviews averaged ninety minutes for each participant, not including rapport-building, comfort break(s) and debriefing (see Appendix 18 for details of debriefing / support contact details sheet).

Following interview, the participants completed the 124-item revised SMI measure (Appendix 3) either within the clinic setting or within their homes. For the in-person interviews, the researcher vacated the room to enable participants to complete the measure with minimal distraction and interruption. The researcher also checked on participants after fifteen minutes had lapsed and returned up to another fifteen minutes later, when needed. The length of time taken to complete the measure ranged between the anticipated fifteen and thirty minutes. Participants completing the measure at home were instructed to complete it immediately following the interview and to return it either electronically or by post within seven days using the provided SAE.

3.8 Ethical Considerations

In accordance with the British Psychological Society's Code of Human Research Ethics (2021) and Good Practice Guidelines for the Conduct of Psychological Research within the NHS (2005), the study adhered to professional ethics at all stages, including the protection of participants, their corresponding data and finite NHS resources. As with all research involving service-users, the process of enquiring about feeling states within the context of 'Personality Disorder' required much sensitivity and thought. The following ethical imperatives were adhered to throughout the study.

3.8.1 Ethical Approval

Figure 4 (below) summarises the complex and lengthy process of securing ethical approval(s) for the study which ensued from the point of submitting the initial draft proposal to UH prior to the recruitment of the first participant.

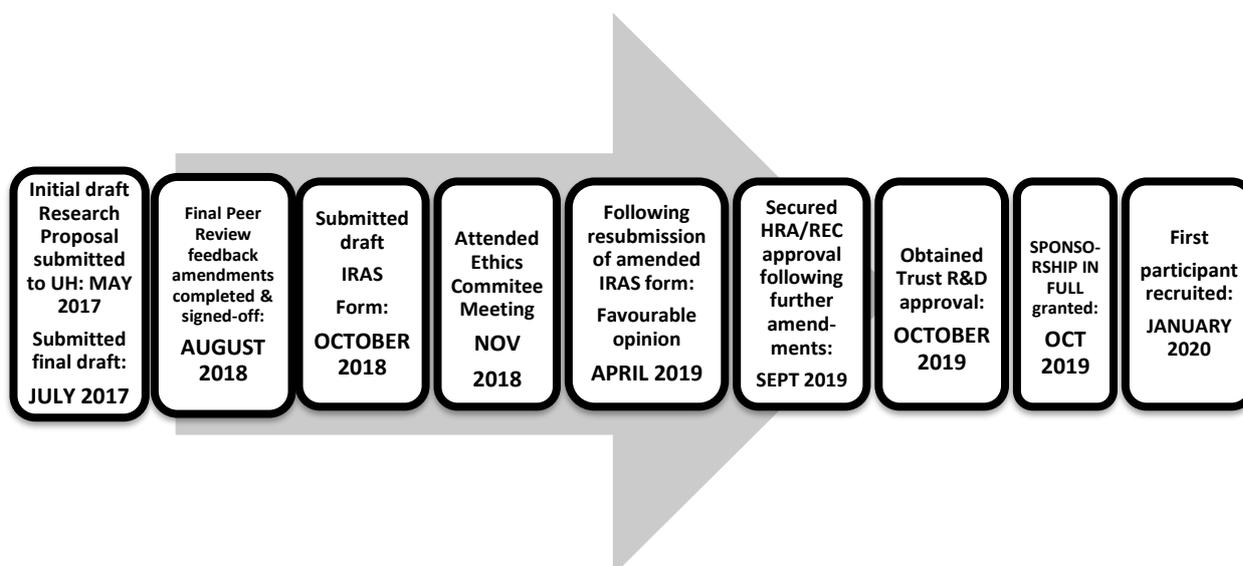


Figure 4. Project Approval Timeline

3.8.2 Obtaining Ethical Approval Through the Integrated Research Application System

As the study aimed to recruit National Health Service patients as participants within two NHS premises, it was subject to scrutiny via the Integrated Research Application System (IRAS), prior to ethical approval being granted. Ethical approval was provisionally granted after attending a meeting with the Cambridge Research Ethics Committee (REC), which proposed various amendments. These included changes to the procedure and the structure / layout of the PIS.

Following the REC's favourable opinion on 5 April 2019 (see Appendix 19), full REC approval was finally granted on 6 September 2019 (Appendix 20).

3.8.3 Securing Ethical Approval via the Health Research Authority

The protocol was subject to parallel scrutiny by the Health Research Authority (HRA) who proposed further amendments and requested the completion of a Statement of Activities and Schedule of Events. A study risk assessment was also completed as part of this process,

which gave considered thought to finite NHS resources, such as the required clinic space(s) needed and the anticipated time impact to clinicians referring to the study. This process fed into to the full REC approval as outlined above.

3.8.4 Trust Research and Development Authorisation and Full University of Hertfordshire Sponsorship

Hertfordshire Partnership NHS Foundation Trust Research and Development (R&D) Department was furnished with all approved documentation and confirmation that the study had been approved for the two sites, as stated within the IRAS form. The R&D Department then granted permission for the study to go ahead, issuing ‘confirmation of capacity and capability’ via email on 1 October 2019. This was forwarded to the UH Research Ethics Office, which then assigned the study with a unique protocol number (LMS/PGR/NHS/02919) and full UH sponsorship status on 11 October 2019 (see Appendix 21). This rubber-stamping meant that the study was able to commence.

Several minor amendments and one major amendment were made to the protocol throughout the life of the project including amending the data collection method from face-to-face meetings to telephone calls due to Covid-19 restrictions, and formally changing the Principal Investigator from Dr Helen Ellis Caird to Dr Keith Sullivan. Please see Appendices 22 and 23 for details of the major amendment and subsequent approval. For an example of a minor amendment, please see Appendices 24 and 25 for minor amendment 1.

The revised UH protocol number (aLMS/PGR/NHS/02919(1) for continued sponsorship following the major amendment was granted on 10 November (2020).

3.8.5 Informed Consent

Participants were required to sign a consent form (e.g., Appendix 17) as a pre-requisite to engaging in the study. As part of the consent process, participants were made aware that if information disclosed during their interview raised any concerns, the issue(s) of risk would need to be discussed with their primary clinician by way of duty of care and could result in a wider team discussion and involvement with an external agency(s) if necessary. Participants were also informed that their interview responses would be audio-recorded to enable transcription.

Cygnets House participants (N=6) were informed that if they were currently on a psychology waiting list or could be in the future, the researcher as an employee of the community team may be assigned to working clinically with them. Participants were assured that should this happen; they would be under no obligation to discuss the study with the researcher unless they wished to do so. The participants were also made aware that they would be free to request another clinician should they so wish. Participants were also reminded that the interviews were not a form of therapy, Schema Therapy or otherwise.

The possibility of participants becoming distressed during the interviews, both face-to-face or over the telephone was also considered, and participants were assured from the outset that they could withdraw if feeling ill at ease, or question(s) could be left unanswered without any detriment to their care. Participants were also made aware that they were free to withdraw their data from the study within two weeks of the date of the interview.

The process of obtaining data was then explained, i.e., there would first be a recorded interview that included the researcher reading out fictitious scenarios and asking related questions. The amended SMI would then be completed and finally, debriefing would take place

(see Appendix 18). Participants were advised that there would be short comfort breaks during the interview and prior to completing the questionnaire.

Once verbal consent was obtained, a face-to-face interview was arranged at participants' convenience where a wet signature of consent was obtained beforehand.

Due to the pandemic, the consent, interview, and questionnaire completion process needed to reflect the UK government's imperative for remote working. For interviews that were conducted during this period (N=3), a similar consent process was conducted over the telephone. The revised PIS and consent forms were emailed to participants in advance, and an informed-consent telephone discussion then took place. The consent forms were signed by participants and returned to the researcher via her secure NHS email.

No individual declined to take part in the study nor withdrew during any part of the process, during contact with the researcher.

3.8.6 Confidentiality and Anonymity

Participants were made aware that their transcribed and questionnaire responses would remain confidential to the researcher, Research Supervisors and Sponsor (UH) unless there was any cause for concern regarding risk to self and / or risk to any other person, whereby the participants' care teams would need to be informed.

Participants' data was pseudonymised, including assigning a unique code to each individual and all identifying information in the transcripts was changed, i.e., substituting participants' names with different ones. According to Article 4 of the General Data Protection Regulation (GDPR, 2018) which was incorporated into the UK Data Protection Act (2018), "pseudonymisation refers to the replacing of any information which could be used to identify an individual with a pseudonym, or in other words, a value which does not allow the individual

to be directly identified”. To this end, various identifiers of third parties were also changed to more neutral terms (i.e., substituting the role of ‘husband’ or ‘wife’ to ‘partner’), to help meet these aims.

A brief ‘research note’ was recorded by the researcher in the participant’s corresponding clinical record to state that the patient consented and participated in the study, citing the unique IRAS protocol number (236003) and the short title of the study. No other part of the clinical record was accessed.

The seven key principles within the Caldicott Report(s) (Department of Health, 1997, 1999, 2013, & 2016) relating to the protection of sensitive information were adhered to at all stages of the research. Table 6 (below) outlines each of the Caldicott principles and the due diligence taken.

Table 6. Caldicott Principles and their Application in the Study

Caldicott Principle	Study Application
Justify the purpose(s) of using confidential information.	This was covered within the Participant Information Sheets and IRAS form and discussed with service-users prior to consent.
Only use confidential information when absolutely necessary.	Participants were made aware that confidentiality would only be broken in the event of concerns about risk(s).
Use the minimum information that is required.	Any information that was considered ‘off topic’ (i.e., participant ventured into an unrelated area) was not analysed or used.
Access should be on a strict need-to-know basis.	Only the Researcher, Principal Investigator, and Field Supervisor had access to interview (and raw questionnaire) data. The Sponsor (UH) is the custodian for the data.

Everyone must understand his or her responsibilities.	This was set out very clearly in the IRAS form (protocol) and related documentation, including HRA, UH and Trust R&D forms. E.g., interview transcripts were pseudonymised by the researcher to protect confidentiality and were stored safely.
Understand and comply with the law.	The relevant laws were complied with at all stages of the research.
The duty to share information can be as important as the duty to protect patient confidentiality.	This possibility was highlighted in the PIS. No issues of concern were needed to be raised with clinicians or external agencies.

Principles reproduced from DoH, Caldicott, 2013

3.8.7 Benefits of Participation

Participants were informed that by taking part in the study, they would be afforded an opportunity to help researchers and health professionals understand more about experiences in relation to Borderline or Emotionally Unstable Personality Disorder. In addition, participants could also contribute to the future development of therapies that could be used to help service users in similar positions to themselves.

3.8.8 Debriefing

In accordance with the IRAS protocol, all participants were thanked and verbally debriefed about the study following data collection. Participants were also given the opportunity to process what was discussed in the interview, ask any questions and to reflect on the process, allowing more time where needed for participants to gather their thoughts.

The researcher also shared contact details of support services (see Appendix 18) that could be accessed if any aspect of the research process raised any difficult feelings or distress. The sheet was emailed to telephone interviewees following the interviews. Participants were

also informed that they were free to contact the researcher, and / or Research Supervisors via email or telephone should any queries or concerns become apparent at a later stage. All participants expressed interest in receiving a written summary of the findings, which will be emailed securely at a later stage.

During and following each interview (face-to-face and via telephone), the researcher ascertained to the best of her ability that none of the participants were in distress, so seeking additional support was not felt necessary. Furthermore, the researcher received no feedback from referrers that any participant required additional intervention because of their involvement in the study.

3.8.9 Participant Remuneration

Participants were reimbursed for travel costs to the research site or for the use of home resources in the form of a £10.00 payment, which was recorded on a study remuneration form (see Appendix 26). This was signed by the participant and the researcher. The telephone participants' signed forms were returned to the researcher via her secure NHS email address following reimbursement.

3.8.10 Storage of Data

Participants were made aware that their data would be stored securely in keeping with Research Governance principles and the Data Protection Act (2018), which is the UK's implementation of the EU General Data Protection Regulation (GDPR, 2018).

The list of code identifiers was stored separately from all other forms of electronic data so that participants' identities remained confidential to anyone not involved in the study.

Access to the electronic data, including the audio recording files, were restricted to the researcher and Research Supervisors only, through the action of password-protecting and

encrypting the respective data files. All electronic data was stored within the researcher's secure, encrypted NHS personal drive. When no longer needed for university examination, the researcher will delete the encrypted audio recording files. The interview discussions previously contained on the recording device were immediately wiped following their transference to the encrypted NHS drive.

The pseudonymised hard copy data (scored SMI measures and signed consent forms) was stored in a locked and fire-retardant cabinet within the East Quadrant research site and will be destroyed up to five years after the study end date (by 1 January 2026).

In accordance with the Data Protection Act / GDPR (2018) and British Psychological Society's Good Practice Guidelines for the Conduct of Psychological Research within the NHS (2005), the electronic transcription data will be retained for up to five years after the study end date (by 1 January 2026) for the potential purpose of writing articles or publications based upon the findings of this research.

Finally, participants were made aware that all electronic data will be securely stored within the Doctorate in Clinical Psychology Research Archives for five years after the study end date (until the 1 January 2026).

3.8.11 Data Withdrawal

Participants' identifiable codes were linked to their corresponding electronic recordings and transcripts in a separate document so that their data could be retrieved if needed, or in the event of participants withdrawing their data from the study. During the consent process, participants were informed that they could withdraw their data up to a maximum of two weeks following the date of their respective interviews and if exercising this right, their recordings and transcriptions would be removed from all data files and destroyed. The two-week time frame took into consideration the combined data being subjected to Thematic Analysis where

any later request to remove transcription data from the entire corpus of data would have been problematic.

3.8.12 Protection of NHS Resources

The researcher was mindful not to book NHS clinic rooms at busier times of the day when space was at a premium, nor were rooms booked out of hours. The researcher also requested that clinicians discuss the study with potential participants during routine clinical appointments, as opposed to taking time out of their busy schedules to contact them separately.

3.9 Data Analysis

3.9.1 Scoring and Profiling Amended Schema Mode Inventory Data

Participants' completed (amended) SMI measures were scored by the researcher, and the mean subscale scores calculated. The raw and mean scores were then transferred to participants' respective scoring sheet and rated in accordance with mode 'severity'. Excel graphs were subsequently produced to illustrate participants' mode 'profiles' (see Results section). Please also see Appendices 14, 15 and 16 for an example of a participant's scoring sheet and corresponding graphs.

3.9.2 Quantitative Data and Analysis Checks

The raw data and quantitative analyses were checked by the Field and Research Supervisors for accuracy. The researcher also consulted with supervisors during the process of comparing the quantitative findings to the qualitative themes as well as checking the findings against Young et al.'s (2003) hypothesised BPD mode descriptors (Appendix 2) and related literature.

3.9.3 Qualitative Data Analysis: Transcription of Interview Data

The researcher familiarised herself with the interview data (Braun & Clarke, 2013) by transcribing the audio recordings for both the face-to-face (N=4) and telephone interviews (N=3). The transcriptions were then checked against the audio recordings to enhance data accuracy and to allow for further immersion into the data. The researcher focused on the words that were said, not how they were conveyed, such as the cadence, rhythm, pitch, or inflection; thereby transcribing at a semantic level. All identifying material such as names and places were replaced with equivalent pseudonyms or an 'X' to protect participants' identities. Transcription conventions were adapted from a notation system suggested by Braun and Clarke (2013) (see Appendix 27) and no transcription software was used. All pseudonymised transcripts were stored on an encrypted, password-protected laptop and personal NHS drive, which could only be accessed by the researcher and Research Supervisors upon request.

3.9.4 Thematic Analysis Process

Braun and Clarke (2006) proposed six key stages of conducting a Thematic Analysis that were adhered to by the researcher. As mentioned in section 3.2 (Study Design), the researcher employed both inductive and deductive Thematic Analysis (Braun & Clarke, 2020). For the deductive (theory-driven) approach, this was informed by (critical) realist, essentialist thinking, whereas the inductive (data-driven) approach leaned towards the relativist, constructionist end of the epistemological spectrum (Braun & Clarke, 2020). The six stages of the process are set out below.

3.9.5 Familiarisation with Interview Data

Following transcription, the researcher familiarised herself with the data through actively listening back to each of the seven audio-recorded interviews with a curious stance.

Using the same stance, the researcher then read and re-read the transcripts while jotting down her initial 'noticings' within the margins.

3.9.6 Coding

Boyatzis (1998, p.63) defined coding as “the most basic element of the raw data or information that can be assessed in a meaningful way, regarding the phenomenon”, while Braun and Clarke (2013, pp. 210-211) described a *good* code as being “as concise as possible...capturing the essence of what it is about the segment of data that interests you”; the latter suggesting that the researcher’s meaning-making is as important a part of the process. To this end, the researcher adopted an ‘experiential’ framework from the outset (Braun & Clarke, 2020) as privileging participants’ voices was paramount; this included assigning significance to participants’ experiences, views, and perspectives. Additionally, all coding was undertaken by the researcher at the ‘semantic’ level, whereby semantic codes were identified through the explicit or surface-level meanings of the data.

This stage of the process involved the researcher working systematically, line-by-line throughout the entire data corpus. Each transcript was coded completely before moving onto the next transcript, with similar coding descriptors used where there was apparent similarity appearing across transcripts. Please refer to Appendix 28 for a coded extract of a participant’s interview. In keeping with the deductive approach, the researcher referred to Young et al.’s (2003) mode descriptions (see Appendix 2) and literature pertaining to other states of self to support coding in this regard. Where participants appeared to be describing a different mode while being specifically asked about another, the data extract(s) in question were annotated with the alternate mode construct and a question mark, prior to checking the mode descriptors. Coding was then carried out in accordance with the mode that was being described (where relevant). An inductive approach was taken for the responses that did not appear to fit with any

theoretical state of self (of which no themes were derived), as well as responses that related to participants' view of their modes.

Coding was then repeated for a second time for all transcripts to ensure a higher level of robustness and completeness. Please refer to Appendix 29 for a sample of the deductive codes for the Abandoned Child mode that were used within the analysis. All other codes that were not found to fit with any of the identified themes were collated into a 'miscellaneous category' (Braun & Clarke, 2013).

3.9.7 Generating Initial Themes

For this stage, it was imperative that the generated themes represented meaningful patterns within the data set in accordance with the research question(s) (Braun & Clarke, 2013). This entailed the researcher making connections between codes and synthesising them in tabular form to produce initial subordinate and superordinate themes. At this stage of the analysis there were 15 deductive themes, and 3 inductive themes. It is important to note that Braun and Clarke (2013) emphasise that such themes do not emerge from the data as is often (mis)understood; they are *derived* by the researcher who is making the links.

3.9.8 Developing and Reviewing Themes

This stage incorporated two levels regarding the development and review of initial themes. For the first level, all the coded extracts that corresponded with themes were checked to determine whether there was 'goodness of fit' and combined into a comprehensible pattern. Where there was a minimal amount of data attached to themes, this data was absorbed into broader themes (where relevant), and the data that no longer resonated was placed under the 'miscellaneous' heading. All miscellaneous codes were subject to further review in case any of them were meaningful. This was the case following consultation with the Field Supervisor who

highlighted various miscellaneous codes of interest, some of which, after cross-referencing with Young's mode descriptors (see Appendix 2), were later subsumed into themes.

In keeping with Braun and Clarke's TA guidance (2013), the researcher remained mindful that each theme remained distinct and did not overlap with any other. For level two, the individual themes were scrutinised with respect to the entire data set and the researcher explored the connections between the themes. At this stage, a total of six superordinate and 11 corresponding sub-themes were generated. Some preliminary theme labels were assigned. A further change after revisiting the Healthy Adult Themes involved the generation of a new superordinate theme linking two sub-themes, where previously the latter were denoted as main themes.

3.9.9 Refining, Defining and Naming Themes

Within this process, careful thought was given to the information that was encompassed within each theme, such as the links with the corresponding central mode and the data set in its entirety. Following feedback from the Service-user and Carer Consultants (Appendix 7), one theme label was renamed (see section 3.9.12, below).

All final theme labels aimed to be consistent with Braun and Clarke's assertion that "theme names need to be concise, punchy and immediately give the reader a sense of what the theme is about" (Braun & Clarke, 2006, p. 93).

Two thematic maps were then produced (Braun & Clarke, 2006) (see Figures 5 and 6). Such mapping helped the researcher to confirm whether the schematics were representative of the patterned meanings within the data, and to enable any missing (or otherwise uncaptured) data to be identified.

3.9.10 Narrative Account

The final stage of the process synthesised the analysis into a narrative account of the findings, set within their specific context and linked to relevant theory. Pseudonymised quotes were presented to illuminate the predominant narrative, validity, and trustworthiness of the analytic process (Cutcliffe & McKenna, 1999).

3.9.11 Credibility of Coding and Themes

During the qualitative data analysis process, both the Field and Research Supervisors were involved in checking the researcher's codes and derived themes to enhance the credibility and trustworthiness of the study (Cutcliffe & McKenna, 1999). Please see Appendix 30 for an extract of participants' codes for the 'Struggling to Cope' Sub-Theme.

The researcher also kept a reflexive journal (see section 3.4) throughout the analytic process (and beyond), which enabled her to pay close attention to evolving thoughts and ideas as she became immersed in the data (Braun & Clarke, 2006).

3.9.12 Checking of Derived Themes

Following the Thematic Analysis, the derived themes were also checked by the Service-user and Carer Consultants for accuracy and acceptability and following their feedback a superordinate theme label was amended to better reflect the 'temperature' of the theme (see Appendix 7). This process was in keeping with triangulation (Denzin, 2012). Member-checking was not undertaken however, which is a weakness of the study and is addressed in the discussion section.

3.9.13 Identification with Young's Modes

Participants' identification or level of resonance with Young et al.'s (2003) hypothesised BPD modes (as enquired about in the interviews), was quantified into 'YES', 'PARTIALLY' and 'NO' responses and can be found in Table 9.

3.9.14 Comparison of Schema Mode Inventory Scores with Themes

Participants' scores on the SMI were 'profiled' in accordance with their ratings of mode severity, which ranged from 'very low' to 'severe' (see Appendix 13). Individuals profiling from 'high' to 'severe' in their modes are considered clinically significant (Young, Arntz & Atkinson et al., 2007). A comparison of participants' SMI ratings was made against their respective comments in the interviews by way of triangulation, noting any patterns and parallels in the data. This was with the exception of the Healthy Adult subscale (which was reversed-scored) as a 'weak' healthy adult mode was not enquired upon directly (see section 4.11).

CHAPTER 4: RESULTS

4.1 Participant Demographics

A total of nine service-users were referred to the study, comprising eight females (89%) and one male (11%). The average age of referrals was 33 years. Of those, seven service-users were eligible to participate in the research (78%); six from the East Quadrant community team (67%) and one from the South-West (11%). All participants (N=7) were female; 67% defined themselves as White British and 22%, White Other. The average age of the participants was 32, ranging from 19 – 57 years. Four participants had a face-to-face interview (57%) and three engaged in a telephone interview (42%) owing to Covid-19 government restrictions on social contact. For the two referred service users that were ineligible to participate (22%), one person (male), went into crisis and was not approached by the researcher, and the other person (female), did not have a confirmed, documented diagnosis of BPD or EUPD. The latter was established after further checks were made after the participant had already been contacted to discuss the study. The demographic details of the participants are shown below.

Table 7. Participant Demographics for the Total Sample (N=7)

Demographics		Frequency	Percentage
Gender	Female	7	100%
Diagnosis	EUPD	7	100%
Age	18-24	4	57%
	25-34	1	14.3%
	35-44	0	0%

45-54	1	14.3%
55-64	1	14.3%
Ethnicity White British	5	71%
White (Other)	2	29%

4.2 Quantitative Results: Amended Schema Mode Inventory Data

Appendix 31 displays the distribution, spread of scores, outliers and extreme values of the central SMI data subscales / central modes, and Appendix 32 relates to all SMI modes (N=7 participants). Please note the Healthy Adult subscale scores are reversed and for brevity will be reported as '(Un)Healthy Adult' as higher scores indicate a 'weaker' healthy adult (mode) in this area.

After calculating the mean scores (see Table 8) for all participants (N=7), they were collectively found to score 'very highly' on Vulnerable (Abandoned) Child, Punitive Parent and (Un)Healthy Adult mode subscales, and 'highly' on Detached Protector, Angry Child, and Impulsive Child subscales. It is of interest that the Angry & Impulsive Child mode is the most associated 'BPD mode' for mental health workers (Young, Klosko & Weishaar, 2003), yet, for the current sample it was not as intensely experienced as the Vulnerable, Punitive Parent and (Un)healthy Adult modes. Combined Detached Protector scores were rated as 'high'; however, this score could have been greater as this mode is considered to be the most frequently occupied for patients living with BPD (Young, Klosko & Weishaar, 2003; Kellogg & Young, 2006).

For the remaining SMI modes (see Appendix 5), the participants scored 'very highly' on the (Un)Contented Child (reversed) subscale and 'highly' on Demanding Parent, Detached Self-Soother, Compliant Surrenderer, Undisciplined Child and Enraged Child subscales,

thereby suggesting the experience of a wider range of modes. The scores for the Self-Aggrandiser and Bully & Attack modes were not clinically significant. Notably, none of the combined mean sub-scale scores were rated as ‘severe’.

Table 8. Mean Schema Mode Inventory Scores and Mode Severity for the Total Sample (N=7)

Mode	Mean Score	Mean Level of Mode Severity	Maximum Score
Vulnerable (Abandoned) Child	4.76	Very High	6
Angry Child ^[a]	3.43	High	6
Impulsive Child ^[a]	3.36	High	6
Punishing (Punitive) Parent	3.94	Very High	6
Detached Protector	3.51	High	6
(Un)healthy Adult ^[b]	3.29	Very High	6 (1=R)
Total Mean Score	18.93		

^[a] Modes of interest (NB: ‘Angry’ and ‘Impulsive’ modes are separate subscales within the SMI)

^[b] Reverse-scored

4.3 Qualitative Results: Summary of Derived Themes

Seven interviews carried out face-to-face (N=4) and over the telephone (N=3) were transcribed from the encrypted audio recordings. All interviews were coded in accordance with Young et al.’s (2003) five central (BPD) schema modes, and the researcher kept an open mind regarding any evidence suggesting alternate modes or states of self. Participants’ views and experiences of their modes were also coded. Although the deductive element of the study was

based on theory, the researcher was mindful to remain as true to participants' lived experiences as possible whereby the analysis, themes and findings strived to reflect this. A Thematic Analysis was then conducted for each of the five mode categories and inductive coding of participants' experiences. The superordinate themes and sub-themes derived from the corpus of data are presented below. Participants' SMI ratings were also compared to some of the comments that arose during the interviews.

As the interviews contained instances of pauses, laughter, verbal utterances, sobs, clarification-seeking, fillers, connective words, repetition, interviewer prompts, and brief interjections, the Thematic Analysis did not interpret these, and interviews were transcribed using a transcription notation system based on Braun and Clarke (2013) (see Appendix 27). These conversational elements were however removed within the write-up of the thesis, using '...' to reduce the quotes' length and for conciseness. Pseudonyms were used throughout the excerpts and participants were referred to by a designated number, e.g., Participant 1, or P.1.

Please note, the interview schedule was not designed to enquire specifically about developmental experiences. Several participants did refer to them when reflecting on various modes, however the study was not set up to explore these experiences at length. Consequently, the links between participants' early experiences and states of self in the present (e.g., evoked Child Modes) were less understood.

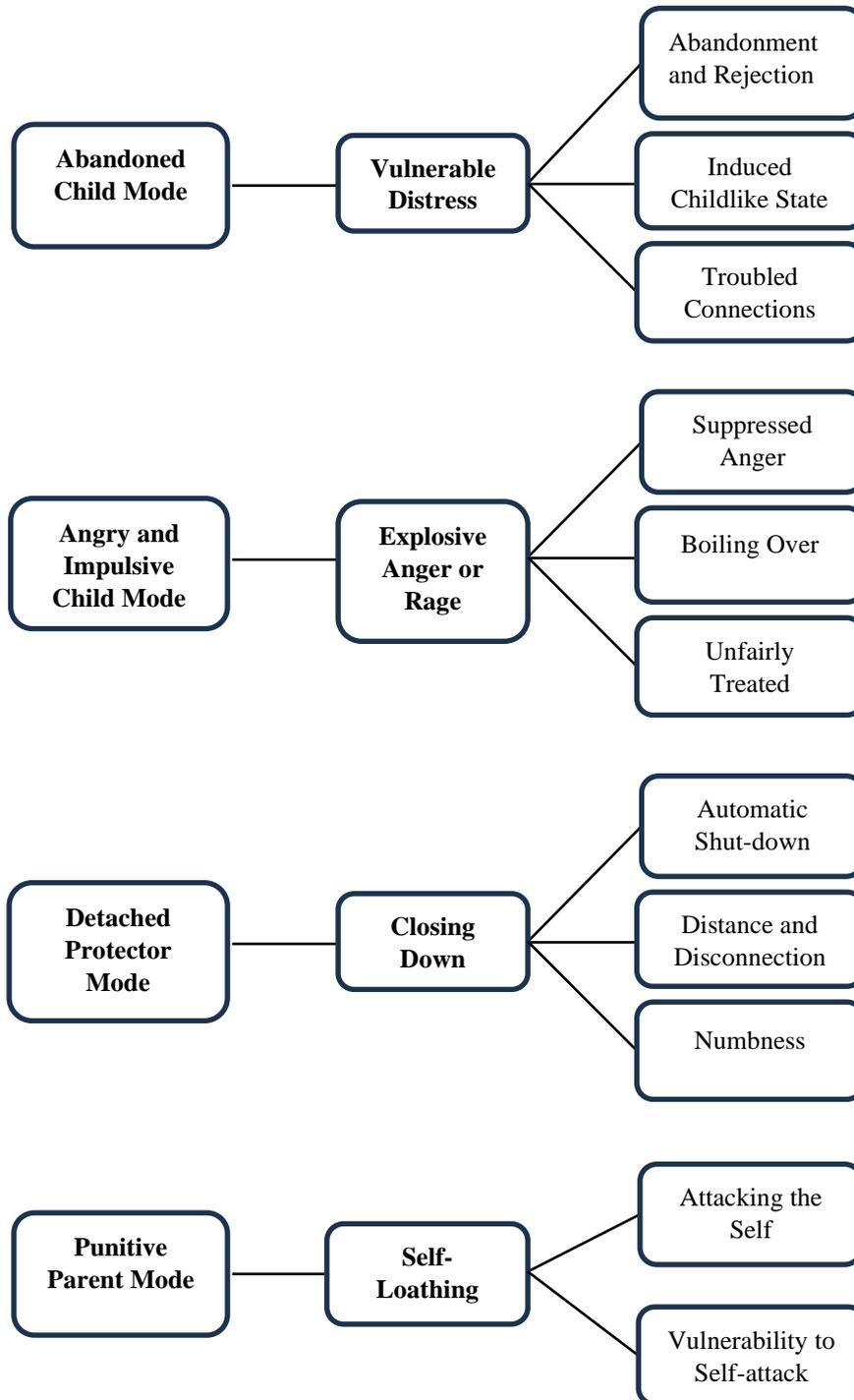
The inductive and deductive Thematic Analyses derived the following five superordinate themes across the seven interview transcripts. Please see Figures 5 and 6 (below) for the deductive and inductive thematic maps, respectively. Each theme's corresponding sub-theme(s) will also be discussed, in turn.

Deductive Themes:

- Theme 1 (Abandoned Child Mode): *Vulnerable Distress*

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

- Theme 2 (Angry & Impulsive Child Mode): *Explosive Anger or Rage*
- Theme 3 (Detached Protector Mode): *Closing Down*
- Theme 4 (Punitive Parent Mode): *Self-Loathing*
- Theme 5 (Healthy Adult Mode): *Resilience*



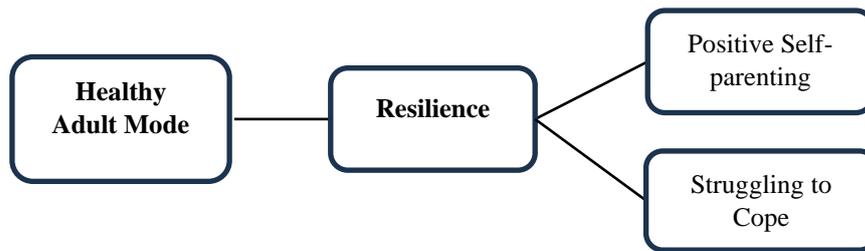


Figure 5. Thematic Map of Superordinate and Subordinate Deductive Themes for the Five Schema Modes for Borderline Personality Disorder

Inductive Theme:

- Theme 6 (Relating to all Central Modes): *Feeling like Myself is Subject to Change*

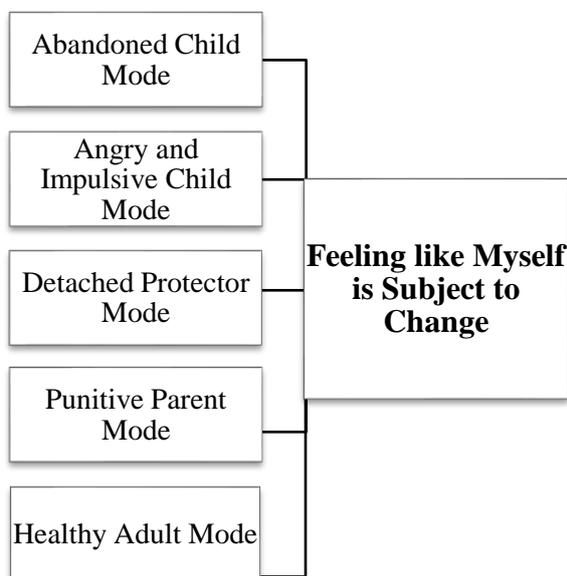


Figure 6. Inductive Theme Map Relating to the Fluctuating Experience of Participants' States of Self

The **Deductive** themes will be reported first, as below.

4.3.1 Abandoned Child Mode

The Abandoned Child Mode “embodies the theme of frightened isolation”. It is a “Core State” (Kellogg & Young, 2006) and represents the suffering inner child that is overly

concerned with abandonment. Individuals caught-up in this mode can feel very alone, helpless, sorrowful, frantic, frightened, unloved, and lost. The inner child is also preoccupied with finding a parental figure to take care of them (Kellogg & Young, 2006). All seven participants identified with this mode in various ways (see Table 9), with many sharing key developmental experiences by way of elaborating on their current experience of the mode. A superordinate theme of ‘**Vulnerable Distress**’ was evident, which demonstrated a strong thread of vulnerability across all participants’ accounts. The three related sub-themes of ‘Abandonment and Rejection’, ‘Induced Childlike State’ and ‘Troubled Connections’ (see Figure 7) are detailed below.

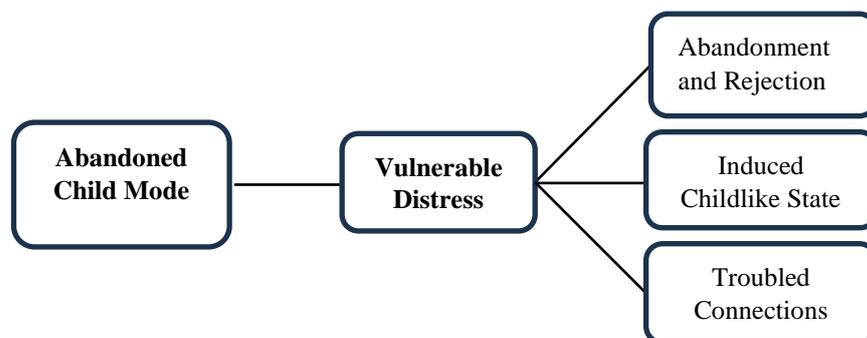


Figure 7. Thematic Map of Superordinate and Three Subordinate Themes for the Abandoned Child Mode

4.3.2 Vulnerable Distress: Abandonment and Rejection Sub-theme

All but one participant (Participant 5) shared different experiences of feeling abandoned or rejected, or otherwise voiced a fear of being abandoned. A sense of not being held in mind, e.g., either participants’ reported being forgotten, or were not thought about, was also evident throughout this sub-theme.

Participant 1 described seeking out ‘another family’ in the form of a religious group after being rejected from her family of origin. This is in keeping with the Abandoned Child

mode, which refers to seeking out parental substitutes following abandonment. For Participant 1 there was a strong sense of not being wanted or feeling part of society, with an impression that she had been abandoned by everyone. P.1 mentioned how the religious group had also turned their back on her, as she increasingly struggled with her mental health:

I suppose I feel I wish I could start again and think about what it is actually I did want to do, because when I was younger, I did catering but I went into the hotel but the hotel people were like the Mormons, but I felt like I was joining them to get away from my parents. But then that wasn't very good, because when I got unwell, they didn't want to know. So, I was banned, I suppose ... My mum was asking them to help with me because I was unwell, and she said they didn't want to know (Participant 1, 684-690).

Participant 4's partner disappeared without informing her where he had gone. This abandonment was experienced as an intolerable and agonising separation, where death was a preferable state to be in. As with the Abandoned Child Mode, P.4 sought refuge in 'parental objects' (including a hospital facility) due to fearing how she would cope without him:

So what happened was he disappeared and didn't tell me where he was, because he was avoiding me. I didn't really understand why, so I was anxious, I genuinely was in so much pain with not understanding why and that he was being so distant. I was staying at a friend's house, I couldn't sleep, I couldn't eat, I was up really early, and I was like "you've got to drive me to the hospital because I can't cope." I was genuinely...like the only way I'd feel better is if I was dead, because I wouldn't feel it anymore (Participant 4, 108-113).

Participant 3 voiced the unsettling, prevailing impact of a key developmental experience of abandonment, whereby as a child, she was promised an exciting outing with a step-parent, only to be forgotten about on the day after having excitedly prepared for the trip. For Participant 3 there was an intense feeling of being left behind and needing to be held by

her mum, to rock away the distress of abandonment. Again, this appears to reflect Young's assertion of seeking-out care within this mode:

It makes me feel like an abandoned child, and especially a child, because... I mean, I was a child, but yes, it seems that every time a situation comes up like that, my brain can interpret in that way, it just drags me back to needing people and needing comfort. It's hard because I feel like I'm quite good at comforting myself ... but yes, I mean, sometimes I just get to the point... when I'm sad it always devolves to, I want my mummy ... I just want to be with my mum, I want her to hold me (Participant 3, 185 - 187).

4.3.3 Vulnerable Distress: Induced Childlike State Sub-theme

All participants described childlike feelings and needs that were difficult to navigate, and at times, these manifested in childlike behaviours. A sense of feeling lonely, vulnerable, or lacking direction were dominant threads throughout this sub-theme. Three of the participants spontaneous comments, linked to their early experiences.

Participant 1 described a strong sense that she was a child living in an adult's world due to her parents placing too much responsibility on her when she was growing up:

Yes ... I do feel childlike. I feel inside, yes, I'm still childlike and I think that could be ... because you haven't had that chance to grow because of what happened to you as a child. They didn't give you the freedom to be you... So, I feel that I'm like a child having to cope with everything and still be an adult as well. Like when I was a child, obviously I had to cope as an adult and now I'm an adult I feel like I'm still a child (Participant 1, 116-120).

Not having the opportunity to live a normal childhood appeared to have had a regressive impact on Participant 1, who described feeling misguided in her ambitions and needing "someone" to help her find her way. This may be linked to an 'Undeveloped Self' schema.

Again, P. 1's experience seemed to reflect Young's depiction of the Abandoned Child Mode whereby she reported feeling lost and helpless:

I'm trying to do a professional course X online and perhaps get a job in the office. But I feel like I'm always going in the wrong direction. I never really go where I want to go ... I feel like I need someone to sit down with to help me find some direction sometimes (Participant 1, 675-679).

Participants' childlike states appeared in several different guises. For Participant 3 her 'coping front' masked how small and afraid she felt inside:

I suppose it is me, but I do get shocked sometimes when people say that I'm confident and whatever, because I'm like I'm as scared as you, I'm just faking it because I'm not going to let you know that I'm scared. Yes, again, that's vulnerable, I'm not going to let other people know that I'm scared, I'll be the biggest voice and the most confident one in the room and you won't have any idea (Participant 3, 700-704).

Participant 4 presented a powerful image of a frantic small child, desperately seeking proximity in order to avoid the suffering of being alone. The situation described below seemed to resonate strongly with the Abandoned Child mode.

Even before him I did it the same way, a relationship ended, I joined Tinder, had some fun, because the boys wanted me, that made me happy ... It's that point where I'm like lonely, nobody really wants to talk to me, so I need to find people to talk to me. So, if I don't have people to talk to, I feel empty, like I'm not good enough, no one wants to talk to me, so I have to find some boy to talk to at all times ... I don't know why I do it. I wish I didn't do, but it's what I do, I've always done it. It's like filling the void or something (Participant 4, 171-184).

Participant 5 spoke of adopting a foetal position when isolating herself, potentially as a form of self-soothing. P.5 also described how she infantilised herself in some of her interactions with others, which may have the function of eliciting care; very much in keeping with the mode.

If I'm withdrawn, for example, I tend to just curl up in bed. I find I do that a lot, I'll just curl up. And other times I feel like I literally behave like a child ... Okay, for example, I might talk like a child and use strange speech and, in a way, kind of infantilise myself a little bit (Participant 5, 313-317).

4.3.4 Vulnerable Distress: Troubled Connections Sub-theme

All but one participant (Participant 5) spoke of their difficulties, both past and present, in finding contentment within their personal relationships and families. Participant 2 spoke of struggling in the recent past with maintaining friendships and her preoccupation with keeping them on track:

I mean, luckily, things with friendships are a bit better now compared to what they used to be, but I guess, even like a couple of years ago. I mean, all I can think about is friendships. I used to struggle with them a lot. I don't really know why, they just always used to go bad (Participant 2, 107-109).

Participant 6 reflected on a repeating pattern of being drawn to people who were unable to provide her with the intimacy, commitment, and stability she craved. For this participant, the feeling of not being held in mind possibly mirrored the familiar treatment she endured from her family of origin, potentially activated by an 'Emotional Deprivation' schema:

I then found relationships, or I went for people that couldn't commit to me ... I would go for emotionally unavailable people, I suppose, so I was just repeating my history. My parents

weren't there for me, my brothers weren't there for me, so you know, no adult was ever there for me (Participant 6, 243-247).

Participant 3 voiced a sense that she often felt misunderstood and different from others, and how these issues prevented her from connecting and relating to people. The realisation of feeling like an outsider was described as very scary existence, which affected P.3's life significantly, and may reflect an underlying 'Defectiveness' schema:

Yes ... just feeling like I'm not going to be able to relate to people or connect with them, because I love to connect with people and relate to them and hear that they're feeling the way that I am ... or hearing people's experiences and knowing them as people, and things like that make me feel further away from people, which can be very lonely. But not lonely like I'm not with a friend at the moment and I want to be, like lonely, as in I'm different from everyone else and I'll never be understood ... but it's like...it affects the whole of my world, like I'm just one different thing from everyone else, and that's very scary (Participant 3, 685-693).

4.4 Angry and Impulsive Child Mode

The Angry and Impulsive Child mode encompasses the part of the inner child who is aware that their needs were not met and that they were treated unfairly. When this mode is activated in real or perceived situations, it can present as disproportionate expressions of anger and rage (Kellogg & Young, 2006). Impulsive urges are difficult to suppress in this mode and can manifest in suicidal threats, parasuicidal behaviours, raised voices and aggressive outbursts. All participants identified with the mode, however, two participants (Participants 1 and 3) identified with the angry aspect only; and Participants 4 and 5 identified only with impulsivity. Despite this, a superordinate theme of '**Explosive Anger or Rage**' was evident across all the transcripts, which highlighted the dominant strength of feeling that the

participants experienced in different ways. The three sub-themes of ‘Suppressed Anger’, ‘Boiling Over’ and ‘Unfairly Treated’ (see Figure 8) are described below.

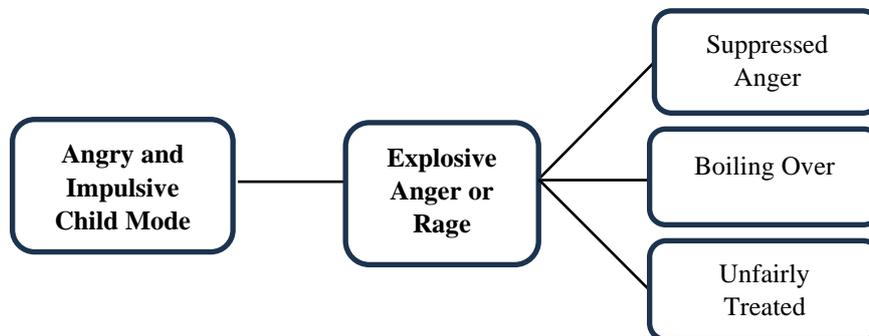


Figure 8. Thematic Map of Superordinate and Three Subordinate Themes for the Angry and Impulsive Mode

4.4.1 Explosive Anger or Rage: Suppressed Anger Sub-theme

The sub-theme of Suppressed Anger reflected how all but one participant (Participant 3) consciously prevented their anger from rising to the surface and the various influences that prohibited their anger from being expressed or acted-upon.

Participant 5 discussed two main influences for her: the suppression of anger and a fear of how to manage her anger safely:

... I tend to suppress anger quite a lot ... It's not something I typically experience, and when I do I try and get rid of it ... I find that the anger is very much linked to the depression. So, I might feel a surge of anger, but it could be related to a traumatic memory, sometimes it could be small things that set it off and I think that's because I've repressed it for a very long time. But I kind of have a fear of anger, in a way. So, when I start to feel angry, I don't know what to do with it, and I don't want to hurt myself, I don't want to hurt someone else. I haven't self-harmed in quite a while and I just don't want to slip back, so I tend to try and bury it, if I can (Participant 5, 135-148).

This example highlights how close P.5's anger is to the surface, and the presence of trauma hints at the development of a Mistrust / Abuse Schema, whereby she may have learnt to detach (cope) in unsafe situations.

Participant 1 talked about a feared psychosocial consequence of venting her anger, in addition to reflecting on the unhelpful nature of suppressing angry feelings:

Yes ... but sometimes I suppose you feel embarrassed about showing your feelings. You don't want to show any feelings of anger. But then perhaps that's why you get all these emotional problems, because you don't want to show you're angry and you're too embarrassed to show you're getting angry or cross (Participant 1, 485-488).

Participant 7 however, commented that it is less typical for her to express feelings unless needed and linked this (earlier in the interview) to a so-called "psychopathic" element to her personality [P.7, line 63] where she was able to exercise remarkable self-control, whenever the need arose:

... I was like frustrated and I said "why can't you just give me the money if I'm going to pay you anyway in five days ... I'll like quietly like be annoyed by it, because I don't necessarily go from like wanting something to immediately being angry about not getting it (Participant 7, 817-823).

4.4.2 Explosive Anger or Rage: Boiling Over Sub-theme

For this sub-theme all participants described different accounts of why and how they lost control (exhibited rage), with expressions of anger ranging from walking out, to hurling objects and engaging in road rage. Participants' rage was reported to be multidirectional; aimed at mainly themselves or objects, and sometimes towards other people.

Participant 5 described venting her frustrations onto technology whenever she could not get a device (in this case, her laptop) to work. Her quote seems to represent the impulsive part of the mode as she immediately lashed out in response to her fury, without any consideration of the consequences:

With the anger, it's a more...I find that it's linked to objects and not to people ... So, for example, say if my technology isn't working, I can get absolutely furious, but it's not directed at a person, it's directed at the object that's not working ... I haven't done anything recently, but some years ago I would throw them, when I was a lot younger. So, this is quite a long-time thing, actually being angry with technology ... But when I was a teenager, I once just got so frustrated I punched up my old laptop, but I punched it so hard, I didn't even realise I'd punched that hard that the ink started leaking (Participant 5, 629-638).

Participant 7 reported venting in a similar way, however her rage appeared to be a punishing response to an intense dislike of her physical appearance (her weight). This suggests that the 'punitive parent' mode may have become activated and punished the 'defective' part of her (Kellogg & Young, 2006), albeit in a seemingly impulsive way:

It's like I don't necessarily put a value of the object, I just throw the object because I'm so angry, so like objects become very like not very valuable to me, even though they are to most people ... I mean, I would say it's quite a strong intensity ... I'll like hurl things to the floor. I remember one time I was very upset about like my weight, so I threw everything off like the counters and stuff, like all the food, the diet foods and stuff, I threw it on the floor, and I like threw out everything with sugar that was in the fridge on the floor. I'll like very much not care in that moment (Participant 7, 729-740).

Similarly, Participant 3 described sometimes lacking in the ability to communicate exactly what she was feeling, to the point her distress culminated in ‘toddler-like’ tantrums or harming herself in a crescendo of frustrated energy.

Yes, childish, like the word tantrum, and like not so much with acting like a child, more like if you told a toddler that they can't have a sweetie because it's just before dinner time and they flip out and throw themselves all around and everything and you kind of look at them like, okay, child, like you're doing a child thing, so you don't have the right communication to tell us what's wrong so you're showing us with your body, and sometimes I feel like I can't...I mean, I'm quite good with communication but sometimes ... I want to throw a tantrum, I want to scream, want to hit out, I want to just cry and make a big physical scene kind of thing, because I feel like I'm full of energy and that's why it needs to come out ... And then that can come out in self-harm as well (Participant 3, 33-41).

Participant 6 relayed how she can easily switch from feeling happy and contented to becoming overwhelmed with anger and rage due to surviving multiple forms of abuse (trauma). This suggested a Mistrust / Abuse schema may be at play where P.6 was likely responding to the unfair treatment she incurred. Again, this seems to resonate with the Angry and Impulsive Child Mode:

But in relation to being in recovery, I'm happy ... but I do also go through the experience, when I'm triggered, of anger and rage because I'm a female survivor of all sorts of abuse (Participant 6, 12-14).

4.4.3 Explosive Anger or Rage: Unfairly Treated Sub-theme

This sub-theme was represented across all seven participants, who described various instances of being subjected to unfair treatment, and how this linked to their anger. Participants

experiences ranged from feeling patronised and disregarded, to incurring interpersonal trauma as well as a general sense that life was unfair.

Participant 6 described a striking experience of feeling manipulated, used, and discarded by friends who previously treated her as one of the family:

And like the relationship was wonderful and I felt really secure, and I've got this new family and sisters and it's lovely ... but then they start dropping off ... And then I start to realise oh, actually I'm not really your sister, am I, and you're not actually my mum and you're not all there for me, and you are all family, and you are all there for each other, and you said you'd be there for me, but you weren't, you're not ... You're only there for me because you're all manipulating me ... so I've done all your mum's gardening for her when you're rich with loads of money and loads of support ... you've got husbands and partners, why the fuck am I the one doing all the gardening for that bit of love and attention? Well, now the weeding's done, she's not my mum anymore ... she's off with her daughters all the time and I've just been left (Participant 6, 729-741).

P.6's quote above is fraught with hurt and betrayal, where the part of her that responded to being unfairly treated (possibly her abandoned inner child) appeared to be taken over (protected) by the Angry element of the mode.

For Participant 3, plans that were repeatedly cancelled by a friend in the final hour felt rage-inducing due to the stark resonance this had with some upsetting childhood memories.

I'm in a situation where my friend has...my best friend has X, but she's not getting treatment, and so that's really, really hard and she often ignores me for long periods of time or cancels plans with me last minute, which is very true again for me, because I had a lot of things like that when I was younger and I just, I know that it really triggers me (Participant 3, 151-155).

In another example, P.3 described an impulsive, angry outburst to another driver who they felt was using the road without due care and attention. Interestingly, this participant seemed to switch into a vulnerable state of self after coming to a realisation that her reactions may have placed her in danger:

I mean, I feel like this is a good example of the...with the road rage, that's what this feels like, it's intensely angry, like full of rage ... if something angers me it feels like I'm full of fire, like inside my chest. Yes, there's a lot of things people do on the road and it's reasonable mistakes ... so I have no right to be shouting at these people and calling them names for doing it, ... Yes, I mean, like once, recently, and I actually haven't told anyone in my life about this because I've been so embarrassed, there's a roundabout near mine and someone just did something stupid on it so I beeped them and they beeped me back and I'm just like "why are you beeping me when you've done something wrong", so I kept my hand on it and they stuck their finger up at me, I stuck my finger up at them, I turned into where I live, they followed me to where I live, she got out of the car and shouted at me ... and she decided to chase me down. And it was terrifying (Participant 3, 555-573).

4.5 Detached Protector Mode

The Detached Protector Mode is hypothesised to be the most occupied mode for individuals living with BPD (Young, Klosko & Weishaar, 2003). This Avoidance Mode is concerned with evading experiences that feel painful such as unwelcome emotions, thoughts, memories, problems, and social encounters. Such emotional avoidance can arguably lead to more welcome feelings of numbness and emptiness, and people occupying this mode can adopt a robotic-like state.

Six participants identified with this mode to a greater extent (see Table 9) with one other (Participant 2) reporting that it did not represent her experience very well. A

superordinate theme of ‘**Closing Down**’ was however evident across all transcripts. This theme demonstrated the various ways and reasons that participants shut down from the world; seemingly creating a mental barrier between themselves and their internal and / or external worlds. Three related sub-themes of ‘Automatic Shut-down’, Distance and Disconnection’ and ‘Numbness’ (see Figure 9) are detailed below.

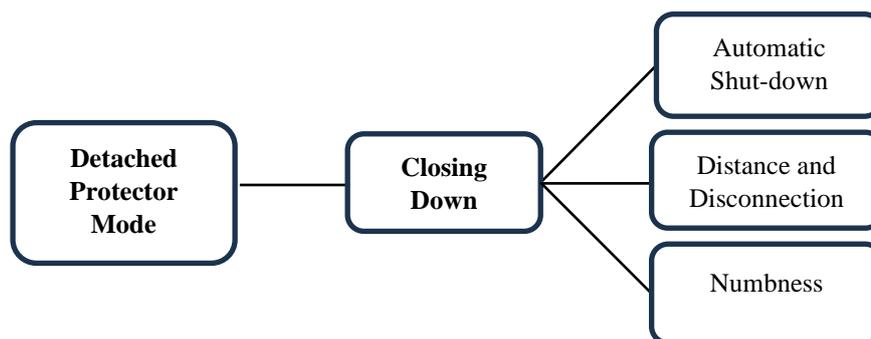


Figure 9. Thematic Map of Superordinate and Three Subordinate Themes for the Detached Protector Mode

4.5.1 Closing Down: Automatic Shut-down Sub-theme

All seven participants commented in different ways about their experience of instinctively shutting down in response to overwhelming or unwelcome stimuli. The process of shutting down seemed to be evoked by both conscious and unconscious efforts, and all reported experiences seemed to be in keeping with the mode.

For Participant 5, stress was the catalyst and shutting down appeared to be outside of her control. In this instance, P.5 painted a striking picture of herself as chained and helpless, while staring into space.

I get really stressed ... It's that feeling of wanting to do more and feeling like I should be doing more, but somehow not being able to make myself get up and do things, and that can be quite basic things, like have a shower. It can take me so long just to get in the shower, and some

days I just can't do it because I'll spend the whole day staring into space ... I guess it ties into that helplessness a little bit ... it's not that I don't want to, it's more I feel like I can't. I'm just kind of shackled to where I'm sitting (Participant 5, 589-597).

Participant 3 described her shut-down experience by using a powerful circuitry metaphor, detailing the process as a partially conscious effort when life got too much:

It feels like...like when you overload a circuit and then it just stops. Like the fuse cuts off or whatever. Like you've put too much into it. There's too much stuff going on, too much stimulus, too much...everything's just too much and so you need to think of a way to stop it from being too much ... you just get cut-off and ... that's a very noticeable feeling and change of state ... Something there to...like a cyanide pill, when things are too bad, you know, we've got this escape route we can do if things get too much (Participant 3, 445-446).

Similarly for Participant 1, her experience of shutting down appeared to be partially within her control at times, however, this was usually in response to traumatic memories:

I was left with quite a lot of intense traumatic memories and some of them are quite... have resurfaced quite recently as well. So, whenever something pops up, I do tend to just dissociate, just switch myself off ... Yes, I think that it can be partially deliberate. I just say "right, I'm done, I don't want to feel this, I don't want to remember this" ... I can't fully control it, but I can kind of trigger, it in a way. It's almost like I decide that, you know, I don't want to experience that. But there's also other occasions where it's not in my control, and then other people notice it, like my partner, for example, that I've switched off (Participant 1, 90-99).

4.5.2 Closing Down: Distance and Disconnection Sub-theme

Five participants shared how they maintained a safe-enough distance or purposefully disconnected from people or activities for reasons such as feeling unsafe, conserving energy, or avoiding potential conflict. This theme was not represented by Participants 4 and 6.

Participant 7 compared her sense of disconnect to a feeling of boredom, where remaining distant and indifferent served a protective function for her self-esteem. Young et al. (2003) noted how individuals within this mode “can adopt a cynical or aloof stance, to avoid emotionally investing in people or activities”:

Yes, I would say, because then I just kind of detach from the situation, like the conversation, because what's the point in me voicing it, because it's just going to be something they're all against, even though it's not necessarily what I say... So, it's almost like you're so bored of like the discussion and you know you can't partake in it, or like you could but it would lead to conflict probably, so you kind of just detach yourself from it entirely because there's no point to it anymore (Participant 7, 530 – 538).

Participant 1 described a similar experience and referred to social interactions as draining, alluding to her sense of separateness from others. Interacting within a low bandwidth was described as an important way of conserving mental and physical energy:

If I don't cut them off, I don't try to talk to people. I just do the minimum ... because sometimes I think other people are all bubbly and happy because they go on holiday; they have nice things; they get to feel better about themselves, and obviously I feel, like inside I feel low and down, or I suppose if you're tired as well you don't give, because it's exhausting. I find talking to... being with lots of people all the time is exhausting. So sometimes being detached helps you just cope with you a bit, and you'll just cope ... just sort of recharge your batteries, I suppose (Participant 1, 406-412).

Participant 5 talked about detaching through using social media and gaming as means of escaping reality, but with negative consequences. This too reflects the Detached Protector mode with behavioural examples including “compulsive distraction and stimulation-seeking” (Young et al., 2003):

So I do the scrolling thing every day, I do social media every day and distraction with games every day, so I think my main coping mechanism is detachment and distraction, but it can interfere with my day to day life so it means that I don't get things done (Participant 5, 528-531).

4.5.3 Closing Down: Numbness Sub-theme

All seven participants talked about a range of experiences where they seemed to be devoid of emotions and / or were functioning in zombie-like states.

Participant 1 talked about the numbing, controlling effect of her psychotropic medication:

It just feels like this numbness, I suppose, you've got a numbness in your head, and you feel like it's just the Prozac keeping the emotions under control (Participant 1, 657-658).

Participant 4 described how she avoided ‘wallowing in sorrow’ by arranging to “hook-up” with a friend. In doing so, she utilised the ability to numb all feelings while engaging in sexual intercourse, rather than connect to the sadness she was distracting from. This numbing of emotions appeared to serve an important function of reducing P.4’s suffering, but such a presentation may have prevented a more meaningful connection from taking place:

Well, yes. It's like I have friends that if, for instance, something like bad has happened and I don't want to lie in bed and cry about it, so I'll ring up one of my friends and be like "want to hook up?" and they'll be like "yes," so then I'll do it, but I won't feel anything. Like I'll turn off

any feeling, any emotions, nothing, and I'll just feel numb the whole time, but I do it to distract, not because...does that make sense? (Participant 4, 323-327).

Participant 5 referred to the experience of being alive but not feeling alive, “a shell of a person”, in limbo. Functioning and not living; lacking a core sense of self, which appeared to reflect the mode:

It's hard to describe, because I am alive, obviously, but I feel like I'm not ... it feels almost like I'm more of a shell of a person, if that makes sense ... It's just like the absence of who I am, it's the absence of emotion, and it can be for things like...it's basically I might feel that the basic things, like I need to go to the toilet, or I need to eat something, or I feel thirsty. So those are the kind of things I experience in that state but it's not...I don't feel like there's any depth to me beyond that (Participant 5, 564-574).

4.6 Punitive Parent Mode

The Punitive Parent Mode consists of the identification and internalisation of the abusive parent and other key attachment figures (Kellogg & Young, 2006). Within this mode, the self is viewed as unlikeable or bad and deserving of chastisement. A sense of defectiveness is often responded to by being drawn to self-punishment, engaging in self-harm and depriving the self of good things. Six of the participants identified with this mode to various degrees (see Table 9) with one individual (Participant 4) reporting that the mode did not represent her experience well. However, a superordinate theme of ‘**Self Loathing**’ was evident across seven participants. This theme demonstrated many instances of self-defective thoughts, beliefs, attitudes, emotions, vulnerabilities, and behaviours that were expressed, making a strong case for participants experiencing an internalised, abusive parent (Young, Klosko & Weishaar, 2003). The two related sub-themes of ‘Attacking the Self’, and ‘Vulnerability to Self-Attack’ (see Figure 10) are described below.

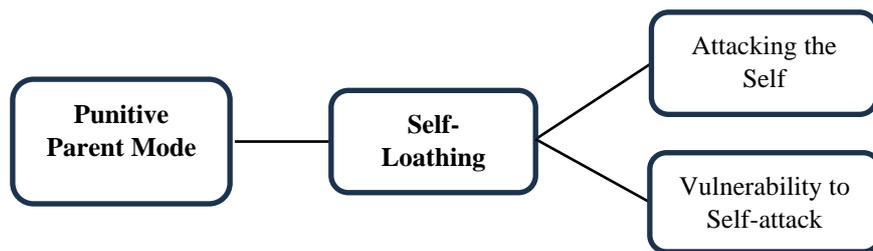


Figure 10. Thematic Map of Superordinate and Two Subordinate Themes for the Punitive Parent Mode

4.6.1 Self-Loathing: Attacking the Self Sub-theme

‘Attacking the Self’ took various guises across all seven participants, with a combination of physical and verbal assaults. There was a distinctive thread of threat-responses from the participants due to a sense of self-defectiveness or for showing their humanness (making mistakes). Some appeared to be drawn to self-sabotage. For all participants there appeared to be an underlying need to be punished and their reported experiences were very much in line with the Punitive Parent mode.

For Participant 7, “not doing a good job” led to a compulsion to hit herself on her head or body: she also destroyed her coursework in the process. This seemed to point towards a ‘Punitiveness’ schema organisation and may have also been influenced by a ‘Demanding Parent’ mode (Young, et al., 2003). Interestingly, P.7 justified inflicting harsh punishment on herself because no one else would do it for her, thereby subjugating herself:

I hit myself if I feel like I'm not doing a good job, like my legs or my head or my hands ... So, because I, I feel like it's deserved, and I feel like because no one else is going to do it, I have to do it ... I know it's happened with the maths, like if I start getting frustrated because I just

feel like I can't do it, so I'll like, rip up my maths book and I'll like chuck it and I'll like, hit myself (Participant 7, 604-610).

Similarly, Participant 3 reported 'bringing herself in line' due to her perceived transgressions; voicing a powerful need for the people that she hurt to know that she was hurting too. P.3 also voiced a sense of shame and exhilaration from having punished (cut) herself so brutally, potentially relating to her scars as 'battle wounds':

Yes ... because I know sometimes I self-harmed, I don't know, for multiple reasons. Definitely I wanted people to notice, but I kind of felt shame and also a bit of exhilaration from having the cuts, because it was like I'm different. But yes ... I always feel really ashamed if I did something to hurt someone else and ... I kissed another boy when I was with my first boyfriend and to show him how bad I felt I cut myself because I was really ashamed ... I know I've done wrong, less that I'm sad about it, more like I do know that what I did was wrong, rather than them thinking I didn't know (Participant 3, 94-101).

Self-disgust was an emotion that Participant 5 had recently become aware of and had reflected on. She gave a vivid and powerful picture of how her body physically recoiled in disgust when embroiled in self-attack mode:

I was thinking about this recently and, interestingly, an emotion that I hadn't picked up on before, but I realised I feel a lot when I am in this mode, is disgust. It's like disgust with myself ... I can feel that quite viscerally in my chest and in my face as well, like in my muscles, and I can tense up and recoil in the way that you would if you saw something disgusting ... it's like eww, and your insides tense up a little bit as well, you recoil a little bit, or at least that's how I feel when I feel disgust (Participant 5, 371-380).

To view oneself as revolting appears to be an extreme response to the self and dovetailed with Young et al.'s (2003) hypothesis that people in this mode can often view themselves as “dirty” or “evil”.

Participant 4 described the internalisation of her critical father, his partner, and the taunts from the bullying she incurred throughout her school years. Compliments were never identified with, received with suspicion, and immediately trampled on. During the interview, Participant 4 made several other critical statements about herself. It did not seem to occur to P.4 that any compliments about her could ever be genuine:

I'm always self-attacking, but ... for instance, it's always about I'm too fat ... I always pick myself apart. For instance, if someone gives me compliments, I can't take it and I'll swiftly turn around and say "well, I don't know what you're talking about, because I'm fat." ... Like I'll just take their compliment and stamp on it ... I just don't do compliments very well. I think I've always been...because of how my dad is, my dad's always been very critical of me, his partner's always been very critical of me, even from the age of four ... Then at school I was bullied for years, so it's like I've always had all these bad things being said so now I believe it and that's all I do (Participant 4, 199-208).

4.6.2 Self-Loathing: Vulnerability to Self-Attack Sub-theme

With the exception of Participant 1, all the other interviewees divulged various experiences that seemed to render them vulnerable to repeated self-attack. Developmental accounts were common across participants, including growing up with a critical caregiver(s), persistently being blamed, instances of bullying, deliberate self-harm, suicidal ideation, coping with negative feelings, low self-worth, or having a sensitive disposition.

Participant 3 spoke of instigating self-punishment from an early age, which did not seem to be associated with receiving similarly harsh punishment. Instead, she chastised herself

whenever her mother was upset about something she did, believing she was responsible for irrevocably damaging their relationship, and deserved the suffering that followed. P.3 presented a striking image of a young child forcing herself to sleep on a hard bedroom floor, by way of teaching herself a lesson:

But yes, definitely, I love punishment. I've always had that in my head since I was young, that I need to punish myself for things ... I remember distinctly things like my mum would be upset with me for something and so rather than sleep in my bed, I would sleep on my floor with my blanket because I didn't deserve the bed ... I feel like I'm very sensitive and she wasn't very sensitive and didn't understand how sensitive I was ... It's nothing she would be angry, angry at me for, but for me I thought I've ruined my relationship with this most amazing woman in my life, you know, I deserve all this crap (Participant 3, 53-68).

High expectations were placed on Participant 6 as a child, who identified with the criticism levied at her by her father, who rarely praised or recognised her efforts. P.6 spoke of later overcoming the urge to criticise herself, but this had a significant impact on her over the years. P.6 described how 'beating herself up' served a function of improving her performance so that she could gain her father's approval, and mitigated the risk of being abandoned by him:

I got 99.5% on an exam once in X, I said to my dad, I was so thrilled, and he went, "Yes, but what about the other point five percent? Why wasn't it 100% X?" ... I've put very, very high expectations on myself. I don't anymore but I did, and I would really beat myself up if I didn't perform ... because it was all linked into being abandoned, you know. I saw my sisters being successful, I thought if I'm successful maybe he'll want me and love me (Participant 6, 505-508).

Participant 5 expressed a long-held view of not feeling entitled to anything good, so all her anger was directed towards herself. This appeared to be a form of self-sabotage, which prevented P5. from developing a healthy self-esteem:

I guess because I'm just not that angry, as a person, and also, even if I do feel anger, it tends to be at myself. I don't tend to feel entitled to anything or like I should be getting something from someone, definitely not (Participant 5, 892-893).

4.7 Healthy Adult Mode

Finally, the Healthy Adult Mode is considered to be largely absent within people with Borderline Personality Disorder (Kellogg & Young, 2006). This mode assists with the basic functions of nurturing, affirming, and encouraging the self; “helping to meet the child’s basic emotional needs” (Young, Klosko & Weishaar, 2003). Furthermore, it protects and soothes the Vulnerable Child’s emotional pain. It asserts self-discipline and instils boundaries for the Angry & Impulsive Child mode, while acting as a mediator for the maladaptive parent and coping modes. This mode only becomes ‘dysfunctional’ when these ‘executive’ functions are lacking (Young, Klosko & Weishaar, 2003).

Four participants reported that they identified with the mode to various extents (see Table 9), but one participant (Participant 5) felt it did not fit as well. The two remaining interviewees did not provide a response to this question. However, this mode seemed well represented across the whole sample, and a superordinate theme of ‘**Resilience**’ was derived. This theme represented participants’ challenges in integrating or remaining within their Healthy Adult mode, as well as providing many compelling examples of self-nurture, self-care, self-compassion, and emotion-regulation. The two related sub-themes of ‘Positive Self-Parenting’ and ‘Struggling to Cope’ (see Figure 11) provide a convincing account of the variable nature of this resilience and are described below.

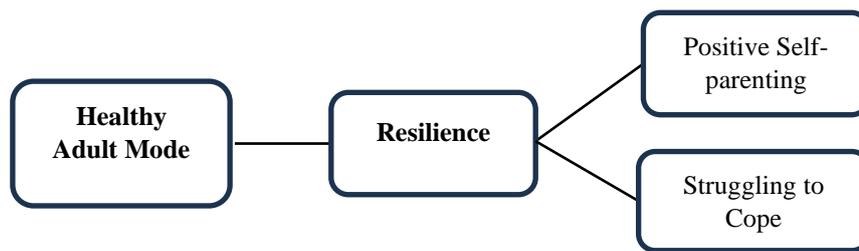


Figure 11. Thematic Map of Superordinate and Two Subordinate Themes for the Healthy Adult Mode

4.7.1 Resilience: Positive Self-Parenting Sub-theme

All seven participants described experiences that appeared to reflect this sub-theme. There was a strong sense that in spite of their difficulties, the participants demonstrated resilience, i.e., were taking responsibility for their lives in domains of health, faith, spirituality, friendships, mental health and developing self-compassion.

Participant 6 recalled some painful losses, and how she tentatively parented herself now; including remaining connected to the people she valued:

Losing my mum, dad and brother was bad, losing my dog was bad, then losing my career or having cancer so not being able to do my career was bad, and then being in a 10-year relationship with somebody I really believed loved me, and when I realised he didn't it went boom. Yeah, those modes. But I can parent myself now. So yes, I've got wonderful friendships with people. I just have to be a bit careful (Participant 6, 1461-1465).

Participant 7 proudly described her sense of accomplishment for the resourcefulness that she fostered within herself:

It's nice being able to like do, and adjust to things that you are not taught ... So, it feels like a sense of "because you did it and no one else helped to do it." Yes. So, I guess, yes, you feel like

a sense of accomplishment for achieving things that you were never taught to do (Participant 7, 911-944).

Participant 3 provided a moving and insightful account of nurturing her inner child; making a choice not to punish her by treating the self with care and compassion. The quote also highlights the role of P.3's healthy adult mode (resilience) in keeping her punitive parent at bay:

Like you can't ... you can't shout a child into being happy and nice and well balanced. Like you need to nurture them and teach them positive reinforcement and everything like that ... so I know that I have an inner child and that when I'm feeling sensitive ... it is the child inside me that's getting hurt by these things. And so, to me, successful and helpful and working on not being the kind of bad person I feel like I am when I'm at the will of my emotions is that I can't just punish myself anymore. I have to be considerate and compassionate. Compassionate (Participant 3, 248-255).

Participant 5 described her sense of satisfaction and increased confidence after taking responsibility for clearing some debts, which paid richly in psychological dividends:

I guess another recent example would be when I cleared a few debts that I had ... So that made me feel quite self-sufficient ... Kind of a sense of satisfaction ... but I guess I stand a bit taller, a bit more confident ... It's hard to describe. It's physically, literally standing a bit taller, because I tend to hunch a lot, it's like I'm closing into myself, and if I feel a bit more confident or I get that little burst of capability I'm more likely to straighten up. It's like shoulders back, head straight, I just feel a bit more confident and the way I move is more confident (Participant 5, 753-765).

4.7.2 Resilience: Struggling to Cope Sub-theme

All participants struggled at times to connect or remain connected to their Healthy Adult Mode, where a switch of mode or the ending of a meaningful activity or task seemed to resign it to a distant memory. There was an overall thread that switching back into maladaptive modes was the norm and resilience was lower. There was also a sense that the Healthy Adult was a shorter-lived mode, as reported by Participant 5, below.

I don't feel it as often as I'd like, but I'd say it lasts maybe... it can last for a few hours. Occasionally it lasts for a day but often the depression will kick in at some point (Participant 5, 767-768).

Participant 4 anticipated feeling happy at having taken part in the study, linking this to brief periods of invulnerability. P.4 described how she anticipated switching rapidly from this state (after the interview) to being overwhelmed, and then again to feeling lost:

Yes, whereas this is kind of just like a levelled...I kind of feel you can do pretty much anything and not get bogged down by it, but obviously sometimes it doesn't actually last very long ... I think it kind of depends. I could be like fine, I might come out here and be like, down and then... I don't know. Everything just switches so quickly it's hard to...like I might get out of here and be really happy that I've done it but feel really overwhelmed that I've just done it, and then in the adult feeling kind of goes and I don't know what to do with myself (Participant 4, 621-627).

Participant 7 acknowledged that her Healthy Adult mode functioned more effectively when it came to meeting the desires and needs of others, thereby subjugating her own:

I feel like I'm better at being like a healthy adult when it comes to other people's things, issues, problems, concerns, whatever (Participant 7, 878-870).

Table 9. Number and Percentage of Participants who Identified with Each Mode

Mode	Did Participants Identify with the Mode?						Total N of Participants
	Yes	%	Partially	%	No	%	
Abandoned Child	N=5	71%	N=2	29%	-	-	N=7
Punitive Parent	N=5	71%	N=1	14%	N=1	14%	N=7
Healthy Adult	N=3	43%	N=1	14%	N=1	14%	N=5 ^[a]
Detached Protector	N=4 N=1 ^[b]	71%	N=1	14%	N=1	14%	N=7
Angry and Impulsive Child	N=3	43%	N=2 ^[c] N=2 ^[d]	57%	-	-	N=7

^[a] N=2 participants gave no response

^[b] More so in the past

^[c] Angry element only

^[d] Impulsivity element only

The **Inductive** theme is reported below.

4.8 Inductive Theme: Feeling like Myself is Subject to Change Superordinate Theme

One inductive theme was derived from the data (see Figure 6, below) which related to the shifting states of self that all the participants experienced in relation to the modes that were discussed.

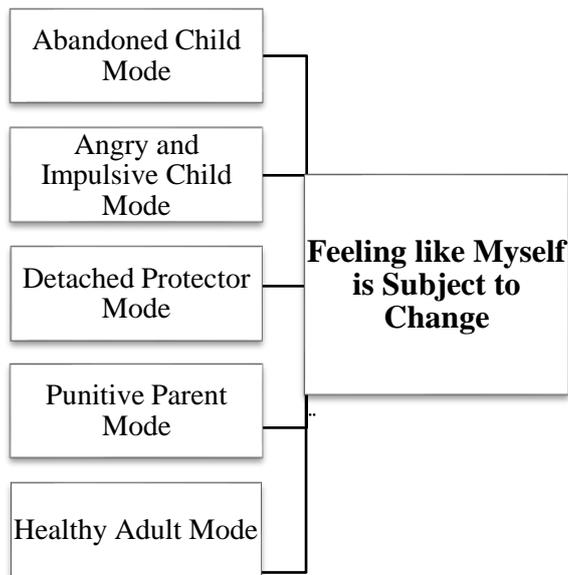


Figure 6. Inductive Theme Map Relating to the Fluctuating Experience of Participants' States of Self

Participant 1 described how she felt restricted when experiencing her states of self and the resultant unpredictable emotions. P.1 imagined how she would be more assertive, confident, and less emotional without them:

I suppose it would be good if the emotions weren't up and down all the time ... Perhaps I wouldn't be so emotional, perhaps. I would perhaps be a bit more assertive, more confident, have more of an idea of where I want to go and what I want to do. (Participant 1, 726-730).

For Participant 2 the sudden and unpredictable nature of her change in emotions was hard to explain and felt confusing:

Yes, I don't know really, my head just goes a bit funny. It's a bit jumbled, like everything, and my thoughts and stuff, I don't really understand it ... and by the time we got home my brain just like switched and I suddenly felt completely different and I could think about it in a completely different way; and even when I tried to think about it in the way I was before, I

couldn't, because I just felt like a bit silly because I was like why was I thinking like that ... But yes, it was really strange. (Participant 2, 41-48).

Participant 2 also described how the hair-trigger nature of the change in modes she experienced, restricted her greatly, due to the fact that she did not know how she was going to 'be' from one day to the next:

I kind of...obviously, I was probably scared as well, I think because I realised I can literally like change so easily or the smallest thing can kind of affect me, I wasn't really ready for that kind of thing. So, I guess it does hold me back quite a lot, because I never know how I'm going to be, day to day. (Participant 2, 651-654).

In a similar vein, Participant 4 described being controlled by her emotions, which left her feeling "vulnerable":

I suppose in a way, I think, and because my emotions kind of control me a bit sometimes, I suppose having that much emotion kind of makes you more vulnerable to the world. (Participant 4, 708-709).

Participant 5 described how she did not have a "consistent" sense of her own identity due to the constant movement between her different feeling states:

Because I fluctuate between different states, I don't feel like I have a very cohesive sense of who I am or of myself, because it's not consistent. (Participant 5, 816-817).

Participant 6 explained how she had drifted between every mode over the course of her life. The change in modes she experienced were often triggered by external events (such as receiving an email from an ex-partner) but all of the modes were pervasive and difficult to "prevent":

I can see, over the last 50 years, those other modes that we spoke about, I've lived in all of them and just drifting from one to the other, to the next to the other. (Participant 6, 1201-1203).

If, for example, I got an email...if I got an email through and it was from my X and he was being abusive again, psychologically, then I would be straight out of Adult Mode, I'd be into the Victim Child Mode and the Angry Mode. It would be difficult, which is why I live like I do, very simply, to try to prevent any of those other modes, because they're so intense and they're there all the time. (Participant 6, 1231-1234).

Participant 7 described feeling confused at the rapid shift between modes and lamented how as a result of this, she struggled to define who she was as a person:

It can be a bit confusing ... It's very unusual for someone to go to one end of the feeling to like a whole other end, but usually it tends to be like in stages until you end up on one end or the other. It's like you do like a massive [91:17], which can be a bit confusing. (Participant 7, 1003-1007).

See, I have quite a hard time understanding who I am. Like, it's almost like I don't know, because there's so many like varieties of me and how I act, it's hard to pinpoint which one you actually are. (Participant 7, 1034-1035).

4.9 Other Modes or States of Self

Coding was also undertaken for other derived modes or states of self, including potential new self-states. For Participant 1, a number of codes suggested the presence of a 'Demanding Parent' mode. Young et al., (2003) hypothesised that the Demanding Parent exerts pressure on the child to be perfect; giving the message that inordinately high standards are the status quo, and the 'wrong way to be' is to exhibit imperfections or show spontaneity (Young, Klosko & Weishaar, 2003). This mode is often linked to schemas of 'Unrelenting Standards'

and ‘Self-sacrifice’ and is not believed to be as prevalent in people with Borderline Personality Disorder. However, this mode was not counted as a theme within the study as it was not well represented across the sample.

The researcher also coded what appeared to be Cognitive Analytic Therapy (CAT) (Ryle & Kerr, 2020) self-states and reciprocal roles for Participants 1, 3 and 4, although these amounted to only seven codes (with a low number of participants) so were not subsumed into a theme. No other states of self were identified from the transcripts.

4.10 Comparison with Amended Schema Mode Inventory Data

All participants completed the amended Schema Mode Inventory following their interview, which helped to ascertain whether the central modes (for BPD) were comparable to what the participants said in the interview; as well as contextualising their scores. The SMI provides ratings from ‘very low’ to ‘severe’ and a rating of ‘high’ or above is considered to be clinically meaningful in this client group. The transcription data indicated that all central modes for BPD were broadly applicable to the sample, and the study sought to triangulate these findings with corresponding ratings from the SMI. However, in using this method, the Abandoned Child mode was not found to be a good fit for Participant 5 (see comparison section, below).

For the combined sample (N=7), all central modes (over 6 sub-scales) were scored as either ‘high’ or ‘very high’ (see Table 8). For N=4 of the individual participants, the Angry Child and Impulsive Child subscales were scored as either ‘average’ or ‘moderate’ (Participants 1, 5 and 4 [AC mode] and Participants 2, 4 and 6 [IC mode]). Only two ratings of ‘severe’ were displayed within the sample for the (Un)healthy adult mode (Participants 2 and 5). Further analyses of participants’ SMI ratings are presented below.

4.11 Comparison of Participants' Schema Mode Inventory Scores with Transcription Data

Similarities and inconsistencies between participants' transcription data and SMI scores were subject to scrutiny. The following results provide a summary comparison between each participants' SMI scores and the respective five central modes that were discussed or identified during the interviews, to help determine the extent of any difference. The comparisons were made using the respective participants' transcripts (coded sections only) and participants' SMI ratings, taking into consideration whether they were clinically meaningful. The remaining eight SMI subscales were not subject to this form of analysis as it would go beyond the scope of the study. Whilst several subscale ratings appeared concordant with participants corresponding transcripts, some disparities were apparent.

Please note that for the Abandoned Child Mode, the SMI subscale represents the (non-BPD) 'Vulnerable Child' mode, which is the closest possible comparison, but does not specifically enquire about abandonment. The SMI also includes a 'Punishing' Parent subscale which was deemed to be a close-enough match for the Punitive Parent Mode. As mentioned previously, the SMI provides respective subscales for 'Angry' and 'Impulsive' modes as opposed to being contained within a single scale. Such variables were considered to have had a bearing on the accuracy of the below comparisons.

In addition, participants' Healthy Adult scores were rated as either 'high', 'very high' or 'severe', which indicated that the participants were 'highly', 'very highly' or 'severely' lacking in that regard. Conversely, all transcripts showed evidence of healthy self-parenting (see Positive Self-Parenting sub-theme [4.7.1]), which may suggest that participants provided exaggerated ratings on the SMI. However, there may have been insufficient time to explore the Healthy Adult mode (as this was asked towards the end of the interviews), or, comparing HA scores to the transcripts was an inadequate method, particularly as 'lack of a HA mode' was

not asked about directly (the HA mode was thereby excluded from the below comparisons). Furthermore, the disparity between the SMI and interview data for this mode may have also been impacted by the deficit-focused nature of the SMI versus the potential for social desirability (i.e., the avoidance of disclosing personally-perceived negative attributes in the presence of another) within verbal accounts.

Finally, 3 items on the SMI were changed at the request of the Cambridge Research Ethics Committee (see Table 5) which affected the Impulsive Child subscale. As previously mentioned, this effectively unstandardised the measure, although the Field Supervisor judged that the amended items were as close to the ‘spirit’ of the modes as possible. The following comparisons will therefore cover the Vulnerable (Abandoned) Child, Angry & Impulsive Child, Detached Protector and Punitive Parent Modes only.

Participant 1

Participant 1 scored ‘highly’ (N=3), ‘very highly’ (N=1) and ‘moderately’ (N=1) on all remaining central SMI subscales (see Appendix 4). P.1’s scores appeared consistent with the transcript across the Vulnerable Child and Detached Protector modes. However, compared to the responses given in the interview it seemed as if P.1 may have under-reported on the Angry Child subscale, which was rated as ‘moderate’ (below clinical significance). It is of note that during the interview, P.1 described mainly anger *suppression* experiences and she also mentioned concerns about being negatively judged and feeling embarrassed about expressing anger.

Conversely, P.1 scored ‘highly’ on the Punishing Parent subscale, but her responses on the interview were not very well represented across the mode, whereby only a small number of P.1’s comments were present in one of the two Punitive Parent sub-themes.

Participant 1’s mode Graph is below.

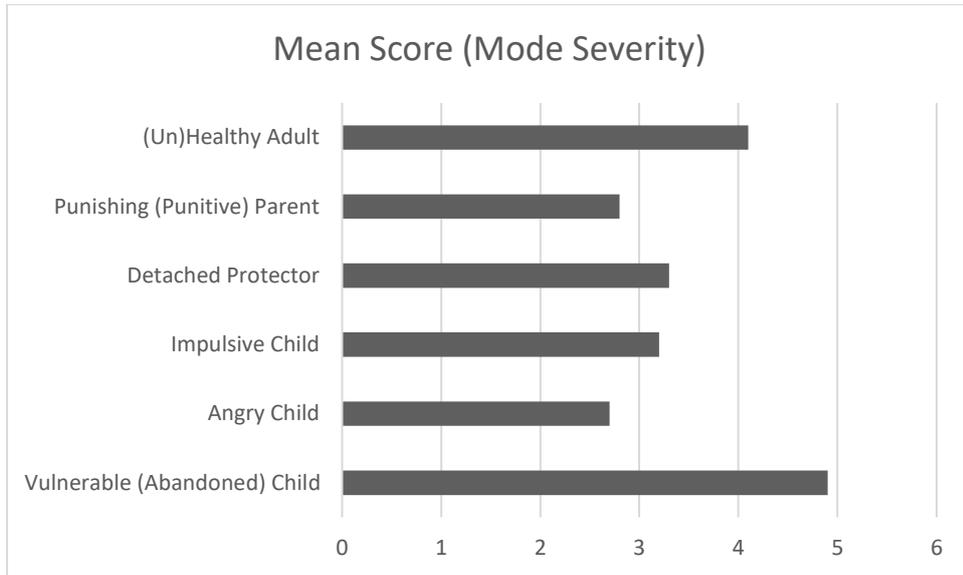


Figure 12. Mode Graph for Participant 1

Participant 2

Participant 2 scored ‘highly’ (N=1), ‘very highly’ (N=2) and ‘moderately’ (N=2) on all remaining central SMI subscales (see Appendix 4). P.2 was one of three participants whose scores on the SMI seemed to be concordant with their interview transcript across all modes. This included a ‘moderate’ score on the Detached Protector sub-scale, which corresponded with far fewer reported experiences of this mode.

Participant 2’s mode Graph is below.

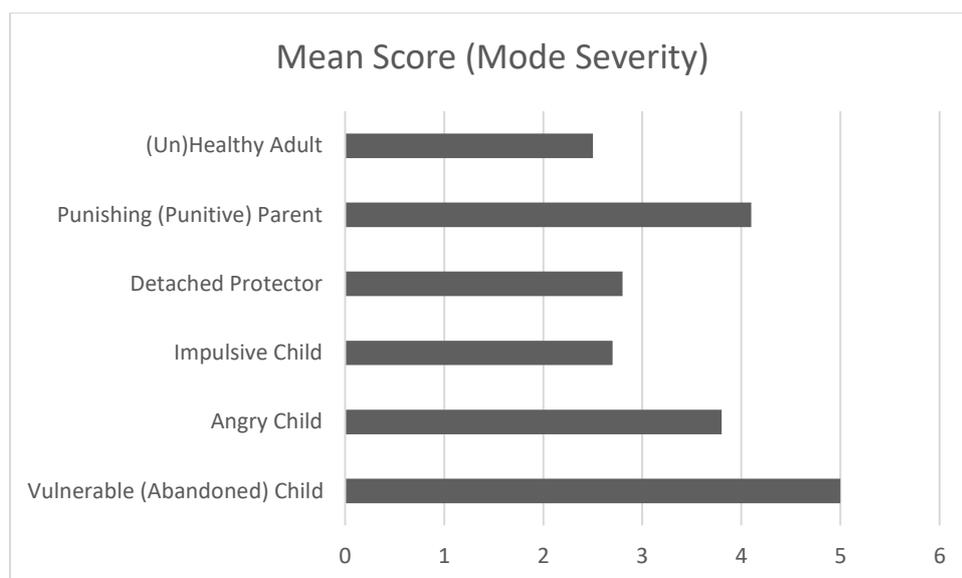


Figure 13. Mode Graph for Participant 2

Participant 3

Participant 3 scored ‘highly’ (N=1) and ‘very highly’ (N=4) on all remaining central SMI subscales (see Appendix 4). P.3’s scores on the SMI were broadly resonant with the transcript, however there were some minor discrepancies. For the Abandoned Child mode, P.3 said that she only partially identified with the mode, yet her SMI rating for the Vulnerable Child mode was rated as ‘very high’ and her comments were also well represented across the Abandoned Child theme of ‘Vulnerable Distress’. One possible explanation could be that Participant 3 did not relate to the fictitious scenarios on the AC mode card as opposed to not identifying with the mode per se.

A point of interest is P.3’s ‘high’ impulsivity rating on the SMI, while during the interview P.3 did not report experiences within the theme of ‘Suppressed Anger’ (Angry and Impulsive mode). This suggests that P.3’s angry feelings were vented more immediately, and this corresponds well with P.3’s responses within the ‘Boiling Over’ sub-theme, and subsequent ‘high’ rating on the angry child sub-scale. Moreover, P.3 also scored very highly

on the Punishing Parent sub-scale, and during her interview she described what appeared to be masochistic tendencies.

Participant 3's mode Graph is below.

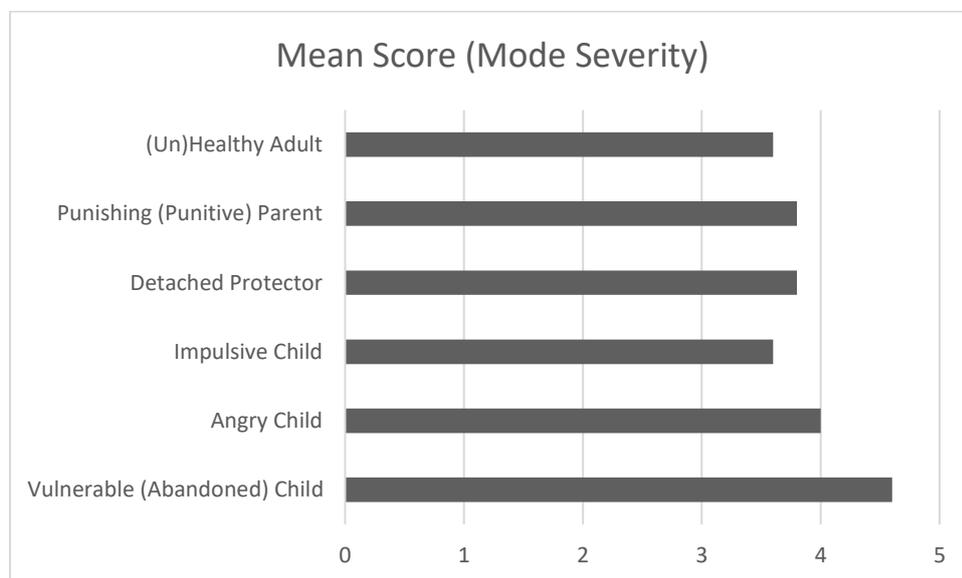


Figure 14. Mode Graph for Participant 3

Participant 4

Participant 4 scored 'highly' (N=2), 'very highly' (N=1), and 'moderately' (N=2) on all remaining central SMI subscales (see Appendix 4). P.4's SMI ratings appeared consistent with the transcript; for example, displaying 'moderate' Impulsive Child and Angry ratings (respectively). These ratings dovetailed with P.4's interview transcript where there was less evidence of her occupying an Angry & Impulsive Child mode.

Interestingly, P.4's Punishing Parent rating was 'very high', and she also described some instances of self-attack; even mentioning that friends were concerned about her self-destructive tendencies. However, after reading the mode card, P.4 said that she did not identify with the mode "very much". This suggests that there may have been a 'disconnect' between how P.4 views herself in relation to this mode, and her reported experiences. An alternative

hypothesis is that P.4 may have exaggerated her responses on the SMI and during the interview; possibly due to a desire to please the researcher, or perhaps what was depicted on the mode card was not relatable.

Participant 4's mode Graph is below.

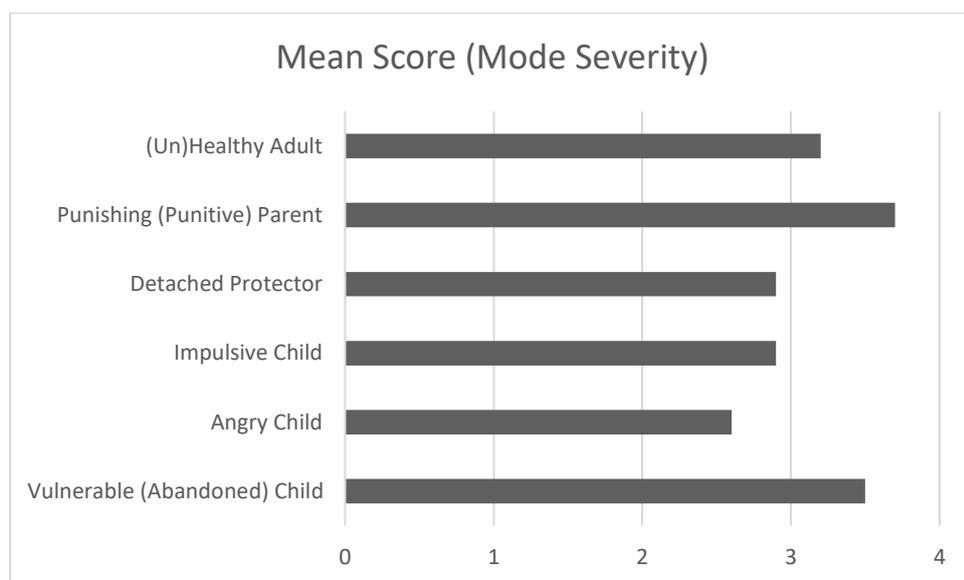


Figure 15. Mode Graph for Participant 4

Participant 5

Participant 5 scored 'highly' (N=2), 'very highly' (N=2), and 'average' (N=1) on all the remaining central SMI subscales (see Appendix 4). While there was some agreement, there were also some intriguing discrepancies between various ratings and the corresponding transcripts.

To begin with, P.5's Vulnerable Child score was 'very high', yet her comments in the interview were represented only in one of the three Abandoned Child sub-themes (i.e., 'Induced Childlike State'), whereas she made no comments relating to the sub-themes of 'Abandonment and Rejection' and 'Troubled Connections'. However, the SMI does not contain items specifically relating to abandonment and served as a helpful reminder that the Vulnerable Child

Mode is not specific to Borderline Personality Disorder (Young, Klosko & Weishaar, 2003). Upon closer inspection of the responses to both, it appeared that the Vulnerable Child mode was a better ‘fit’ than the Abandoned Child state for this participant, albeit there is some overlap.

Another interesting finding was the ‘average’ Angry Child sub-scale score. During the interview, Participant 5 reported that the angry element of the Angry & Impulsive mode was a less occupied state for her. Although P.5 was rated as ‘average’ on the Angry Child subscale, the strength of her anger appeared to be represented more in the interview, albeit P.5 reported to either suppress rageful feelings or vent them impulsively by throwing objects. This seemed to link to P.5 identifying more with the impulsivity element of the Angry & Impulsive mode, which in turn was triangulated by a ‘high’ Impulsive Child subscale score.

It is of note that P.5 reported suppressing her anger and denied being an angry person, but there were times her anger seemed to get the better of her. One hypothesis for these findings is the possibility that P.5’s anger reaches crescendo point and is experienced in a dissociated state. This may lead to an impulsive action to rid herself of the feeling, even when experienced fleetingly. However, what is then left is potentially a lasting impression of the damage ‘impulsivity’ causes (such as breakages), whereby P.5’s anger remains safely out of conscious reach.

Participant 5’s mode Graph is below.

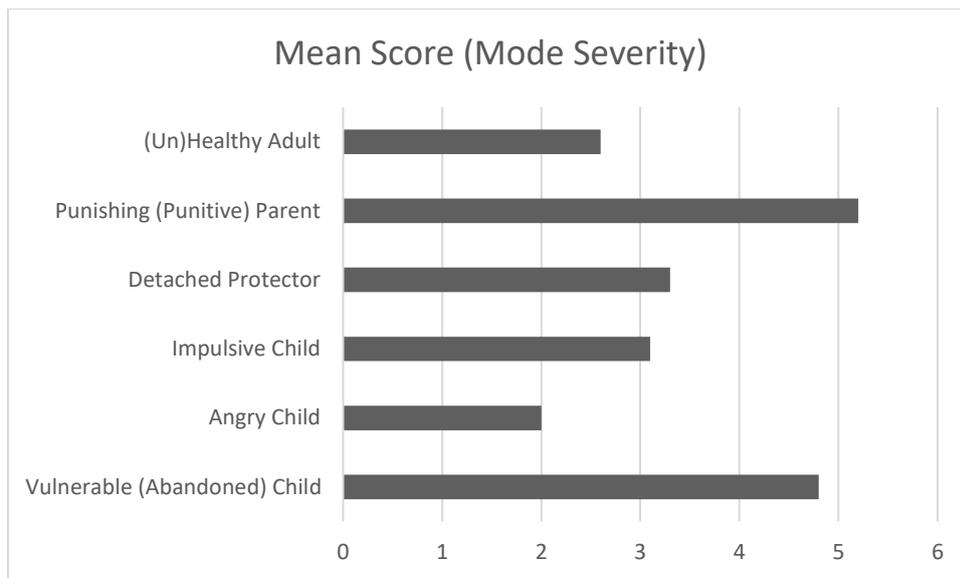


Figure 16. Mode Graph for Participant 5

Participant 6

Participant 6 scored ‘highly’ (N=1), ‘very highly’ (N=3), and ‘moderately’ (N=1) on all remaining central SMI subscales (see Appendix 4) and was one of the three participants whose scores on the SMI were consistent with their interview transcripts across the modes. For example, P.6 described feeling like an “orphan”, having experienced abandonment and rejection, as well as abuse and victimisation. This appeared to be represented by her Vulnerable Child rating, displaying a ‘very high’ score. Notably, P.6 stated that she had spent her “whole life” in the Abandoned Child mode. Similarly, a high score for the Detached Protector subscale, corresponded with her interview transcript, including a reflection that the Detached Protector mode was her “primary state”.

Participant 6’s mode Graph is below.

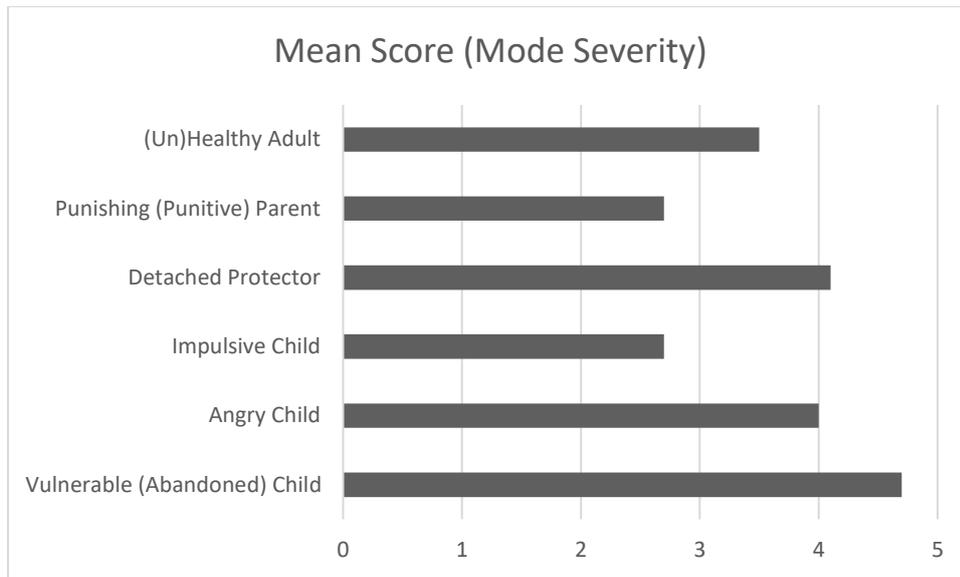


Figure 17. Mode Graph for Participant 6

Participant 7

Participant 7 scored ‘very highly’ on all remaining central SMI subscales (N=5) (see Appendix 4) and was the last of the participants whose scores on the SMI were consistent with their interview responses. However, this participant scored ‘very highly’ for all subscales, and this may have been a reflection on her current life circumstances, where it is known that modes are transient by their very nature. This could potentially tie into P.7’s reported tendency to sacrifice her needs to help others (as described in the interview, including [possibly] her taking part in the study), which may have led to a sense of being overwhelmed.

Participant 7’s mode Graph is below.

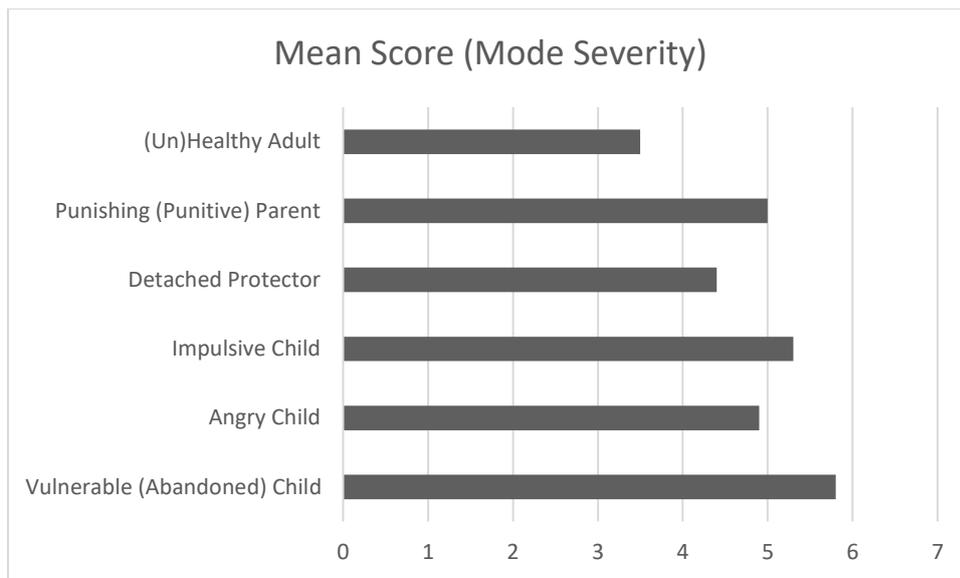


Figure 18. Mode Graph for Participant 7

4.12 Comparison Across Participants

As shown above, the participants appeared to vary in terms of how concordant their SMI and transcription data was. Various factors may have influenced these disparities including whether the interviews were carried out face-to-face (N=4) or over the telephone (N=3) (Heath et al., 2018), participants mood, motivation, temperature (some of the interviews were carried out within a heat-wave); rapport with the researcher; social desirability; the lengthy and deficit-nature of the SMI; and influences of medication. It is also possible that collecting data in one sitting may have been tiring and could have affected the accuracy of responses on the SMI, which was completed near the end. The sample also differed in age and aspects of culture, although all were female. Last but certainly not least, was the very significant impact of Covid-19.

It might also be assumed that some people within the sample were better able to access their emotions than others, which may have had a bearing on the accuracy and quality of the data. While past or present therapy experience was not screened, it became apparent within the

interviews that some participants had undergone therapy, e.g., CBT (P.5) and DBT (Pt.'s 2, 3, & 5) and therefore may have found it easier to reflect on their experiences. For one participant, she appeared to struggle at times with finding the words to describe her experience, however, was rated as 'very high' on all SMI measures. Such high ratings could therefore have been a form of 'compensation' on her part.

The disparities displayed between some of the SMI scores, and transcription data emphasises the imperative for triangulation of measures (Denzin, 2012) when evaluating schema modes. However, this must be considered alongside the risk of obtaining high social desirability responses when conducting interviews, as well as being mindful of the type of measures used.

CHAPTER 5: DISCUSSION

5.1 Summary of Findings

This mixed-methods study aimed to explore individuals' (diagnosed with EUPD or BPD) states of self, as compared to Young, Klosko and Weishaar's (2003) Schema Mode concept for Borderline Personality Disorder. The study also paid attention to whether any alternative states of self or 'parts' could be identified from the transcripts as based on existing theory or otherwise. Participants' views of their modes were also explored. The Thematic Analysis resulted in five superordinate deductive themes and thirteen related sub-themes, with one inductive theme derived. Four of the superordinate themes were in keeping with Young's modes with the exception of the Healthy Adult mode. No other consistent state(s) of self were identified across the transcripts and all participants reported a sense of self that was 'in flux' due to their modes. The SMI data showed a general agreement between the subscale scores and what was discussed in the interviews, however there were some discrepancies and similarities found, and one participant appeared to occupy a Vulnerable Child mode as opposed to an Abandoned Child state of self.

The findings of this study will be discussed in relation to the primary and secondary research questions, design limitations and implications for clinical practice. The chapter will also incorporate some reflective observation about the research process and the study's wider implications. Finally, recommendations will be made regarding extending the research in this area. The study results are summarised below in respect of the primary and secondary research questions.

5.1.1 Research Question 1

The primary research question was concerned with the extent that participants' comments made during the semi-structured interviews were representative of Young et al.'s BPD mode concept.

- To what extent do the participants' responses compare to Young et al.'s modes for BPD (2003), namely Abandoned Child, Angry & Impulsive Child, Punitive Parent, Detached Protector and Healthy Adult modes?

There appeared to be a strong case for the Abandoned Child, Angry & Impulsive Child, Punitive Parent, and Detached Protector modes, with evidence of a strong Healthy Adult (mode) as well as challenges in maintaining or connecting to this mode. However, due to the way the interview schedule was designed (with a focus on present day experiences, not the past) there are limitations as to the extent that can be determined from the transcripts. An evaluation of the transcription and SMI data for the derived themes is discussed below.

5.1.2 Vulnerable Distress (Abandoned Child Mode)

In keeping with Young et al.'s Abandoned Child mode the participants discussed key themes of abandonment and rejection, childlike feelings, and discontent in their relationships. There appeared to be a compelling flavour of core pain and emotional distress in all sub-themes which resonated with Young's assertion that the Abandoned Child is where 'emotions are housed' (Young, Klosko & Weishaar, 2003). Notably during the interviews, participants made various spontaneous comments about their childhood in relation to this mode, suggestive of unmet core needs in the here and now. Although this added context and a dimension of richness to discussions, the interview schedule was not designed to explore childhood experiences as it was concerned with 'here and now' states of self. Although this could imply a missed opportunity for further exploration, it was important that the researcher remained mindful not

to ‘dial up’ vulnerable, core feelings, so not to evoke distress. When triangulating the findings with the SMI data (see Appendix 4), mode severity for the Vulnerable Child mode (the closest mode to the Abandoned Child mode) was the highest for five out of seven participants and all scores were clinically meaningful. This also chimes with Young’s theory which views the Abandoned Child as a ‘core state of being’ (Kellogg & Young, 2006).

5.1.3 Explosive Anger or Rage (Angry and Impulsive Child Mode)

Participants’ experience of this mode resonated more with the ‘anger’ element (Bach & Farrell, 2018) although impulsivity was discussed too (within the ‘Boiling Over’ sub-theme) but this presented as being ‘driven’ by rage. Two participants identified with the impulsivity element only (see Table 9) and did not connect with the theme of anger. However, the interview transcripts told a different story in respect of the derived superordinate theme of Explosive Anger or Rage across the transcripts. In accordance with Young, Klosko and Weishaar (2003), the Angry and Impulsive Child mode is concerned with unmet needs and has more of a primitive and ‘immediacy’ feel to it, and this was evident within the majority of participants’ experiences. Moreover, the Angry and Impulsive Child mode is seen to be frequently triggered by the Vulnerable Child mode (Aalbers et al., 2009) and this was illustrated within the sub-theme of ‘Unfairly Treated’. This theme appeared to encompass a ‘signature’ of “why are my needs not attended to?” The SMI data (Appendix 4) showed that mode severity for the impulsive sub-scale was higher than the anger sub-scale for three participants; however, as the Angry and Impulsive Child mode is separated into two sub-scales, triangulating this finding with the qualitative data remains a challenge.

5.1.4 Closing Down (Detached Protector Mode)

When discussing the Detached Protector mode, all participants gave rich accounts of detachment from their internal and external worlds, describing many nuanced instances of deliberately and automatically cutting-off physical experiences and shutting themselves down by way of surviving their difficulties, and were resonant with Young et al.'s theory. Such avoidant coping mechanisms appeared to present on a 'spectrum'; from rational withdrawing as a way of managing exhausting social encounters, to numbing overwhelming sensations and suffering. At the other end of the spectrum, periods of time and perspective became lost due to dissociation, which is common in people with BPD (Young, Klosko & Weishaar, 2003; Watson, et. al., 2006) and was reported in the transcripts to be linked to past traumas. However, research has shown that rather than the Detached Protector mode, it is the 'Abandoned' and 'Angry and Impulsive' Child modes that are predictive of dissociation in this client group (Johnston et al., 2009). The majority of participants said that they identified with the mode (see Table 9), which was reflected in the SMI findings (Appendix 4) where most participants scored very highly or highly on the DP subscale. This lends further support to Young et al.'s assertion that the Detached Protector mode is a highly prevalent mode for individuals coping with BPD.

5.1.5 Self-Loathing (Punitive Parent Mode)

This mode appeared to capture the essence of Young et al.'s Punitive Parent mode well. In the sub-theme 'Attacking the Self', participants shared moving accounts of evoked internalised critic(s), self-punishment and self-sabotage. Embodied responses such as viewing the self with disgust, defectiveness, shame, and engaging in deliberate self-harm were also employed as assaultive self-weaponry. 'Attacking the Self' served further functions of bringing the self 'in line', which may have been adaptive in the past (Young, Klosko & Weishaar, 2003), pre-empting criticism, or avoiding compliments. Participants' vulnerabilities in occupying this

mode ('Vulnerability to Self-Attack' sub-theme) were shared in terms of linked developmental experiences including being harshly parented, potentially filling the void of an encouraging, patient sense of self. As the Punitive Parent mode is fused with vulnerability (Young, Klosko & Weishaar, 2003), such sensitive developmental accounts provided further evidence for Young's theory. Further vulnerabilities included finding punishment exhilarating, past bullying episodes, and having excessively high expectations foisted upon them by caregivers. Six of the participants identified with the mode (see Table 9) and when triangulating with the SMI (see Appendix 4), mode severity for the Punishing (Punitive) Parent was reported as high or very high.

5.1.6 Resilience (Healthy Adult Mode)

Participants conversely occupied both a 'weak' and 'strong' Healthy Adult mode(s), which demonstrated an overall theme of Resilience. This was an interesting finding as Young, Klosko and Weishaar (2003) hypothesised that this mode was weaker in, or for the most part, missing in people with Borderline Personality Disorder. According to Young et al. (2003), this mode holds the 'meta perspective' of all the other modes and is seen as the 'conductor' of the metaphorical mode orchestra. The hypothesised weakness in this mode is argued to be instrumental in the lives of people with BPD (Aalbers et al., 2009) as without it, the terrain of life can be fraught with significant turbulence (Young, Klosko & Weishaar, 2003; Kellogg & Young, 2006). Moreover, a present and robust Healthy Adult mode sets important limits with the Child modes and will support the Vulnerable Child to meet core needs in healthier ways. This mode also possesses the ability to 'dial-up' or 'dampen down' emergent maladaptive coping mode(s) in order to get needs met.

During the interviews, all participants described a range of experiences that resonated with a strong Healthy Adult mode, with many examples of taking responsibility for their lives, embracing self-compassion, meeting both individual and interpersonal needs, and nurturing

vulnerability. The participants also spoke of struggling to ‘dial up’ or remain connected to their Healthy Adult mode, where there was a familiar sense of reverting back into maladaptive modes and was triangulated with a ‘very high’ (un)Healthy Adult score on the SMI (see Appendix 4). The finding for this sub-theme (‘Struggling to Cope’) resonated with Young et al.’s theory and also fits with the notion of ‘mode flipping’, which is believed to contribute to identity confusion (Kellogg & Young, 2006). To this end it would also have been beneficial to explore in greater depth the experience of mode shifts in terms of their specific repertoires and sequences. In spite of the apparent presence of a weaker Healthy Adult mode (at times), the findings within the sub-theme of ‘Positive Self-Parenting’ are in direct opposition to Young et al.’s theory, and therefore holds particular significance in how individuals with Borderline Personality Disorder are perceived and thought about.

5.2 Secondary Research Question 1

- Do the participants’ responses in the interviews suggest alternative theoretical or novel states of self?

This secondary research question enquired into whether participants’ reported experiences suggested any new or existing self-states or schema modes such as Internal Family Systems Therapy (IFST) (Schwartz, 1995) and Cognitive Analytic Therapy (CAT) (Ryle & Kerr, 2020) or suggest the possibility of new modes or self-states. With the exception of Participants 1, 3, and 4 who described a small number of CAT self-states (and possible reciprocal roles), this was not found to be the case *across* all transcripts. However, the SMI scores hinted that other modes may indeed be at play for the (total) sample, namely the (Un)Contented Child, Demanding Parent, Detached Self-Soother, Compliant Surrenderer, Undisciplined Child and Enraged Child modes (please see Appendix 5). As such modes were not hypothesised to be prevalent in people living with Borderline Personality Disorder, it was interesting that these

modes reached clinical significance for the sample, however these modes were not discussed in the interviews as this went beyond the scope of the study. Nevertheless, it seems feasible that the researcher, as relatively naïve to Schema Therapy and some other therapy modalities, was less able to discern further states of self from within the transcripts.

5.3 Secondary Research Question 2

- How do the participants view their modes or states of self?

The final secondary research question was interested in how the participants viewed their modes or states of self, following the main discussion in the interview.

What emerged from the transcripts were many reflections about how the modes were experienced by the participants. In this regard, there was a prevailing sense that the participants were familiar with the experience of all five BPD modes (including a weaker Healthy Adult mode) but were often felt in a state of flux or change when experiencing these modes, almost akin to being controlled or swept-up by them. This appears to reflect the role of dissociation (Young, Klosko & Weishaar, 2003; Watson, et. al., 2006) in the organisation, maintenance, and procedure of dysfunctional schema modes in people living with Borderline Personality Disorder, whereby the flipping of modes is believed to represent a dissociative response from one part of the self to another. Young and colleagues argued that such dissociative symptoms occur on a continuum. Moreover, the notable rapid shifting from one dysfunctional mode to another is believed to be the “hallmark” of the characterological structure of BPD due to “facets of the self that have failed to integrate into a cohesive personality structure” (Johnston et al., 2009). The origin of this dissociative process is believed to be rooted in trauma, with its primary mechanism to protect the self. However, there is debate as to whether childhood trauma directly relates to the mode shifts themselves (Johnston et al., 2009). The findings within the inductive theme are intriguing and understanding more about mode shifts (from the lived perspective of

participants) would help clinicians to better understand and formulate service-users' 'mode signatures' or repertoires so that therapeutic interventions could be targeted in a more attuned way.

5.4 Methodological Strengths

The researcher recognised that the study was complex and the aims ambitious, which was highlighted in the UH Peer Review. Despite these challenges, the research encompassed many strengths. These included the researcher's (prior) lived experience of mental health difficulties, which is not unusual within the profession of Clinical Psychology (e.g., Grice et al., 2018). This significantly helped the researcher to empathise and adopt active listening with the participants, but at the same time, was sometimes a hindrance as there were occasions that participants' experiences resonated with her own. By employing measures such as reflexive journaling, principles of bracketing (Ahern, 1999; Chan et al., 2013), and engaging in reflective conversations with the Research and Field Supervisors, the risk of over-identification and contaminating the findings was mitigated. This was imperative so that the researcher could remain as close to the participants' data as possible.

Another strength of the study was in its mixed-methods design, which allowed for some of the qualitative findings to be triangulated. However, in qualitative research the triangulation process is complicated, particularly when taking a critical realist stance (Braun & Clarke, 2006). A particular strength of the study was gaining access to NHS service-users directly and engaging them in dialogue, which arguably held greater ecological validity than solely administering a questionnaire to patients or interviewing a non-clinical sample. For example, service-users within the NHS are likely to be worn-out at the prospect of completing yet another outcome measure, however the researcher offered a more flexible approach to participation (Health et al., 2018). Exploring experiences of core typology with the participants meant that

the data spoke to them personally and captured vital nuance. Using both interview and questionnaire methodology appeared to have piqued participants' interest (albeit this was an unintended consequence) which was commented upon following several interviews. Furthermore, the modes section of the interview was designed to end on a strengths-based note by asking about the Healthy Adult mode last, as it was important to mitigate participants' distress as the interviews wound to their conclusion. It is to the study's credit that none of the participants reported feeling upset during the debriefing stage.

5.5 Study Limitations

There were several limitations within the study which were likely to have had some impact on the findings. What particularly stands out is the impact of the Covid-19 pandemic, whereby there were significantly lower numbers of participants recruited to the study. Although this could not be known for sure, the response prior to the pandemic was good; once recruitment was up and running, several people expressed an interest in taking part.

The pandemic was perceived to have affected referral routes significantly for a number of reasons, e.g., there were fewer clinicians on the ground; service-users were not receiving their usual packages of care (e.g., DBT-informed groups went 'on hold' for a time), and many service-users were coping with the effects of forced isolation, away from their families and friends. It is also possible that the lack of choice given for the interview method(s), i.e., initially carried out face-to-face, and then via telephone, may have adversely impacted upon recruitment numbers (Heath et al., 2018). However, recruitment may have been affected over and above the impact of the pandemic due to the researcher having a weaker relationship with the Colne House Team, and her role in triaging referrals within Cygnet House may have influenced study referrals at this site.

Another limitation was the researcher's employed role within the Cygnet House service. While holding this role was helpful in encouraging referrals, especially during such a difficult period, this is likely to have substantially increased the power differential between researcher and participant, even though participants were reassured that their care would not be affected in any way. In this regard, the researcher was mindful to mitigate this in every aspect of the study. Recruiting participants from the researcher's place of work may have also influenced how the participants responded within the interviews, potentially giving socially desirable responses or 'faking bad' due to unspoken beliefs about what may have been expected of them.

In terms of the study design, the mode cards may have over-influenced participants to shape their responses around the scenarios, and therefore the derived themes were not based entirely on participants' own experiences.

The telephone participants may have also responded in different ways to the in-person interviewees due to feeling more comfortable discussing personal and sensitive matters over the telephone (in Heath et al., 2018). In contrast to previous studies investigating interview methods, newer research has demonstrated that telephone-interviewed, as compared to face-to-face participants, are troubled less about the potential for humiliation when candidly discussing intimate subject-areas (in Heath et al., 2018). This issue may be particularly relevant for individuals attracting the diagnosis of Emotionally Unstable, or Borderline Personality Disorder who may strongly anticipate negative judgement/s when sharing their stories; including from the direction of mental health professionals (Lewis & Appleby, 1988; Chartonas et al., 2017). Furthermore, Borbasi et al. (2002, cited in Heath et al., 2018) argued that research facilitated outside of clinical environments may serve to enhance participants' self-disclosure. In Heath et al.'s., (2018) study, the researchers highlighted participants' preference for telephone interviews compared with face-to-face, Skype, and email methodologies. The

researchers concluded that telephone interviews afforded greater convenience of participation as well as enhancing more safe and honest communication, likely due to the increased ‘social distance’ between researcher and participant. It is therefore plausible that the participants in the present study who attended interviews in-person (N=4) with the added stigma of meeting in a mental health setting, may have felt more restricted in how open they could be.

The study was also restricted by the extended length of time it took to be completed, which meant that crucial momentum was lost on several occasions. This was confounded by several factors, including numerous changes in supervisor, which meant having to build rapport with new supervisors, the researcher having to deal with some personal problems, Covid-19, and the lengthy and convoluted research ethics process, which was experienced as frustrating at times. All of the aforementioned issues had an impact upon the motivation of the researcher, who at times, slipped into an avoidant coping mode.

Finally, member-checking, also referred to as participant validation (McKim, 2023), was not undertaken, which meant the participants were not able to review the findings to determine how strongly they resonated with their experiences. Such a validity measure is an important component of establishing data integrity and its omission is a further weakness of the study.

5.5.1 Participant Sample

All the participants were women and reported being from a ‘white’ or ‘white other’ background, which implied the sample was highly restricted in terms of both gender and cultural diversity. The Census for 2021 (which provided the most recent data in relation to when this research was conducted) did not report regional data for gender but showed that for cultural diversity, 92.3% of people in East Hertfordshire identified their ethnic group as being

‘white’, as opposed to other ethnic groups (Office for National Statistics, 2023). This may have accounted for the high number of white participants within the East Hertfordshire site.

In Watford (within the Colne House site region) however, fewer (60.9%) people in the census reported their ethnic group within the ‘white’ category (Office for National Statistics, 2023), which suggests a missed opportunity for the study to capture the lived experiences of ethnically diverse people. However, the significant change to NHS business operations during the pandemic could have influenced whether the research was at the forefront of clinicians’ minds, especially for the Watford site (mental health team) where the researcher was not based. Notably, only one participant was recruited from this site. Furthermore, the lack of heterogeneity in the sample encompassed many disadvantages, including reducing the range of responses and understanding difference. While Borderline Personality Disorder is primarily diagnosed in women (Widiger & Weissman, 1991; Skodol & Bender, 2003) and is associated with being young, single, and female (Zimmermann and Coryell, 1990, cited in Davidson, 2008), newer research suggests that there are no gender differences in the prevalence rates of Borderline Personality Disorder (Sansone & Sansone, 2011). While this is hypothesised to be partially attributed to sampling or diagnostic bias (Skodol & Bender, 2003), the present study missed a vital opportunity to recruit men who were missing from the findings; and their experiences are important to understand too. Furthermore, the smaller sample size (N=7) restricted the generalisability of the findings.

It should be noted that all participants generously volunteered their time to participate in the study, which may suggest that this group of participants’ level of social desirability may be higher than others. In addition, the offer of £10.00 compensation (see Appendices 9 and 26) towards travel or use of home resources (for the telephone interviews) may have influenced some individuals to participate. However, the researcher attempted to mitigate this by making it clear on the Participant Information Sheets and in verbal discussions that they were free to

avoid answering any questions, withdraw from the study during the interview, or within a defined period following, regardless of remuneration.

5.6 Clinical Implications

Clinical implications of the findings include their relevance and significance to multidisciplinary teams. By identifying participants' modes this study presents a unique opportunity to intervene in clinical practice, e.g., in mode-monitoring and recognising when a client shifts into a maladaptive mode. An example of this would be if a client flipped into a Vulnerable Child mode, a more attuned member of the MDT could respond with empathy and curiosity about what unmet need this may be communicating; not dissimilar to 'limited reparenting' interventions within Schema Therapy. In this regard, it is recommended that clinicians imagine the face of a child (on their client) when presented with a Vulnerable Child mode, which could help to summon increased compassion and empathy. The emergence of a Punitive Parent mode could be met with kindness and validation, i.e., welcoming all parts of the self with patience and empathy.

In addition, having a more 'mode aware team' could result in recognising service-users' resources and supporting them to play to their strengths. This could involve clinicians 'taking a step forward or back' as appropriate to allow the Healthy Adult (or Positive Self-Parent) to flourish. However, it is acknowledged that paying attention to one's own modes would also be important so that clinicians are not unwittingly reenacting dynamics relating to their own past. This could be harnessed through offering multidisciplinary teams the option to engage in Schema-informed reflective practice, thereby encouraging reflective discussions and formulation around modes in everyday work.

Finally, the findings of this research could also help multidisciplinary team members to better understand the more challenging presentations (or modes) within Borderline (or

Emotionally Unstable) Personality Disorder (Nysaeter & Nordahl, 2008) which could help to challenge the existing narrative that relies on diagnostic overshadowing, i.e., viewing patients with BPD / EUPD as “irrational” or “difficult”, particularly when occupying an Angry and Impulsive Child Mode. In the case of dissociated states of self, this could be reframed in terms of its survival function in response to past and present traumatic or abusive events (Young, Klosko & Weishaar, 2003).

5.6.1 Implications for the Profession of Clinical Psychology

Clinical Psychology adopts a scientist-practitioner model as central to its values, competencies, and offerings of the profession (Shapiro, 2002). Integration of science and practice is not only based on experimentally rigorous findings (such as those produced by RCTs), but increasingly, on real-world clinical settings, practice-based evidence and informed by service-user narratives, which are arguably more applicable to clinical practice and building relationships with service-users.

This research focused on the perspectives of service-users in receipt of NHS Services, which was triangulated with a psychometric outcome measure (amended SMI), as well as acting on Service-user Consultant feedback (see Appendix 7). Enhancing psychological formulation and understanding of therapeutic ‘fit’ is crucial to clinical psychologists working in an increasingly underfunded NHS, particularly due to services’ reliance on the medical model which privileges psychiatric diagnosis as opposed to lived experiences of service-users (Marzillier & Hall, 2009). As well as being scientist-practitioners, clinical psychologists largely remain critical of pathologising psychological distress as well as the systems of power that can at times, perpetuate service-users’ difficulties. By obtaining service-users’ first-person accounts of their experiences, including their strengths, this research was in keeping with the values of clinical psychology. This is because such research enables clients’ lived experiences

to enter mental health services as well as the evidence base, which has the potential to influence clinical practice as well as dilute pathologising narratives.

5.7 Wider Implications

This research has the potential to filter down to help change the conversation about women diagnosed with Borderline (and Emotionally Unstable) Personality Disorder. This could be through education, normalising that everyone has modes (including service-users) and that resilience forms part of the picture too.

5.8 Future Research

For future research, it is recommended that the Healthy Adult Mode is explored further in patients with a diagnosis of EUPD which could provide further insights into the many strengths this client group holds. Other studies could also explore service-users' mode sequences to understand better what may trigger a particular embodied response such as crying inconsolably or acting impulsively. Although the study did not identify the presence of other states of self across the transcripts, there were suggestions that other modes were present (from the SMI findings). Identifying the presence of modes outside of Young's BPD concept could add further richness to these findings.

Targeting diverse communities is of the utmost importance, as the study did not provide any insight into schema mode experience beyond a white Westernised and female perspective, which greatly limits the generalisability of the findings.

Finally, conducting further research in this area is important, particularly due to the lower sample size of this study. Now that Covid-19 restrictions have settled down, it is likely that increased support for research projects within NHS Trusts would now be given.

5.9 Conclusions

Due to the gaps in the quantitative and qualitative literature (e.g., Puri et al., 2021, and cited in Young & Brown, 2003) this mixed-methods study aimed to explore whether ‘modes’ or other ‘states of self’ could be identified in those with a diagnosis of Borderline or Emotionally Unstable Personality Disorder, and if so, how participants’ talked about them (or in other words how modes or states were subjectively experienced) and to what extent they compared with Young et al.’s (2003) mode concept (i.e., how the modes manifested with respect to theory). Through exploring participants’ experiences via semi-structured interview and triangulating with an amended schema mode measure this study has contributed to the relatively small evidence-base by highlighting the extent of agreement with Young et al.’s (2003) central modes (for BPD), in four out of five modes, thus bringing to life the abstract concept of modes and making the concept more accessible to people with BPD and the clinicians they work with.

The research also stressed the importance of understanding the impact of service-users’ experience which has relevance for Psychologists and Psychological Therapists using the Schema Therapy model and increasing awareness within multidisciplinary teams. The research findings were largely conclusive and showed how Young et al.’s (2003) central schema modes were experienced by a small sample of women with Borderline Personality Disorder diagnoses, as well as demonstrating how their modes affected them, particularly in relation to their resilience. Recommendations were also made concerning clinical practice and future research.

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APPENDICES

Appendix 1. Early Maladaptive Schemas

1. Abandonment/Instability

The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable (e.g., have angry outbursts), unreliable, or present only erratically; because they will die imminently; or because they will abandon the individual in favour of someone better.

2. Mistrust/Abuse

The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or “getting the short end of the stick.”

3. Emotional Deprivation

The expectation that one’s desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:

A. Deprivation of Nurturance: Absence of attention, affection, warmth, or companionship.

B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing of feelings from others.

C. Deprivation of Protection: Absence of strength, direction, or guidance from others.

4. Defectiveness/Shame

The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects or that one would be unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one’s perceived flaws. These flaws may be **private** (e.g., selfishness, angry impulses, unacceptable sexual desires) or **public** (e.g., undesirable physical appearance, social awkwardness).

5. Social Isolation/Alienation

The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.

6. Dependence/Incompetence

Belief that one is unable to handle one’s everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.

7. Vulnerability to Harm or Illness

Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following:

- (A) **Medical catastrophes** (e.g., heart attacks, AIDS)
- (B) **Emotional catastrophes** (e.g., going crazy)
- (C) **External catastrophes** (e.g., elevators collapsing, victimisation by criminals, airplane crashes, earthquakes).

8. Enmeshment/Undeveloped Self

Excessive emotional involvement and closeness with one or more significant others (often parents) at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by or fused with others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.

9. Failure

The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers in areas of achievement (school, career, sports, etc.). Often involves beliefs that one is stupid, inept, untalented, lower in status, less successful than others, and so forth.

10. Entitlement/Grandiosity

The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (e.g., being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward or domination of others: asserting one's power, forcing one's point of view, or controlling the behaviour of others in line with one's own desires without empathy or concern for others' needs or feelings.

11. Insufficient Self-Control/Self-Discipline

Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals or to restrain the excessive expression of one's emotions and impulses. In its milder form, the patient presents with an exaggerated emphasis on discomfort avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion at the expense of personal fulfilment, commitment, or integrity.

12. Subjugation

Excessive surrendering of control to others because one feels coerced - submitting in order to avoid anger, retaliation, or abandonment. The two major forms of subjugation are: A. Subjugation of needs: Suppression of one's preferences, decisions, and desires. B. Subjugation of emotions: Suppression of emotions, especially anger. Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to

others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally, leads to a build-up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behaviour, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, “acting out,” substance abuse).

13. Self-Sacrifice

Excessive focus on voluntarily meeting the needs of others in daily situations at the expense of one’s own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one’s own needs are not being adequately met and to resentment of those who are taken care of. (Overlaps with concept of co-dependency).

14. Approval-Seeking/Recognition-Seeking

Excessive emphasis on gaining approval, recognition, or attention from other people or on fitting in at the expense of developing a secure and true sense of self. One’s sense of esteem is dependent primarily on the reactions of others rather than on one’s own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement as means of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying or in hypersensitivity to rejection.

15. Negativity/Pessimism

A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc.) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation in a wide range of work, financial, or interpersonal situations that things will eventually go seriously wrong or that aspects of one’s life that seem to be going well will ultimately fall apart. Usually involves an inordinate fear of making mistakes that might lead to financial collapse, loss, humiliation, or being trapped in a bad situation. Because they exaggerate potential negative outcomes, these individuals are frequently characterized by chronic worry, vigilance, complaining, or indecision.

16. Emotional Inhibition

The excessive inhibition of spontaneous action, feeling, or communication, usually to avoid disapproval by others, feelings of shame, or losing control of one’s impulses. The most common areas of inhibition involve: (a) inhibition of anger and aggression; (b) inhibition of positive impulses (e.g., joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one’s feelings, needs, and so forth; or (d) excessive emphasis on rationality while disregarding emotions.

17. Unrelenting Standards/Hypercriticalness

The underlying belief that one must strive to meet very high internalized standards of behaviour and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down and in hyper-criticalness toward oneself and others.

Must involve significant impairment in pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships. Unrelenting standards typically present as (a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, the need to accomplish more.

18. Punitiveness

The belief that people should be harshly punished for making mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others because of a reluctance to consider extenuating circumstances, allow for human imperfection, or empathize with feelings.

*Adapted from Young, Klosko, and Weishaar (2003) (pp. 14-17).

Appendix 2. Young's Schema Modes for Borderline Personality Disorder including Commonly Associated Schemas / Category Coding for Thematic Analysis

CHILD MODES

Child Modes	Description	Commonly Associated Schemas
Abandoned Child	The suffering inner child. Specifically concerned with the focus on abandonment. Patients appear fragile and childlike. Can appear sorrowful, frantic, frightened, unloved and lost. Also feels helpless, utterly alone and obsessed with finding a parent figure who will take care of them. Idealises nurturers and have fantasies of being rescued by them. Engage in desperate efforts to prevent caretakers from abandoning them, and at times their perceptions of abandonment approach 'delusional proportions'.	Abandonment, Mistrust/Abuse, Emotional Deprivation, Defectiveness, Social Isolation, Dependence/Incompetence, Vulnerability to Harm or Illness, Enmeshment/Undeveloped Self, Negativity/Pessimism.
Angry and Impulsive Child (Believed to be the least inhabited mode for people living with BPD).	Vents anger directly in inappropriate ways. Appearing enraged, demanding, devaluing, controlling, or abusive. Patients may make demands that seem entitled or spoiled and that alienate others. They act impulsively to meet their needs and may make suicidal threats and engage in parasuicidal behaviour. However, these demands are reflective of attempts to meet their basic (unmet) emotional / core needs as opposed to reflecting entitlement.	Abandonment, Mistrust/Abuse, Emotional Deprivation, Subjugation (or, at times, any of the schemas associated with the Vulnerable Child). Entitlement, Insufficient Self Control / Self-Discipline.

DYSFUNCTIONAL PARENT MODE

Dysfunctional Parent Mode	Description	Commonly Associated Schemas
Punitive Parent	Restricts, criticizes, or punishes the self or others. This mode is an internalisation of one or both parents' rage, hatred, loathing, abuse, or subjugation of the patient as a child. Signs and symptoms include self-loathing, self-criticism, self-denial, self-mutilation, suicidal fantasies, and self-destructive behaviour. They become angry	Subjugation, Punitiveness, Defectiveness, Mistrust/Abuse (as abuser).

	at themselves for having of showing normal selves, for example, by cutting or starving themselves and speak about themselves in mean, harsh tones, saying things such as they are ‘evil’, ‘bad’ or ‘dirty’.	
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AVOIDANCE MODE

Avoidance Mode	Description	Commonly Associated Schemas
Detached Protector (Believed to be the most inhabited mode for people living with BPD).	The function of this mode is to cut off emotional needs, disconnect from others and behave submissively in order to avoid punishment. May appear as ‘good’ patients. Rather than being true to themselves they remain cut off from their own needs and feelings. Signs and symptoms include depersonalisation, emptiness, boredom, substance abuse, bingeing, self-mutilation, psychosomatic complaints, ‘blankness’ and robot-like compliance. Often switch into this mode when feelings are stirred up.	Not described in Young et al.

HEALTHY ADULT MODE

Healthy Adult Mode	Description	Commonly Associated Schemas
Healthy Adult	Like a good parent, the Healthy Adult mode serves the following three basic functions: 1. Nurtures, affirms, and protects the Vulnerable Child. 2. Sets limits for the Angry Child and the Impulsive/Undisciplined Child, in accord with the principles of reciprocity and self-discipline. 3. Battles or moderates the maladaptive coping and dysfunctional parent modes.	None. Absence of activated schemas.

Replicated from Young, Klosko, and Weishaar (2003) (pp.307-311) and the Schema Therapy Institute Website (Schema Modes, n.d.). Category coding for the five modes broadly correspond with the hypothesised ‘central (maladaptive) modes’ in common with BPD.

All of the above modes are broadly represented within Young’s Schema Mode Inventory (SMI), although, for the purpose of the study the ‘Abandoned Child’ mode is represented by the ‘Vulnerable Child’ mode, and the ‘Angry & Impulsive’ mode is represented by 2 separate subscales (‘Angry’ and ‘Impulsive’).

Appendix 3. Amended Schema Mode Inventory

Amended Schema Mode Inventory (SMI)

Following each interview, participants were asked to complete the (amended) SMI questionnaire (approximately 15-30 minutes):

Participant No.

Date of Birth:.....

Highest Educational Level:.....

Today's Date:.....

SMI

INSTRUCTION: Listed below are statements that people might use to describe themselves. Please rate each item on **how often** you believe or feel each statement **in general** using the frequency scale:

FREQUENCY: In general	
1 = Never or Almost Never	4 = Frequently
2 = Rarely	5 = Most of the time
3 = Occasionally	6 = All of the time

Frequency	In general...
	1. I demand respect by not letting other people push me around.
	2. I feel loved and accepted.
	3. I deny myself pleasure because I don't deserve it.
	4. I feel fundamentally inadequate, flawed, or defective.
	5. I have impulses to punish myself by hurting myself (e.g., cutting myself).
	6. I feel lost.
	7. I'm hard on myself.
	8. I try very hard to please other people in order to avoid conflict, confrontation, or rejection.
	9. I can't forgive myself.

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	10. I do things to make myself the centre of attention.
	11. I get irritated when people don't do what I ask them to do.
	12. I have trouble controlling my impulses.
	13. If I can't reach a goal, I become easily frustrated and give up.
	14. I have rage outbursts.
	15. I act impulsively or express emotions that get me into difficulties and distress other people.
	16. It's my fault when something bad happens.
	17. I feel content and at ease.
	18. I change myself depending on the people I'm with, so they'll like me or approve of me.
	19. I feel connected to other people.
	20. When there are problems, I try hard to solve them myself.
	21. I don't discipline myself to complete routine or boring tasks.
	22. If I don't fight, I will be abused or ignored.
	23. I have to take care of the people around me.
	24. If you let other people mock or bully you, you're a loser.
	25. I physically attack people when I'm angry at them.
	26. Once I start to feel angry, I often don't control it and lose my temper.
	27. It's important for me to be Number One (e.g., the most popular, most successful, most wealthy, most powerful).
	28. I feel indifferent about most things.
	29. I can solve problems rationally without letting my emotions overwhelm me.
	30. It's ridiculous to plan how you'll handle situations.
	31. I won't settle for second best.
	32. Attacking is the best defence.
	33. I feel cold and heartless toward other people.
	34. I feel detached (no contact with myself, my emotions or other people).
	35. I blindly follow my emotions.
	36. I feel desperate.
	37. I allow other people to criticize me or put me down.
	38. In relationships, I let the other person have the upper hand.

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

	39. I feel distant from other people.
	40. I don't think about what I say, and it gets me into trouble or hurts other people.
	41. I work or play sports intensively so that I don't have to think about upsetting things.
	42. I'm angry that people are trying to take away my freedom or independence.
	43. I feel nothing.
	44. I do what I want to do, regardless of other people's needs and feelings.
	45. I don't let myself relax or have fun until I've finished everything I'm supposed to do.
	46. I throw things around when I'm angry.
	47. I feel enraged toward other people.
	48. I feel that I fit in with other people.
	49. I have a lot of anger built up inside of me that I need to let out.
	50. I feel lonely.
	51. I try to do my best at everything.
	52. I like to do something exciting or soothing to avoid my feelings (e.g., working, gambling, eating, shopping, sexual activities, watching TV).
	53. Equality doesn't exist, so it's better to be superior to other people.
	54. When I'm angry, I often lose control and threaten other people.
	55. I let other people get their own way instead of expressing my own words.
	56. If someone is not with me, he or she is against me.
	57. In order to be bothered less by my annoying thoughts or feelings, I make sure that I'm always busy.
	58. I'm a bad person if I get angry at other people.
	59. I don't want to get involved with people.
	60. I have been so angry that I've hurt someone.
	61. I feel that I have plenty of stability and security in my life.
	62. I know when to express my emotions and when not to.
	63. I'm angry with someone for leaving me alone or abandoning me.
	64. I don't feel connected to other people.
	65. I can't bring myself to do things that I find unpleasant, even if I know it's for my own good.
	66. I break rules and regret it later.
	67. I feel humiliated.

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

	68. I trust most other people.
	69. I act first and think later.
	70. I get bored easily and lose interest in things.
	71. Even if there are people around me, I feel lonely.
	72. I don't allow myself to do pleasurable things that other people do because I'm bad.
	73. I assert what I need without going overboard.
	74. I feel special and better than most other people.
	75. I don't care about anything; nothing matters to me.
	76. It makes me angry when someone tells me how I should feel or behave.
	77. If you don't dominate other people, they will dominate you.
	78. I say what I feel, or do things impulsively, without thinking of the consequences.
	79. I feel like telling people off for the way they have treated me.
	80. I'm quite capable of taking care of myself.
	81. I'm quite critical of other people.
	82. I'm under constant pressure to achieve and get things done.
	83. I'm trying not to make mistakes; otherwise, I'll get down on myself.
	84. I deserve to be punished.
	85. I can learn, grow, and change.
	86. I want to distract myself from upsetting thoughts and feelings.
	87. I'm angry at myself.
	88. I feel flat.
	89. I have to be the best in whatever I do.
	90. I sacrifice pleasure, health, or happiness to meet my own standards.
	91. I'm demanding of other people.
	92. If I get angry, I can get so out of control that I injure other people.
	93. I am invulnerable.
	94. I'm a bad person.
	95. I feel safe.
	96. I feel listened to, understood, and validated.

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

	97. It is impossible for me to control my impulses.
	98. I destroy things when I am angry.
	99. By dominating other people, nothing can happen to you.
	100. I act in a passive way, even when I don't like the way things are.
	101. My anger gets out of control.
	102. I mock or bully other people.
	103. I feel like lashing out or hurting someone for what he/she did to me.
	104. I know that there is a 'right' and a 'wrong' way to do things; I try hard to do things the right way, or else I start criticizing myself .
	105. I often feel alone in the world.
	106. I feel weak and helpless.
	107. I'm lazy.
	108. I can put up with anything from people who are important to me.
	109. I've been cheated or treated unfairly.
	110. If I feel the urge to do something, I just do it.
	111. I feel left out or excluded.
	112. I belittle others.
	113. I feel optimistic.
	114. I feel I shouldn't have to follow the same rules that other people do.
	115. My life right now revolves around getting things done and doing them 'right'
	116. I'm pushing myself to be more responsible than most other people
	117. I can stand up for myself when I feel unfairly criticized, abused, or taken advantage of.
	118. I don't deserve sympathy when something bad happens to me.
	119. I feel that nobody loves me.
	120. I feel that I'm basically a good person.
	121. When necessary, I complete boring and routine tasks in order to accomplish things I value.
	122. I feel spontaneous and playful.
	123. I can become so angry that I feel capable of harming someone.
	124. I have a good sense of who I am and what I need to make myself happy.

Appendix 4. Schema Mode Inventory Means and Mode Severity for the 5 Modes (6 sub-scales) for Each Participant and the Total Sample (N=7)

MEAN MODES AND MODE SEVERITY FOR PARTICIPANT 1

Mode	Mean Score	Mean Level of Mode Severity	Total Sample (N=7) Mean Mode Severity Level
Vulnerable (Abandoned) Child	4.9	Very High	Very High
Angry Child ^[a]	2.7	Moderate ^[c]	High
Impulsive Child ^[a]	3.2	High	High
Punishing (Punitive) Parent	2.8	High	Very High
Detached Protector	3.3	High	High
(Un)Healthy Adult ^[b]	4.1	High	Very High
Total Mean Score	17.8		

^[a] Modes of interest (NB: 'Angry' and 'Impulsive' modes are separate subscales within the SMI)

^[b] Reverse-scored

^[c] Not clinically significant

MEAN MODES AND MODE SEVERITY FOR PARTICIPANT 2

Mode	Mean Score	Mean Level of Mode Severity	Total Sample (N=7) Mean Mode Severity Level
Vulnerable (Abandoned) Child	5.0	Very High	Very High
Angry Child ^[a]	3.8	High	High
Impulsive Child ^[a]	2.7	Moderate ^[c]	High
Punishing (Punitive) Parent	4.1	Very High	Very High
Detached Protector	2.8	Moderate ^[c]	High
(Un)Healthy Adult ^[b]	2.5	Severe	Very High
Total Mean Score	18.2		

^[a] Modes of interest (NB: 'Angry' and 'Impulsive' modes are separate subscales within the SMI)

^[b] Reverse-scored

^[c] Not clinically significant

MEAN MODES AND MODE SEVERITY FOR PARTICIPANT 3

Mode	Mean Score	Mean Level of Mode Severity	Total Sample (N=7) Mean Mode Severity Level
Vulnerable (Abandoned) Child	4.6	Very High	Very High
Angry Child ^[a]	4.0	Very High	High
Impulsive Child ^[a]	3.6	High	High
Punishing (Punitive) Parent	3.8	Very High	Very High
Detached Protector	3.8	Very High	High
(Un)Healthy Adult ^[b]	3.6	High	Very High
Total Mean Score	19.8		

^[a] Modes of interest (NB: ‘Angry’ and ‘Impulsive’ modes are separate subscales within the SMI)

^[b] Reverse-scored

MEAN MODES AND MODE SEVERITY FOR PARTICIPANT 4

Mode	Mean Score	Mean Level of Mode Severity	Total Sample (N=7) Mean Mode Severity Level
Vulnerable (Abandoned) Child	3.5	High	Very High
Angry Child ^[a]	2.6	Moderate ^[c]	High
Impulsive Child ^[a]	2.9	Moderate ^[c]	High
Punishing (Punitive) Parent	3.7	Very High	Very High
Detached Protector	2.9	High	High
(Un)Healthy Adult ^[b]	3.2	Very High	Very High
Total Mean Score	15.9		

^[a] Modes of interest (NB: ‘Angry’ and ‘Impulsive’ modes are separate subscales within the SMI)

^[b] Reverse-scored

^[c] Not clinically significant

MEAN MODES AND MODE SEVERITY FOR PARTICIPANT 5

Mode	Mean Score	Mean Level of Mode Severity	Total Sample (N=7) Mean Mode Severity Level
Vulnerable (Abandoned) Child	4.8	Very High	Very High
Angry Child ^[a]	2.0	Average ^[c]	High
Impulsive Child ^[a]	3.1	High	High
Punishing (Punitive) Parent	5.2	Very High	Very High
Detached Protector	3.3	High	High
(Un)Healthy Adult ^[b]	2.6	Severe	Very High
Total Mean Score	17.9		

^[a] Modes of interest (NB: 'Angry' and 'Impulsive' modes are separate subscales within the SMI)

^[b] Reverse-scored

^[c] Not clinically significant

MEAN MODE AND MODE SEVERITY FOR PARTICIPANT 6

Mode	Mean Score	Mean Level of Mode Severity	Total Sample (N=7) Mean Mode Severity Level
Vulnerable (Abandoned) Child	4.7	Very High	Very High
Angry Child ^[a]	4.0	Very High	High
Impulsive Child ^[a]	2.7	Moderate ^[c]	High
Punishing (Punitive) Parent	3.0	High	Very High
Detached Protector	4.1	Very High	High
(Un)Healthy Adult ^[b]	3.5	Very High	Very High
Total Mean Score	19.3		

^[a] Modes of interest (NB: 'Angry' and 'Impulsive' modes are separate subscales within the SMI)

^[b] Reverse-scored

^[c] Not clinically significant

MEAN MODES AND MODE SEVERITY FOR PARTICIPANT 7

Mode	Mean Score	Mean Level of Mode Severity	Total Sample (N=7) Mean Mode Severity Level
Vulnerable (Abandoned) Child	5.8	Very High	Very High
Angry Child ^[a]	4.9	Very High	High
Impulsive Child ^[a]	5.3	Very High	Very High
Punishing (Punitive) Parent	5.0	Very High	Very High
Detached Protector	4.4	Very High	High
(Un)Healthy Adult ^[b]	3.5	Very High	Very High
Total Mean Score	23.6		

^[a] Modes of interest (NB: 'Angry' and 'Impulsive' modes are separate subscales within the SMI)

^[b] Reverse-scored

Appendix 5. Schema Mode Inventory Means and Mode Severity for the 8 Remaining Modes (8 sub-scales) for the Total Sample (N=7)

Mode	Mean Score	Mean Level of Mode 'Severity'
(Un)Contented Child [a]	2.37	Very High
Demanding Parent	4.30	High
Detached Self-Soother	3.94	High
Compliant Surrenderer	3.84	High
Undisciplined Child	3.79	High
Enraged Child	2.56	High
Self-Aggrandiser	2.89	Average [b]
Bully and Attack	1.99	Average [b]
Total Mean Score	29.04	

[a] Reverse-scored

[b] Not clinically significant

Appendix 6. Reflective Diary Entry Following the Pilot Interviews

After completing pilot interviews with two of the study's Service-user and Carer Consultants, I received helpful feedback regarding their respective experiences, which focused more upon the process of the interviews, as opposed to their content. After discussing the pilot interviews and feedback with my Field Supervisor, I have reflected further on these experiences, including paying attention to the thoughts and feelings that emerged within me.

Upon carrying out the interviews I noticed a significant weight of responsibility on my shoulders. I was keen not to cause my interviewees any distress, and clearly recall my (heavy) emphasis on interviewee's taking a break or withdrawing from the process if needed; particularly for the first (younger) interviewee. I was also feeling a little anxious, partly due to not having conducted a research interview for some time and was feeling out of practice.

Immediately prior to the first interview, the interviewee informed me that they were feeling nervous. I later wondered if this was due to how I set-up the process (as above), which may have led to an enhanced expectation of a 'difficult' conversation to come. I also wondered if the less helpful and familiar 'need to get it right' part of me was competing with the 'care of interviewee' part, which meant that I was not as present within the first interview. Although it did not appear that the interviewee noticed (albeit consciously), they did comment on the interview being too lengthy, and conversely, that more time could have been dedicated to some of the modes, to the exclusion of others.

Upon reflection this may have been due to me sticking quite rigidly with each area of the schedule as opposed to settling into a semi-structured format, but at the same time I am aware that there is a lot of ground to cover. Taking this knowledge into my second pilot interview, I did my best to let go of the need to be a perfect interviewer and instead directed my focus to the interviewee's comments and moved back and forth between the different areas

when needed. As a result, I was less anxious and more responsive to what was being discussed and the interviewee's feedback reflected this; they felt the interview had a natural 'flow' to it.

When discussing the process of the first pilot interview and feedback with my supervisor, it was suggested that I carry out a further (unstructured) practice interview with a friend or peer on the experience of coping with toothache. This was borne out of my supervisor's observation of a tendency to skim over more 'difficult' material by moving onto a different area of the schedule. By approaching a more 'benign' topic in an exploratory way, this would hopefully provide a helpful experience of staying with such material, and to encourage further elaboration when needed.

Although initially sceptical, I carried out an interview of this nature with a friend and found this surprisingly helpful in further improving my research interview style. For example, I noticed that I was more present to the conversation and was better able to revisit difficult subject areas (requesting clarification). I was also mindful not to 'contaminate' the interview by closing-down avenues of exploration. However, this experience left me curious as to why I am able to stay with difficult conversations in therapy and less so in a research capacity. Upon reflection, I wondered if this was related to feeling somewhat overwhelmed with the sheer volume of information shared (during the first pilot interview) which created confusion about which areas to explore. This is a helpful learning point which I will address within the research interviews through adopting a curious and open manner while also making notes to help me to remember to return to areas of interest, using the various prompts on the schedule.

Conducting these interviews has also taught me the importance of managing my anxieties prior to carrying out the research interviews, where I have made a commitment to allow myself space to focus on my breathing prior to conducting each interview.

In conclusion, completion of the pilot and practice interviews enabled me to become more acquainted with semi-structured interviewing, where I hope that my confidence continues to grow and enables an environment where my participants feel comfortable enough to share their lived experiences.

Appendix 7. Experts by Experience Consultant Feedback (Extracts) Concerning Themes, Proposed Revisions and Study Documentation

Feedback re: Themes and Proposed Revisions (6th June 2022)

Tuesday, 31 May 2022 [Redacted]

Hi Laraine

Please find comments below. Your research looks very comprehensive. [Redacted]

[Redacted].

Best wishes

Wendy

----- Forwarded message -----

From: Laraine James [Redacted]

To: [Redacted]

Sent: Monday, 6 June 2022

Subject: Re: States of the Self Research (Qualitative themes)

Hi Wendy & Janine,

Thank you both so much.

I've responded to the comments below (in bold). Please can you share them with Janine?

Very comprehensive. Thank you both; that's really validating! I tried really hard to capture the essence of what the participants were telling me. I have had to select quotes very carefully for the write-up so that it doesn't become overwhelming for the reader.

Just a query on the phrase used "Not held in mind." Not heard this term before so unsure what it means or whether it needs clarifying for others. Really good point, it's often used by therapists when formulating difficulties; it can cover both being 'forgotten' or 'not thought about'. I have added a brief explanation in the write-up so that the term is clearer.

There is no mention of panic. Thank you. Although panic was mentioned by some participants on occasions it did not appear as frequently to warrant its own coding or assigning panic as a theme / sub-theme.

Rage is mentioned in terms of "Road Rage" but should be mentioned as a standalone too as the feeling experienced is much more than anger. Thank you so much for sharing, that's massively helpful and also backed up by several of the codes within the transcripts referring to rage (representing various participants' experience). I have since amended the theme 'Explosive Anger' to 'Explosive Anger or Rage' to encapsulate this.

[Redacted] [Redacted] Thank you for highlighting this, your experience reminds me of what one of the participants said in their interview.

[Redacted] Thank you for sharing and highlighting this too. I have since mentioned this point (not referencing you personally) in my discussion as one of the critiques of the study.

Just a few suggestions to add to the Positive Self Parenting

Pets / animals help – something to look after, care for, get out of bed for.

Doing activities such as cooking, bread making, crafting, gardening.

Daily journal helps me to look back over moods, times of year when get depressed etc.

Weekly Group Therapy helps, especially to get through a crisis.

Walking

Thank you, that's more food for thought (pardon the pun!) and these are really lovely examples.

I remember that one participant in particular, mentioned getting out and about in nature and playing sports, and others talked about using therapy skills. I would have really liked to hear more about the other activities the participants were doing, and your highlighting your 'healthy adult mode' made me wonder if they would have expanded more, had the healthy adult question taken place earlier on in the interview....It was a tricky balance as I deliberately asked about the healthy adult mode last, so that the interviews ended on a strengths-based / positive note, but the participants may have been (understandably) more tired then. I have since mentioned this in the write-up as both a criticism and a strength :)

Thank you so much Janine for your valuable points and suggestions :) And you too, Wendy (and Milly) for enabling this project to happen :)

Warmest regards,

Laraine

**Consultant feedback / comments are denoted in italics.*

Appendix 7. (Cont). Experts by Experience Consultant Feedback (Extracts) Concerning Themes, Proposed Revisions and Study Documentation

Feedback re: Participant Information Sheet and Consent Form (24th June 2019)

Participant Information Sheet

Background to study

document - add page numbers – Done

Para 3: wording - could this be clarified? [redacted] said she didn't know what a mode was, not what she experiences, can't relate to the word mode. States is a better word.

Please see page 2 (done).

Consistency on acronyms and full diagnosis names

Was wondering if a brief explanation was needed as to the different diagnosis names - EUPD and BPD as it can be confusing which one to use.

Both diagnostic terms have now been summarised.

Are there any risks in taking part? the word "upset" seems trivializing. Distressed and worried better words.

Thank you – the word worried has replaced “upset”.

Illegal activity number 2

- this might put people off or they might not be honest. They may have been involved in trivial things or a long time ago which they think might get dragged up. Would number 1 not cover everything or be reworded to cover all.

Excellent point, but a tricky one. The ethics committee wanted this to be an explicit point so that participants were fully consenting / made aware of what could come up and the possible implications (although I won't be asking about these issues directly).

If people decide not to take part, then appreciate it's their choice not to do so, but as you say we may otherwise elicit less honest responses (although this could be the case for other parts of the interview too) or there is less take-up in the study.

People might feel uncomfortable about having such things recorded.

Very true! Although I won't be able to analyse the data without the interviews being audio recorded. My memory is too unreliable(!)

Where would it take place?

Colne House or CMHTs and clinical environments might be an issue for some service users who have had a bad experience of services. Risk might be an issue, but could there be some neutral spaces for interviews?

I agree. It would be a shame if I was not able to reach those service-users. At the same time, I also wondered if it could be a positive thing as participants won't be familiar with me and meeting within the service could feel 'safe' for some people. I unfortunately don't have any additional funding for external room space.

Might also seem too connected to services rather than being an independent study.

That is a really helpful point for me to reflect on as I hadn't thought of this before. As a Trainee of UH (who has undertaken the majority of placements in HPFT) and now a permanent employee of HPFT I guess there is a connection with the two services, even if not a direct one to the study. I have now changed my contact email address from my NHS to my university one.

What info?

Might want to add something about info (other than risk etc) not being passed back to CMHT/Care Coordinator if service users don't have a good relationship with their CC or services.

Agree: I have added to the paragraph to highlight this.

I would like to take part.

Please could you include more options than contact by phone as some service users don't use the phone when unwell. [REDACTED] don't use phones - phone calls go through other family members. Could add text, email, letter, contact through nominated person.

Thank you. Other (flexible) contact options have been added.

Who will be informed?

What if the service user doesn't have a care co ordinator?

Thank you. I have included Primary Mental Health Worker as well (which could be any other MH worker).

Consent Form

Para 1. Instead of sheet, maybe document as it is longer than a sheet.

I agree! I have to keep the official title of the document but have included the page number formatting as 1/9, 2/9, etc. (so that whoever will be reading the document will be prepared!).

***As you can see, I have also added further mandatory information relating to GDPR (data protection), as requested by the ethics committee.**

Consultant feedback / comments denoted in italics.

Appendix 8. PowerPoint Presentation of Study to Site Community Mental Health Teams

UoB University of Bradford

My Major Research Project:

How Do Clients Diagnosed with Borderline Personality Disorder Experience 'Schema Modes' or other States of Self?

Laraine James
Doctorate in Clinical Psychology Researcher
Cygnet House (Trainee)

IRAS protocol number: 236003

UoB University of Bradford

Background and Study Rationale (1)

- Schema therapy (ST) (Young et. al. 2003) is a form of Cognitive Behaviour Therapy (CBT) that combines a number of therapeutic approaches.
- The therapy aims to address the links between a person's thoughts, feelings and behaviours as well as considering the impact of childhood experiences and the therapeutic relationship.
- ST was originally developed for service-users with more complex difficulties, such as 'borderline personality disorder' who were not able to benefit from standard CBT.

Background and Study Rationale (2)

L18 2022

- Prior to the existence of ST, Young and colleagues noticed that people attracting the label of BPD tended to report a range of 'symptoms' including rapidly changing states of self.
- Young later described these states of self as 'Modes' which he argued, explained many of the abrupt changes in thoughts, feelings and behaviours observed.
- Through Young's clinical observations, five mode concepts were proposed as typically experienced by people with BPD:-

Background and Study Rationale (3)

L18 2022

Young's Modes for 'BPD': -

- -Abandoned Child
- -Angry and Impulsive Child
- -Punitive Parent
- -Detached Protector
- -Healthy Adult

(Some) of what we know already / Limitations 



- Quantitative studies have provided some evidence of the 'existence' of these Modes (Young's SMI).
- Findings limited in that service-user's perspectives are absent / not tapped into.
- Quantitative studies can only examine the prevalence of the Modes included in the (very lengthy) questionnaire.
- Other Modes or 'States of Self' may be present – such modes could map onto other therapeutic constructs or otherwise not at all.

Aims of the Research 



- Specifically, this research aims to explore whether Modes or States of Self can be identified in those who attract the diagnosis of BPD / RUPD.
- If so, how these Modes are talked about by participants (patients of HPFT) or subjectively experienced?
- To what extent they map onto Young's Mode concept for the five Modes.
- (If not) What are participants experiences of alternate State constructs?

Reminder: Modes of interest 



Modes for 'BPD': -

- Abandoned Child
- Angry and Impulsive Child
- Punitive Parent
- Detached Protector
- Healthy Adult

How will this be achieved? (1) 



- Recruitment of between 8-15 Service-users within Cygnat House and Colne House CMHT's.
- Audio-taped single semi-structured interview will take place in either Colne or Cygnat House for approx. a hours (with a break in-between if needed).
- Young's SMI questionnaire will be completed too (some Q's have been amended).

Inclusion / Exclusion Criteria

- Must have a diagnosis of BPD or EUPD and have had the opportunity to explore the Dx within their system.
- No comorbid personality disorder Dx, major psychiatric or neurodevelopmental diagnoses (with the exception of anxiety and depression)

How will this be achieved? (2)





- No restriction on gender.
- Considered not to be in current distress or crisis.
- Attending appointments regularly.
- Seem interested in the study or want to find out more.
- Deemed to possess the ability to give informed consent and to withdraw consent (capacity).
- Unfortunately no budget for interpreters: Good level of English (speaking / reading), whether first or second language.
- None of my current clients!

This is where you come in!





- Doctors and Care co-ordinators can refer to the study once reasonably satisfied that their service-user is likely to meet criteria.
- Data capture / screening sheet can help you with deciding who you can approach (please return to me once completed).
- Potential participants to be given a Flyer and Participant Information Sheet to read.
- I will contact them if they wish to find out more or they can contact me at Cygnus House.
- Referrers will be required to make a brief Paris note, stating that the study was introduced to the service-user and what action will be taken (e.g. LJ to call them back).

What will happen next? 

- I will arrange for the formal consent process and interviews / questionnaire completion to take place.
- All participants will receive £10.00 towards the cost of their travel to the interview.
- No feedback will be given about individual questionnaires or audio-taped interviews.
- Remember this is research and not therapy!
- A written summary of the (combined) results will be made available if participant s so wish.
- Findings will be presented within the University, Trust and Service-user forums (to be decided).

Please consider who is on your caseload! 

- Do have a think *now* about who you might ask about participating in the study.
- I will circulate electronic and further hard-copies of the Flyer and Patient Information Sheets.
- I may also *gently* remind you to consider who you might discuss the study with / refer if I don't receive any referrals ☺
- Any questions..?

Appendix 9. Participant Information Sheet, Version 1, Pre-pandemic (Cygnet House)

University of Hertfordshire

School of Psychology

Health & Human Sciences Research Institute

Health Research Building, College Lane Campus

University of Hertfordshire

Hatfield, AL10 9AB

Participant Information Sheet about a Research Study

This information sheet is designed to help you to decide whether you would like to take part in this research study. The study forms part of my Professional Doctorate in Clinical Psychology at the University of Hertfordshire and has received a favourable opinion from an independent research ethics committee (Study ID: 236003).

Title of research study

How do Individuals diagnosed with Emotionally Unstable or Borderline Personality Disorder experience their states of self?

What is the study about?

The aim of this study is to interview people who are being seen within CYGNET HOUSE Community Mental Health Team (NHS) about their various experiences relating to emotionally unstable or borderline personality disorder diagnoses. Emotionally unstable personality disorder relates to the UK diagnostic classification system and borderline personality disorder relates to the American classification. Both terms (diagnoses) are often used interchangeably within the UK. The study also aims to understand experiences through the completion of a standardised questionnaire. Ultimately, I would like to explore whether there are particular ways that service-users experience, respond to, cope and relate to their difficulties.

It is anticipated that this study will help professionals to improve ways of working with service-users and possibly to further develop psychological therapies.

The completed study will be written in the form of an academic thesis (dissertation). I may use the research findings to write further articles that might appear in academic or practice publications, as well as presenting the findings to academic and service-user audiences.

Why have I been invited to take part?

Your Care Co-ordinator or Primary Mental Health Worker has identified you as someone who may be eligible to take part. As you are being seen within CYGNET HOUSE Community Mental Health Team and have been diagnosed with Emotionally Unstable or Borderline Personality Disorder, you might have had some experiences associated with this diagnosis. I believe that hearing directly from service-users is the best way to understand their range of experiences.

Background to Study

Schema therapy (Young et al. 2003) is a form of Cognitive Behaviour Therapy (CBT) that combines a number of therapy approaches. Schema Therapy aims to address the links between a person's thoughts, feelings and behaviours as well as considering the impact of childhood experiences and the therapeutic relationship between the client and the therapist.

Schema Therapy was originally developed for service-users with more complex difficulties, such as emotionally unstable (EUPD) or borderline personality disorder (BPD), who were not able to benefit from standard CBT. Before Schema Therapy was developed, Young and colleagues noticed that people coping with BPD tended to show inconsistent, persistent patterns in their relationships, reporting a range of 'symptoms' including rapidly changing 'states of self'. These states were later described as 'Modes' which were argued to explain many of the abrupt changes in thoughts, feelings and behaviours observed.

Although there is mixed scientific evidence for the presence of particular modes for BPD, and the clinical relevance of the mode concept, to date there has been no published qualitative research that has identified Young's modes or other 'states of self' outside of a therapy setting. Furthermore, there are no studies that explore how modes are experienced by service-users, including what they may think about them.

The proposed study aims to interview people with EUPD or BPD to understand whether modes can be identified, how they are talked about and experienced, and to what extent these relate to Young's mode concept. The study hopes to make recommendations about understanding BPD, assessment and clinical decision-making.

What's involved?

I am interested in meeting you to take part in an interview that would last for around one and a half hours (plus a short break/s in between if needed). This would involve me asking you

some questions and then making an encrypted audio recording of the interview. The types of questions asked will be exploratory and relate to feeling states. There will also be some fictitious scenarios presented that you will be asked to think about in relation to how you may feel and identify with them.

After the interview, I would then ask you to complete a questionnaire which would take between 15 and 30 minutes. The questionnaire requires you to rate the extent you believe a number of statements describe yourself. The total time commitment for participation would therefore be up to 2 hours and 15 minutes, excluding a break.

Immediately following the interview there will be an opportunity to discuss your experience of the interview and / or questionnaire should you wish.

I will then score the questionnaire, listen back to the audio recorded interview and type up into a password protected and encrypted Word document which would enable me to identify any patterns or themes that may emerge from our discussion.

What are the benefits of taking part?

By taking part in the interview and completing the questionnaire, you will have the chance to help researchers and health professionals understand more about experiences in relation to Emotionally Unstable or Borderline Personality Disorder. You may also be helping to develop therapies that could be used to help service users in similar positions to yourself in the future.

Are there any risks in taking part?

There are no risks or dangers involved in taking part, although it is possible you might feel worried during or after your interview if you were talking about difficult experiences. If you did get upset, there are some ways I could offer support to you:

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

- People who agree to participating in the interview and completion of the questionnaire are welcome to approach me about any distress they may experience. I would not be able to offer therapy, but I would be available to think about how you are feeling in relation to the recorded interview and questionnaire. We might think together about who might be able to help and who you would like to share your concerns with.
- If I notice that you appear to be worried or upset during the recorded interview or while completing the questionnaire, a break would be offered, and / or the interview ended if necessary.
- After the interview and completion of the questionnaire, I would provide a list of organisations that could provide you with further support.
- You could also contact a member of your clinical team at CYGNET HOUSE Community Mental Health Team for support if you needed to.

Please note, as a researcher I have a responsibility to consider the safety of the people who take part in this study.

If I am concerned about the safety or well-being of yourself or others, I am legally required to inform someone who may need to know or help. This is likely to be someone from your care team at CYGNET HOUSE. I will discuss this with you first where possible.

There are two main situations where this might happen:

- 1) If I am worried about your safety and well-being, or the safety and well-being of other people linked to you.

- 2) If you mention any illegal activity you have taken part in.

All data will be analysed for the purpose of the study, unless you advise otherwise.

Will I be reimbursed for participation?

Although the study does not pay for participation, you will receive a standard amount of £10.00 towards the cost of travel, which you will receive on the day of the interview.

Where would it take place?

Interviews would take place in a pre-booked clinic room at CYGNET HOUSE Community Mental Health Team.

What information will you have about me and how will you keep it safe?

Your Care Co-ordinator or Primary Mental Health Worker will check if they can pass on your name and contact details to me if you seem eligible to participate and you express an interest in being contacted about the study. Your Care Co-ordinator or Primary Mental Health Worker will also check with you if I can be informed of your: date of birth, gender, ethnic origin, mental health diagnoses (including whether you were given the opportunity to discuss your personality diagnosis), if you are attending appointments with your Community Mental Health Service and to confirm that you are currently not in crisis. Apart from any issues of significant risk, nothing you discuss in the interview will be passed on to your Care Co-ordinator or Primary Mental Health Worker.

I would record the interview using an encrypted audio voice recorder and the file immediately (on the same day) transferred onto an encrypted and password-protected computer. The recording will then be deleted from the audio device. Only I or my two research supervisors (see below) would listen to the recording and I will type them up into transcripts. Any names

or places that were mentioned and anything that would make you or anyone else identifiable would be changed in the transcript.

As this research study forms part of my University doctorate, three supervisors will be supporting me with the study, and I will be discussing information from the interviews and questionnaires with them. The typed transcript where you will be assigned a pseudonym will be read by my field research supervisor (Mr John Rhodes) at the University of Hertfordshire and might also be read by my academic research supervisors (Dr Helen Ellis-Caird and Dr Nicholas Hawkes) at the University of Hertfordshire who are all psychologists. The examiners who test me when the thesis is assessed might also read it. No one else will have access to your transcript.

The final thesis will include a small number of quotes from the interviews. I will make sure that these quotes will not identify who you are. All data that you provide will be pseudonymised which means that although you will not be identifiable from the transcripts, thesis or publication material (e.g. academic journals), it would be possible for my research supervisors and I to identify you from the pseudonym that you will be assigned. You would not be identifiable to any other person from your transcript.

If there were concerns about your welfare or that of another person, then I would need to break confidentiality by informing your Care Co-ordinator or Primary Mental Health Worker about my concerns, although I would not share your transcript or completed questionnaire with them.

The encrypted audio file, typed transcript and other research data will be saved on an encrypted NHS computer that is password protected. All research data will be backed-up on a secure personal drive within Hertfordshire Partnership NHS Foundation Trust.

The University of Hertfordshire is the sponsor for this study based in the United Kingdom. We will be using information from you and your Care Co-ordinator or Primary Mental Health Worker in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The

University of Hertfordshire will keep identifiable information about you for five years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained, except your audio recording and questionnaire data (which will be deleted) up to two weeks from the date of the interview. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting research-sponsorship@herts.ac.uk.

CYGNET HOUSE will keep your name, date of birth, gender, ethnic origin, mental health diagnoses and participation status confidential and will not pass this information to The University of Hertfordshire. CYGNET HOUSE will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from The University of Hertfordshire and regulatory organisations may look at your research records to check the accuracy of the research study. The University of Hertfordshire will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

CYGNET HOUSE will keep identifiable information about you from this study on your clinical record indefinitely (i.e. a record that you have agreed to take part, withdraw from the study or declined participation) after the study has ended.

As a university we use personally-identifiable information to conduct research to improve health, care and services. As a publicly-funded organisation, we have to ensure that it is in the public interest when we use personally-identifiable information from people who have agreed to take part in research. This means that when you agree to take part in a research study, we

will use your data in the ways needed to conduct and analyse the research study. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained, as mentioned previously (on page 5).

Health and care research should serve the public interest, which means that we have to demonstrate that our research serves the interests of society as a whole. We do this by following the UK Policy Framework for Health and Social Care Research.

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO).

Our Data Protection Officer is Ian Hanahoe and you can contact them at [REDACTED].

How long would you keep my information for?

- When we meet for the interview I will record our conversation onto an encrypted password-protected device (audio recorder). On the same day of the interview your data (audio file) will be transferred from the audio recorder onto an encrypted password-protected laptop and backed-up on my personal secure NHS drive. When no longer needed for university examination, the audio file will be deleted from the laptop and secure drive.
- The written, encrypted transcript and other research data related to you will be kept as a password-protected and encrypted computer file, backed up on my secure personal

NHS drive for five years from the date of study completion, and might be used to help me to write articles or publications based upon the findings of this research.

What if I decide to take part, but then change my mind?

You can change your mind at any time; however, I cannot delete your audio file and questionnaire data after two weeks from the date of interview. You do not have to give a reason why and your treatment or support at the Community Mental Health Service will not be affected in any way. During the interview, if you do not feel comfortable answering a question, you do not have to answer it and we can move on. If you would like me to stop or pause recording, then I can do this at any point.

Future care

As a service-user within CYGNET HOUSE it is possible you may have psychological therapy in the future with the researcher who is an employee of HPFT. Should this happen you are under no obligation to discuss your participation or non-participation in the study and are free to request another clinician should you wish to.

I have some questions about the study - can I contact you?

Yes, I am happy to answer any questions. You can contact me by email or phone to leave a message where I can arrange to phone you back at a convenient time; my details are at the bottom of this information sheet.

I would like to take part. What should I do now?

If you would like to take part, please contact me by phone: [REDACTED] or email: [REDACTED]. Or you can ask a nominated person to contact me or speak to your Care Co-ordinator or Primary Mental Health Worker on [REDACTED] at CYGNET HOUSE Community Mental Health Team. You will be asked for contact details so that I can reach you to discuss further. After you have had adequate opportunity to consider whether you would want to take part, I will then arrange a date and time to meet you for the interview.

When you meet me for the interview, I will give you a consent form to read and sign before we start. You will have the opportunity to ask more questions if you need to before you decide whether to sign the form.

Who will be informed about my participation in the study?

Your Care Co-ordinator or Primary Mental Health Worker and possibly the other people involved in your care at CYGNET HOUSE will be informed that the study has been discussed with you and whether you will take part. A short note will then be entered onto your electronic patient record by your Care Co-ordinator / Primary Mental Health Worker to state that a discussion has taken place and a further note will state if you have taken part or not. I (the Researcher) will not be accessing your patient record.

What if I'm not happy with how the study has been conducted?

If you have any questions or concerns about how the study has been conducted, please contact the study's Chief Investigator, Dr Helen Ellis Caird at the University of Hertfordshire: [REDACTED] or Tel: [REDACTED].

There is insurance cover in place that has been arranged by the University of Hertfordshire. Should you believe that you have been harmed as a consequence of participating in this research, please contact Dr Helen Ellis-Caird for details about how to lodge a claim.

Alternatively, you may wish to contact the Patient Advice and Liaison Service (PALS) for advice and support. Their details are also at the bottom of this information sheet.

How can I find out the results of the study?

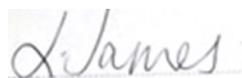
Once the thesis has been examined you are welcome to receive a written summary of the results. If you would like to receive a summary, please inform the Researcher (Ms Laraine James) to request this via my email address below.

Ethical approval

This study has been approved by the Cambridge South Research Ethics Committee, study ID: 236003.

Thank you so much for taking an interest in this research study.

Yours sincerely,



Laraine James

Doctoral Researcher and Trainee Clinical Psychologist

Researcher's Contact details:

Ms Laraine James

[REDACTED]

[REDACTED]

Research Supervisors' Contact Details:

Chief Investigator

Dr Helen Ellis-Caird: [REDACTED]

[REDACTED]

Academic / Field Supervisor

Mr John Rhodes: [REDACTED]

Tel: [REDACTED]

Academic Supervisor (2)

Dr Nicholas Hawkes

[REDACTED]

[REDACTED]

Patient Advice and Liaison Service (PALS):

HPFT Head Office

The Colonnades

Beaconsfield Road

Hatfield

AL10 8YE

Tel: 01707 253916

Email: hpft.pals.herts@nhs.net

Appendix 10. Study Flyers, Both Sites: Pre-pandemic (Version 1) and Post-pandemic, (Version 2)

RESEARCH STUDY:
'STATES OF THE SELF' IN EMOTIONALLY UNSTABLE & BORDERLINE PERSONALITY DISORDER

DO YOU HAVE A DIAGNOSIS OF EMOTIONALLY UNSTABLE PERSONALITY DISORDER (EUPD) OR BORDERLINE PERSONALITY DISORDER (BPD)?

WOULD YOU BE WILLING TO DISCUSS SOME OF YOUR EXPERIENCES TO ENABLE RESEARCHERS TO UNDERSTAND MORE ABOUT DIFFERENT 'STATES' IN PERSONALITY DISORDER?

IF YOU DECIDE TO TAKE PART IN A SINGLE INTERVIEW AND COMPLETE A QUESTIONNAIRE, YOU WILL RECEIVE A STANDARD £10.00 CONTRIBUTION TOWARDS TRAVEL COSTS.

TO FIND OUT MORE: -

**PLEASE CONTACT MS LARAIN JAMES,
DOCTORAL RESEARCHER / TRAINEE CLINICAL PSYCHOLOGIST**

THIS RESEARCH STUDY: NO. 236003 HAS RECEIVED A FAVOURABLE OPINION FROM AN INDEPENDENT RESEARCH ETHICS COMMITTEE.

Flyer: 15th October 2018. Vers 1

(Appendix 10., cont.) Post-pandemic, (Version 2), Both Sites

RESEARCH STUDY:
'STATES OF THE SELF' IN EMOTIONALLY UNSTABLE & BORDERLINE PERSONALITY DISORDER

DO YOU HAVE A DIAGNOSIS OF EMOTIONALLY UNSTABLE PERSONALITY DISORDER (EUPD) OR BORDERLINE PERSONALITY DISORDER (BPD)?

WOULD YOU BE WILLING TO DISCUSS SOME OF YOUR EXPERIENCES TO ENABLE RESEARCHERS TO UNDERSTAND MORE ABOUT DIFFERENT 'STATES' IN PERSONALITY DISORDER?

IF YOU DECIDE TO TAKE PART IN A SINGLE TELEPHONE INTERVIEW AND COMPLETE A QUESTIONNAIRE, YOU WILL RECEIVE A STANDARD £10.00 CONTRIBUTION TOWARDS THE USE OF YOUR HOME FACILITIES.

TO FIND OUT MORE: -

**PLEASE CONTACT MS LARAIN JAMES,
DOCTORAL RESEARCHER / TRAINEE CLINICAL PSYCHOLOGIST**

[REDACTED CONTACT INFORMATION]

THIS RESEARCH STUDY: NO. 236003 HAS RECEIVED A FAVOURABLE OPINION FROM AN INDEPENDENT RESEARCH ETHICS COMMITTEE.

Flyer: 5th June 2020. Vers 2

Appendix 11. Data Capture Form for Referrers to the Study (Both Sites)**Data Capture / Screening Form: Info to be obtained via Care Co-ordinators:**

Participant Name				
D.O.B				
Gender & ethnic origin				
EUPD / BPD diagnosis?	Yes	No		
Other Mental Health diagnoses?				
Current or recent substance misuse?	Yes	No		
Aware of EUPD / BPD diagnosis?	Yes	No		
Explore EUPD / BPD diagnosis?	Yes	No		
Significant risks towards self (service-user) or researcher that would preclude taking part?	Yes	No		
Read and Speak English well?	Yes	No		
Regular engagement with service?	Yes	No		
Currently in crisis (e.g. referred to CAT Team)?	Yes	No		
Px interested in taking part / finding out more?	Yes	No		
Participant Contact Details		N/A		

Appendix 12. Semi-Structured Interview Schedule and Mode Cards (Version 1)

Interview Schedule

Part 1: Open, explorative questions and follow-up examples (approximately 30 minutes)

1. What emotions do you tend to feel day to day?

- i.* Does this [emotion] stay the same or change? What about this [emotion/s]?
- ii.* What typically causes this [emotion] to change?
- iii.* How bad / intense / pleasurable does this [emotion] get?
- iv.* How long does it last?
- v.* Is there a recent example that springs to mind that you could tell me about?
- vi.* How does [the emotion] stop?
- vii.* Do you ever feel nothing at all? What is that like?

2. What do you feel like when you're with important people in your life?

- i.* Can you tell me about when you feel your best [with this person]?
- ii.* And when you feel your worst?
- iii.* Had anything happened at that time to trigger that reaction(s)?
- iv.* Does this also happen in reaction to other people in your life?
- v.* [If not] what do you feel like then?

Part 2: Questions specific to Young's modes (approximately 10 minutes per mode)

Descriptions of each primary mode will be placed onto separate laminated cards as below. Participants will be handed one card at a time and given a few minutes to read it. The researcher will also read each card aloud, then ask the following questions.

Researcher: *"Let me tell you a bit about the way that many people's difficulties are viewed in accordance with a psychological therapy called Schema Therapy, and tell me if you think it fits for you. In Schema Therapy it is assumed that everyone has what they (Jeffrey Young and colleagues) call 'modes'. They describe modes as emotional states that we all inhabit or express from time to time. They can sometimes lie dormant or hidden for a long time, but are sometimes activated by certain triggers. We can be in one mode for a while, but can then flip over into other modes, depending on the situation. For example, someone might feel happy and relaxed one moment, but sad and vulnerable in another moment. In other situations, that person might not feel anything at all.*

I have some modes written down on five laminated cards. I am going to give you a card to read, one at a time and I will read it out to you as well. Then I will ask you some questions about it. I will then give you the next card and so on. Do you have any questions about what will happen next?"

Mode cards (adapted from www.schematherapysouthafrica.co.za and <http://www.schematherapy.com>):

Angry and Impulsive Child Mode

Feels intensely angry, enraged, infuriated, frustrated, impatient whenever his / her needs are not met. Suppressed anger is expressed in inappropriate ways. May make demands that seem entitled or spoiled and that alienate others.

e.g. Rachel texted her husband to ask him if he fancied eating out after work and because he did not reply straight away she became enraged and threw her mobile phone across the room, smashing it to pieces.

Whenever Kerry finds herself waiting in a supermarket queue for more than a few minutes she either becomes frustrated and snappy with the cashier, or storms out of the shop abandoning her unpaid purchases at the till point.

Questions:

- i. What comes to mind when you read / hear about that mode (e.g. does it fit)?
- ii. Can you tell me about a recent time when you have felt like this?
- iii. How often do you feel like this?
- iv. How big / intense does this feeling get?
- v. How long (or how brief) does this feeling last?
- vi. How does this feeling usually stop? OR
- vii. What do you usually do when you feel that mode, the [e.g. Angry Child] mode (e.g. distract)?

Abandoned Child Mode

Feels the emotional pain and fear of abandonment. Has the emotions of a lost child: sad, frightened, vulnerable, defenceless, hopeless, needy, victimised, worthless, alone and lost. Appears fragile and childlike. Are obsessed with finding a parent figure who will take care of them.

e.g. Whenever Clare senses that a romantic relationship is due to end she becomes clingy and frantic; pleading with her partner not to leave. Shortly after a relationship has ended, Clare manages her intense sadness by jumping into a new relationship – someone whom she hopes will pick up the pieces and make her feel whole again.

Sylvia dismisses the fact that her oldest friend, Sam, can be spiteful and often takes advantage of her. Rather than discuss what is going on, or even end the relationship - Sylvia desperately clings on to the memories of when her friend was “kind”; fearing that she will be left abandoned and alone.

Questions:

- i. What comes to mind when you read / hear about that mode (e.g. does it fit)?
- ii. Can you tell me about a recent time when you have felt like this?
- iii. How often do you feel like this?
- iv. How big / intense does this feeling get?
- v. How long (or how brief) does this feeling last?
- vi. How does this feeling usually stop? OR
- vii. What do you usually do when you feel that mode, the [e.g. Abandoned Child] mode (e.g. withdraw)?

Punitive Parent Mode

Feels that oneself or others deserves punishment or blame and often acts on these feelings by being blaming, punishing, or abusive towards the self (e.g. self-harm) or others.

e.g. Marc applied for a job he really wanted, and the application process required him to take some on-line tests. Shortly after completing them, Marc received feedback that he performed brilliantly on eight of the assessments, however he did not do as well on the final two. In spite of being shortlisted for interview, Marc swiftly became enraged that he hadn't performed better; his self-criticism increased, and he proceeded to punch his laptop. This caused Marc's knuckles to become painful and bruised as well as damaging his machine in the process.

Sarah was driving to her parents' house and while on the motorway a commercial van driver undertook her and cut Sarah up - causing her to swerve and brake hard. Sarah was furious - she sounded her horn loudly, but the driver did not acknowledge his mistake and instead sped off. Sarah managed to catch up with the van driver and scribbled down his registration number and company details. Sarah gleefully called the driver's employer later that day to report his "dangerous driving".

Questions:

- i. What comes to mind when you read / hear about that mode (e.g. does it fit)?
- ii. Can you tell me about a recent time when you have felt like this?
- iii. How often do you feel like this?
- iv. How big / intense does this feeling get?
- v. How long (or how brief) does this feeling last?
- vi. How does this feeling usually stop? OR
- vii. What do you usually do when you feel that mode, the [e.g. Punitive Parent] mode (e.g. punishing)?

Detached Protector Mode

Feels distracted, disconnected, depersonalised, empty or bored; cuts off needs and feelings. Detaches emotionally from people and rejects help. Pursues distracting, self-soothing or self-stimulating activities in a compulsive way or to excess. May adopt a pessimistic stance to avoid investing in people or activities.

e.g. Louise finds it a challenge balancing the demands of looking after her home and working part-time while caring for her young son. As soon as her partner returns home from work, Louise shuts herself away in the bedroom where she spends a lot of time on social media, sleeping irregularly or playing Angry Birds on her phone.

Graham's relationship with his girlfriend is often fraught with disagreements. Following another blazing row, Graham finds himself in the pub, alone, drinking more than he'd like to on a week-day. The drink helps to numb his feelings. Graham ignores the offer of a supportive conversation with his brother and instead turns off his mobile phone, preferring to manage the situation by himself.

Questions:

- i. What comes to mind when you read / hear about that mode (e.g. does it fit)?
- ii. Can you tell me about a recent time when you have felt like this?
- iii. How often do you feel like this?
- iv. How big / intense does this feeling get?
- v. How long (or how brief) does this feeling last?
- vi. How does this feeling usually stop? OR
- vii. What do you usually do when you feel that mode, the [e.g. Detached Protector] mode (e.g. withdraw)?

NB: This part of the interview will deliberately end with questions relating to the 'Healthy Adult' mode.

Healthy Adult Mode

This mode performs appropriate adult functions such as obtaining information, evaluating, problem-solving, working, parenting. Takes responsibility for choices and actions, and makes and keeps to commitments. In a balanced way, pursues activities that are likely to be fulfilling in work, intimate and social relationships, sporting, cultural, and pleasurable adult activities.

e.g. Although Sonia felt tired and bogged-down with everything, she kept to her promise of visiting her best friend Rita who lived over two-hundred miles away – even purchasing her train tickets in advance in case she felt tempted to cancel.

Alison was anxious and worried about delivering a presentation at college - believing that she would come across as nervous, boring and weak. As she awaited her turn, Alison took a deep breath and told herself that it was normal to feel nervous and that her classmates were probably feeling the same. Alison also reminded herself that she had done the very best she could and tried to imagine how she would feel if her presentation went well.

Questions:

- i. What comes to mind when you read / hear about that mode (e.g. does it fit)?
- ii. Can you tell me about a recent time when you have felt like this?
- iii. How often do you feel like this?
- iv. How big / intense does this feeling get?
- v. How long (or how brief) does this feeling last?
- vi. How does this feeling usually stop? OR
- vii. What do you usually do when you feel that mode, the [e.g. Healthy Adult] mode (e.g. respond in a particular way/s)?

Part 3: Reflective Section (approximately 15-20 minutes)

The final section of the interview will ask participants to reflect back upon what they discussed earlier in relation to the five modes or otherwise states of self.

Questions:

Researcher: *“You have described a range of modes or states that you experience in different situations. Finally, I would like to ask you a bit about your view of these modes or states”.*

- i. What is it like for you to feel [mode / state] and then [mode / state]?
- ii. How does it impact upon you that you have these intense feelings of [mode / state]?
- iii. Do you feel most or least like yourself when you experience these [modes / states]?
- iv. What is it like to feel like yourself?
- v. Do these [modes / states] ever cause you to feel anything else [e.g. worried / confused / alert / spiralling out of control / losing your mind / ashamed / content]?
- vi. Can you imagine how would life be if you *never* experienced these [modes / states]?
- vii. Do you think that these [modes / states] accurately represent your own moment-by-moment experiences in certain situations? If not, why not?

Young Schema Mode Inventory (SMI)

Following each interview, participants will be asked to complete the SMI questionnaire (this will take approximately 15-30 minutes). See separate attachment for the amended measure.

Appendix 13. Table of Norms / Scoring Key for Young's Schema Mode Inventory

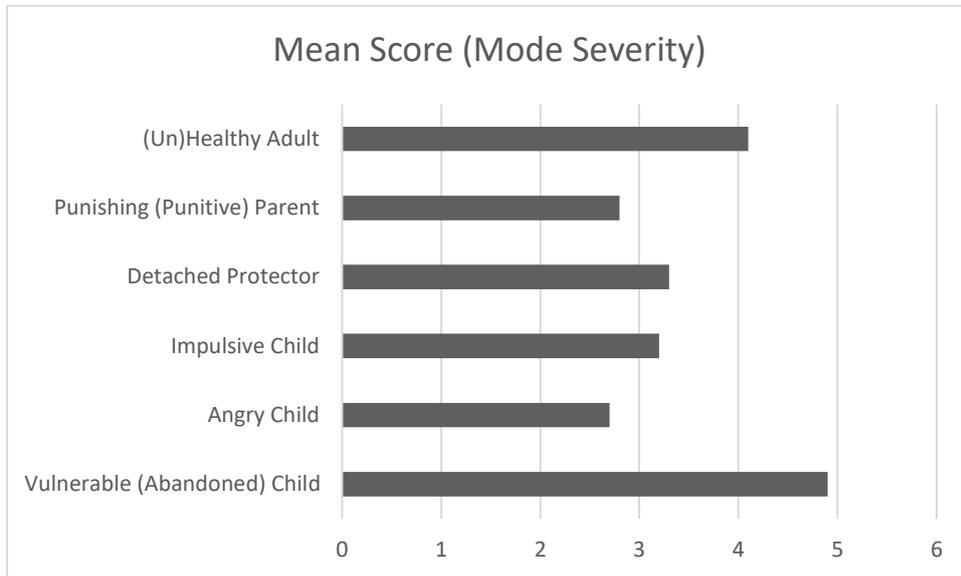
Mode	Score	Very Low	Average	Moderate	High	Very High	Severe
Child Modes							
Vulnerable Child (VC)		1	1.47	1.98	3.36	4.47	6
Angry Child (AC)		1	1.81	2.29	3.09	4.03	6
Enraged Child (EC)		1	1.20	1.49	2.05	2.97	6
Impulsive Child (IC)		1	2.15	2.68	3.05	4.12	6
Undisciplined Child (UC)		1	2.27	2.87	3.47	3.89	6
Contented Child (CC) (Reversed)		6	5.06	4.52	2.88	2.11	1
Avoidant Modes							
Compliant Surrenderer (CS)		1	2.51	3.07	3.63	4.27	6
Detached Protector (DP)		1	1.59	2.11	2.95	3.89	6
Detached Self-Soother (DSS)		1	1.93	2.58	3.32	4.30	6
Overcompensating Modes							
Self Aggrandizer (SA)		1	2.31	2.90	3.49	4.08	6
Bully & Attack (BA)		1	1.72	2.23	2.74	3.25	6
Parent Modes							
Punitive Parent (PP)		1	1.47	1.86	2.75	3.72	6
Demanding Parent (Dpa)		1	3.06	3.66	4.26	4.86	6
Healthy Adult Modes							
Healthy Adult (HA) (Reversed)		6	5.16	4.60	3.60	2.77	1

Adapted from the Schema Mode Inventory Interpretation Grid

Appendix 14. Illustrative Example of a Scored (Amended) Schema Mode Inventory for Participant 1

Mode (Question numbers)	Participant 1 Item Score										Mean Score
1. Vulnerable (Abandoned) Child (n=10) (4, 6, 36, 50, 67, 71, 105, 106, 111, 119)											4.9 Very high
2. Angry Child** (n=10) (22, 42, 47, 49, 56, 63, 76, 79, 103, 109)											2.7 Moderate
3. Enraged Child (n=10) (14, 25, 26, 46, 54, 60, 92, 98, 101, 123)											1.6 Moderate
4. Impulsive Child** (n=9) (12, 15, 35, 40, 66, 69, 78, 97, 110)											3.2 High
5. Undisciplined Child (n=6) (13, 21, 30, 65, 70, 107)											2 Very low
6. Happy Child (n=10) R (2, 17, 19, 48, 61, 68, 95, 96, 113, 122)											2.6 Very high
7. Compliant Surrender (n=7) (8, 18, 37, 38, 55, 100, 108)											5.6 Very high
8. Detached Protector (n=9) (28, 33, 34, 39, 43, 59, 64, 75, 88)											3.3 High
9. Detached Self-Soother (n=4) (41, 52, 57, 86)											5.3 Very high
10. Self-Aggrandizer (n=10) (10, 11, 27, 31, 44, 74, 81, 89, 91, 114)											2.9 Moderate
11. Bully and Attack (n=9) (1, 24, 32, 53, 77, 93, 99, 102, 112)											1.8 Average

Appendix 15. Mean Schema Mode Inventory Scores (Graph) for the Subscales (Modes) of Interest for Participant 1



**Clinically significant (see below):*

Mode Severity level:

**(Un)Healthy Adult=High*

**Punishing (Punitive) Parent=High*

**Detached Protector=High*

**Impulsive Child=High*

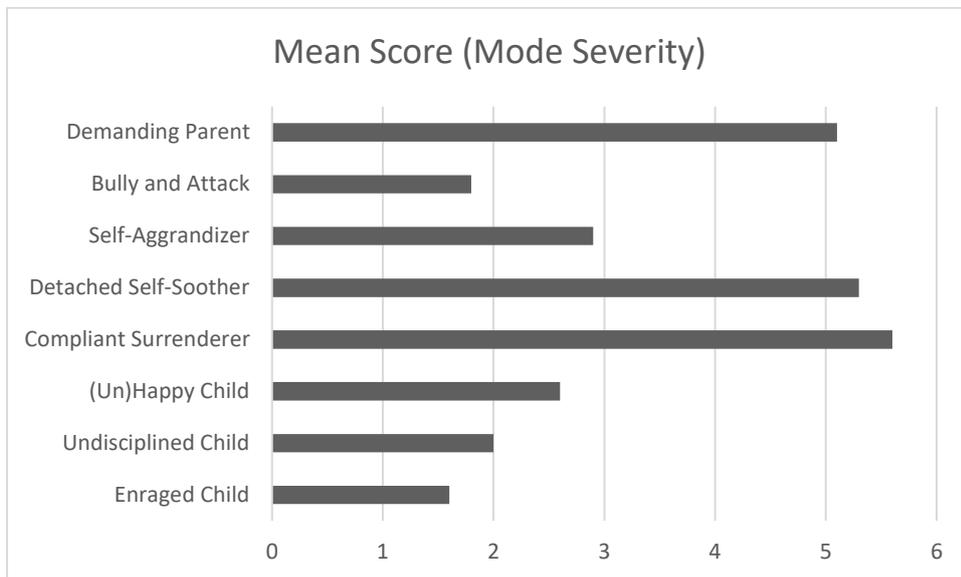
Angry Child=Moderate

**Vulnerable (Abandoned) Child=Very high*

SMI Mode Severity Range: Very Low – Severe

N.B. please refer to the Table of Norms in Appendix 13 for intensity thresholds.

Appendix 16. Mean Schema Mode Inventory Scores (Graph) for the Remaining Sub-scales (Modes) for Participant 1



**Clinically significant (see below):*

Mode Severity level:

**Demanding Parent=Very high*

Bully and Attack=Average

Self-Aggrandizer=Moderate

Bully and Attack=Average

**Detached Self-Soother=Very high*

**Compliant Surrender=Very high*

**(Un)Happy Child=Very high*

Undisciplined Child=Very low

Enraged Child=Moderate

N.B. please refer to the Table of Norms in Appendix 13 for intensity thresholds.

Appendix 17. Participant Consent Form, Both Sites: Pre-pandemic (Version 5)

Study ID No. **236003**

University of Hertfordshire

School of Psychology
Health & Human Sciences Research Institute
Health Research Building, College Lane Campus
University of Hertfordshire
Hatfield, AL10 9AB

Consent to Participate in a Research Study

IRAS ID: 236003

Ethics Committee: Cambridge South Research Ethics Committee.

Research Site: CYGNET HOUSE / COLNE HOUSE [please delete]

Participant Identification Number for this study:

Title of Project: How do individuals diagnosed with Emotionally Unstable or Borderline Personality Disorder experience their states of self?

Name of Researcher: Ms Laraine James

Please
initial box

1. I confirm that I have read the information sheet dated 23rd August 2019 (version 5) for the above study and have been given a copy to keep. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is entirely voluntary, and I am free to withdraw at any time during participation without my mental health care or legal rights being affected.
3. I understand that my audio and questionnaire data can be withdrawn up two weeks after my interview date and that after this point it will not be possible. All of my data will be held securely by the Researcher and Sponsor.

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

4. I understand that my involvement in this study and information I give, will remain confidential. Only the researcher and research supervisors involved in the study will have access to information that identifies me.

5. I understand that information I provide will be kept confidential unless I disclose information regarding risk of harm to myself or others, in which case I will be informed of the action that would be necessary in order to ensure my safety and that of others. This may involve the researcher contacting my Care Co-ordinator or Primary Mental Health Worker who may then decide to involve outside agencies.

6. I agree to my interview being audio recorded on the basis that my data will be held securely.

7. I understand that anything I say will be pseudonymised during transcription, analysis and the write-up of the research.

8. I understand that anonymised quotes relating to me may be used in publications arising from this research.

9. I agree to my Care Co-ordinator or Primary Mental Health Worker being informed of my participation in the study and any necessary exchange of information about me (as outlined in the aforementioned Information Sheet) between my Care Co-ordinator / Primary Mental Health Worker and the researcher.

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

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Participant Consent Form: 23rd August 2019, Vers. 5. Original Consent Form to be retained by the Participant and a copy retained by the Researcher.

Appendix 18. Debriefing Summary and Participant Additional Support Contact Information Sheet (Cygnet House)

Debriefing

At the end of the interview participants were asked how they were feeling about the conversation, informed about the purpose of the study, and asked if they had any questions at this stage. Following completion of the questionnaire, contact details for further support were shared (below) in case this was required. No participant required immediate support from a Duty Worker.

Support Services Contact Details Sheet

Thank you so much for taking part in this study, exploring states of the self in Emotionally Unstable and Borderline personality disorder.

Should anything discussed in the interview bring up any upset or distress, you may wish to consider accessing the following sources of support listed below: -

- Care Co-ordinator / Named staff member [NAME, DESIGNATION, TELEPHONE NUMBER]
- Duty telephone number for Cygnet House: [REDACTED]
- Mental Health Helpline: [REDACTED]
- Samaritans 24 hour telephone support: 116 123

Appendix 19. Favourable Opinion Letter (1)



Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

05 April 2019

Dr Helen Ellis-Caird
Research Tutor
University of Hertfordshire
Doctorate in Clinical Psychology,
Dept of Psychology and Sports Science
University Of Hertfordshire, College Lane, Hatfield
AL10 9AB

Dear Dr Ellis-Caird

Study title:	How do Individuals Diagnosed with Emotionally Unstable Personality Disorder Experience 'Schema Modes' or other States of Self?
REC reference:	18/EE/0374
Protocol number:	02919
IRAS project ID:	236003

Thank you for your letter responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at <http://www.rctforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Copies of advertisement materials for research participants [Flyer]	V1	15 October 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsors Insurance]		31 July 2018
Interview schedules or topic guides for participants [Interview Schedule]	V2	09 March 2019
IRAS Application Form [IRAS_Form_18032019]		18 March 2019
Letter from sponsor [In Principle Letter from Sponsor]		25 September 2018
Other [Contact details post-interview for Participants: Colne House]	V1	15 October 2018
Other [Contact details post-interview for Participants: Cygnet House]	V1	15 October 2018
Other [Sponsors Public Liability Certificate]	V1	19 July 2018
Other [Participant Information Sheet: Colne House]	V2	09 March 2019
Other [Amended SMI items]	V2	09 March 2019
Other [Data capture / Screening Form]	V1	09 March 2019
Other [List of Contact Details / Support]	V2	09 March 2019
Other [List of contact details / support Colne House]	V2	09 March 2019
Other [Responses to Ethics Committee]	V1	09 March 2019
Participant consent form [Consent form (both services)]	V2	09 March 2019
Participant information sheet (PIS) [Participant Information Sheet: Cygnet House]	V2	09 March 2019
Referee's report or other scientific critique report [UH Peer Review report and amendments made]		03 August 2018
Research protocol or project proposal [States of the Self Research Protocol]	V1	07 July 2017
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		01 May 2017
Summary CV for student [Student CV]		15 October 2018

Summary CV for supervisor (student research) [John Rhodes CV and Publications]		27 September 2018
Validated questionnaire [Schema Mode Inventory 2007]		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at:

<https://www.hra.nhs.uk/planning-and-improving-research/learning/>

18/EE/0374	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project.

Yours sincerely

Dr Ian Dumbelton
Chair

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

Email: nrescommittee.eastofengland-cambridgesouth@nhs.net

Enclosures: "After ethical review – guidance for researchers" [SL-AR2]

Copy to: Ms Ellie Hubbard

Appendix 20. Health Research Authority Study Approval Letter



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales



Dr Helen Ellis-Caird
Research Tutor
University of Hertfordshire
Doctorate in Clinical Psychology,
Dept of Psychology and Sports Science
University Of Hertfordshire, College Lane, Hatfield
AL10 9AB

Email: hra_approval@nhs.net
HCRW_approvals@wales.nhs.uk

06 September 2019

Dear Dr Ellis-Caird

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title: How do Individuals Diagnosed with Emotionally Unstable Personality Disorder Experience 'Schema Modes' or other States of Self?
IRAS project ID: 236003
Protocol number: 02919
REC reference: 18/EE/0374
Sponsor University of Hertfordshire

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

STATES OF THE SELF IN BORDERLINE PERSONALITY DISORDER

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The document "After Ethical Review – guidance for sponsors and investigators", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 236003. Please quote this on all correspondence.

Yours sincerely,
Helen Penistone
Approvals Specialist

Email: hra.approval@nhs.net

Telephone: 0207 104 8010

Copy to: *Ms Ellie Hubbard*

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List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Copies of advertisement materials for research participants [Flyer]	V1	15 October 2018
HRA Schedule of Events	1	14 May 2019
HRA Statement of Activities	1	14 May 2019
Interview schedules or topic guides for participants [Interview Schedule]	V2	09 March 2019
IRAS Application Form [IRAS_Form_18032019]		18 March 2019
Letter from sponsor [In Principle Letter from Sponsor]		25 September 2018
Other [Contact details post-interview for Participants: Colne House]	V1	15 October 2018
Other [Contact details post-interview for Participants: Cygnet House]	V1	15 October 2018
Other [Sponsors Public Liability Certificate]	V1	19 July 2018
Other [Amended SMI items]	V2	09 March 2019
Other [Data capture / Screening Form]	V1	09 March 2019
Other [List of Contact Details / Support]	V2	09 March 2019
Other [List of contact details / support Colne House]	V2	09 March 2019
Other [Responses to Ethics Committee]	V1	09 March 2019
Participant consent form	5	23 August 2019
Participant information sheet (PIS) [Cygnet House]	5	23 August 2019
Participant information sheet (PIS) [Colne House]	5	23 August 2019
Referee's report or other scientific critique report [UH Peer Review report and amendments made]		03 August 2018
Research protocol or project proposal [States of the Self Research Protocol]	V1	07 July 2017
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		01 May 2017
Summary CV for student [Student CV]		15 October 2018
Summary CV for supervisor (student research) [John Rhodes CV and Publications]		27 September 2018
Validated questionnaire [Schema Mode Inventory 2007]		

IRAS project ID	226003
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Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Type of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Overlight expectations	HR Good Practice Resource Pack expectations
There will be one study site type where all site activities will take place as per the protocol.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	A Statement of Activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used. HRA Approval is conditional upon this information being transferred to the Organisation Information Document, which should be provided to sites in the Local Information Pack.	No external funding has been sought.	A local Principal Investigator is expected at site.	It is not anticipated that any additional HR arrangements will be necessary as all activities will be undertaken by the student researcher who is employed at the single site.

Appendix 21. Sponsorship in Full Letter of Approval (Version 1)



Dr H Ellis-Caird & Ms L James
Department of Psychology and Sport Sciences
School of Life and Medical Sciences

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone: +44 (0) 1707 284000
Fax: +44 (0) 1707 284115
Website: www.herts.ac.uk

11 October 2019

Dear Dr Ellis-Caird and Ms James

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:
RESEARCH STUDY TITLE: How do Individuals Diagnosed with Borderline Personality Disorder Experience 'Schema Modes' or other States of Self
NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Helen Ellis-Caird
NAME OF INVESTIGATOR (Student): Ms Laraine James
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER:
LMS/PGR/NHS/02919

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements.

Permission to seek changes as outlined above should be requested from myself before submission to the Health Research Authority (HRA) NHS Research Ethics Committee (REC) and I must also be notified of the outcome. It is also essential that evidence of any further NHS Trust Management Permissions (formerly known as R&D Approval) is sent as soon as they are received. Copies of annual reports and the end of study report as submitted to the HRA also need to be provided. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely

Professor J M Senior
Pro Vice-Chancellor (Research and Enterprise)



University of Hertfordshire Higher Education Corporation is an exempt charity

Appendix 22. Major Amendment 1 (SA1) Application and Approval Notification

UNIVERSITY OF HERTFORDSHIRE

FORM SP2: APPLICATION FOR APPROVAL TO SUBMIT AN AMENDMENT TO PROJECT WHERE THERE IS UNIVERSITY SPONSORSHIP*

* That is, when applying for an amendment to a study with Health Research Authority (HRA) approval, including NHS Research Ethics Committee (REC), Social Care REC (SREC) or other relevant regulatory body such as the Medicines and Healthcare Products Regulatory Agency (MHRA).

As a condition of receiving University of Hertfordshire sponsorship, it the responsibility of the Chief Investigator to inform the Sponsor of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations, from the protocol, which may require re-evaluation of the sponsorship arrangements before submission of the amendment to the REC and/or HRA.

(Note on student projects: Students must consult with their supervisor. Applications for sponsorship of student research projects, including doctoral level students, must be made in the name of the student's University-employed academic supervisor, as must any application to the HRA or REC.)

1. Health Research Authority NHS or Social Care Research Ethics Committee (REC) reference: **236003**

2. UH Protocol number: **LMS/PGR/NHS/02919**

3. Research study title: **How do individuals diagnosed with Emotionally Unstable or Borderline Personality Disorder experience their states of self?**

4. Contact details:

i. Chief (Principal) Investigator name (for student research projects this must be the University-employed academic supervisor): **Dr Keith Sullivan (see below)**

ii. Student name (if applicable): **Ms Laraine James**

5. State to which regulatory body/bodies the amendment request is being made (eg NHS REC, MHRA): **NHS Rec**

6. Specify if you consider this is a substantial or non-substantial amendment (see HRA website for [guidance](#)):

Substantial Non-substantial

7. Amendment number: **SA1**

8. Specify the nature of the amendment being requested (that is, what is the amendment and what is the reason for it?):

Major amendment: -

The PI of the study has changed to Dr Keith Sullivan from Dr Helen Ellis Caird, and as such, will need to be reflected on the IRAS form; generating a substantial amendment.

9. Detail any changes to the risk assessment (if applicable) due to the amendment:

No changes to risk assessment.

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Keith Sullivan

Signature of Chief (Principal) Investigator:

Date: 27/04/2020

A handwritten signature in cursive script, appearing to read "A. James".

Signature of Student (if relevant):

Date: 27/04/2020

Once you have signed this form using an electronic signature(s), please email to research-sponsorship@herts.ac.uk with any revised documentation (ensure the changes from the original approved version are indicated clearly) and await email confirmation of approval to proceed.

From: Research Sponsorship <[REDACTED]>
Sent: 04 May 2020 17:33
To: Laraine James <[REDACTED]>
Cc: Helen Ellis-Caird <[REDACTED]>; Keith Sullivan <[REDACTED]>; Research Sponsorship <research-sponsorship@herts.ac.uk>; [REDACTED]
Subject: Submission of SA1 for 18/EE/0374

Dear Laraine,

Further to receipt of your completed SP2 form, this is to confirm approval for the amendment to be submitted. The next steps are:

- You should request electronic authorisation of the amendment form on IRAS
- Once you receive the automated email confirming all necessary authorisations have been given, you may submit your IRAS form with any necessary accompanying documentation
- When you receive approval from the Health Research Authority NHS/Social Care Research Ethics Committee, you must inform [REDACTED] so continued University sponsorship of this research project can be confirmed.

Regards, Ellie

Ellie Hubbard
Research Information and Governance Manager & Deputy REF Manager
Research Office, University of Hertfordshire

[REDACTED]

Appendix 23. Amendment to IRAS Form and Favourable Opinion Letter (2)

Amendment Tool		For office use		
v1.1 22 May 2020		QC: No		
Section 1: Project Information				
Short project title*	States of the Self within Emotionally Unstable Personality Disorder			
IRAS project ID* (or REC reference if no IRAS project ID is available)	18/SC/0623			
Sponsor amendment reference number*	SA1 09/05/2020			
Sponsor amendment date* (enter as DD/MM/YY)	09 May 2020			
Summary of amendment including justification*	Change of Chief Investigator and Data Controller / Custodian from Dr Helen Ellis-Caird to Dr Keith Sullivan.			
Project type:	<input checked="" type="checkbox"/> Specific study <input type="checkbox"/> Research tissue bank <input type="checkbox"/> Research database			
Has the study been reviewed by a UKECA-recognised Research Ethics Committee (REC) prior to this amendment?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
What type of UKECA-recognised Research Ethics Committee (REC) review is applicable?	<input checked="" type="checkbox"/> NHS/HSC REC <input type="checkbox"/> Ministry of Defence (MoDREC)			
Is all or part of this amendment being resubmitted to the Research Ethics Committee (REC) as a modified amendment?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Where is the NHS/HSC Research Ethics Committee (REC) that reviewed the study based?	England	Wales	Scotland	Northern Ireland
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the study a clinical trial of an investigational medicinal product (CTIMP) OR does the amendment make it one?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Was the study a clinical investigation or other study of a medical device OR does the amendment make it one?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Did the study involve the administration of radioactive substances, therefore requiring ARSAC review, OR does the amendment introduce this?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Did the study involve the use of research exposures to ionising radiation (not involving the administration of radioactive substances) OR does the amendment introduce this?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Did the study involve adults lacking capacity OR does the amendment introduce this?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Did the study involve access to confidential patient information without consent OR does the amendment introduce this?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Did the study involve prisoners OR does the amendment introduce this?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Did the study involve NHS/HSC organisations prior to this amendment?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Did the study involve non-NHS/HSC organisations OR does the amendment introduce them?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	England	Wales	Scotland	Northern Ireland
Lead nation for the study:	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Which nations had participating NHS/HSC organisations prior to this amendment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Which nations will have participating NHS/HSC organisations after this amendment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Section 2: Summary of change(s)				
<p>Please note: Each change being made as part of the amendment must be entered separately. For example, if an amendment to a clinical trial of an investigational medicinal product (CTIMP) involves an update to the Investigator's Brochure (IB), affecting the Reference Safety Information (RSI) and so the information documents to be given to participants, these should be entered into the amendment tool as three separate changes. A list of all possible changes is available on the "Glossary of Changes" tab. To add another change, click the "Add another change" box.</p>				
Change 1				
Area of change (select)*:	Researchers			
Specific change (select - only available when area of change is selected. Enter):	CI - New CI, or temporary arrangements to cover the absence of a CI			
Further information (free text):	Due to a period of ill health Dr Helen Ellis-Caird is unable to continue in her role as CI of the study. Dr Keith Sullivan will be the new CI.			

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Applicability:	England	Wales	Scotland	Northern Ireland
Where are the participating NHS/SC organisations located that will be affected by this change?*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Will all participating NHS/SC organisations be affected by this change, or only some?*	☒ All		☐ Some	
Add another change: 13				

Change 2	
Area of change (select)*:	Administrative details for the project
Specific change (select - only available when area of change is selected first)*:	Other administrative change - Please specify in the free text below
Further information (free text):	Change of Data Controller / Custodian from Dr Helen Ellis-Caird to Dr Keith Sullivan.

Applicability:	England	Wales	Scotland	Northern Ireland
Where are the participating NHS/SC organisations located that will be affected by this change?*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Will all participating NHS/SC organisations be affected by this change, or only some?*	☒ All		☐ Some	
Add another change: 11				

Section 3: Declaration(s) and lock for submission

Declaration by the Sponsor or authorised delegate

- I confirm that the Sponsor bears responsibility for the completed assessment tool
- I confirm that I have been formally authorised by the Sponsor to complete the assessment tool on their behalf

Name (first name and surname)*:	John Senior
Email address*:	j.m.senior@herts.ac.uk

Lock for submission

Please note: This button will only become available when all mandatory (*) fields have been completed. When the button is available, clicking it will generate a PDF copy of the completed amendment tool that can be included in the amendment submission. Please ensure that the amendment tool is completed correctly before locking it for submission.

Lock for submission

Section 4: Review bodies for the amendment

Please note: This section is for information only. Details in this section will complete automatically based on the options selected in Sections 1 and 2.

	Review bodies												Category:	
	UK wide			England and Wales			Scotland			Northern Ireland				
	HMRC	Competition Authority	Information Commissioner	HM Treasury	HMRC (HMRC)	HMRC (HMRC)	HMRC (HMRC)	HMRC (HMRC)						
Change 1:	Y			Y			(Y)							C
Change 2:	N			Y			(Y)							C
Overall reviews for the amendment:														
Full review:	Y			Y			N							
Notification only:	N			N			Y							
Overall amendment type:	Substantial for review													
Overall Category:	C													

(Appendix 23. cont.) Favourable Opinion Letter



East of England - Cambridge South Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS



Dear Ms James

Study title: How do Individuals Diagnosed with Emotionally Unstable Personality Disorder Experience 'Schema Modes' or other States of Self?
REC reference: 18/EE/0374
Protocol number: 02919
Amendment number: SA1 09/05/2020
Amendment date: Jul 3 2020
IRAS project ID: 236003

The above amendment was reviewed the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Completed Amendment Tool [Completed Amendment Tool (Major Amendment 1)]	1	09 May 2020
Other [Documented Proposed Changes]	V1	09 May 2020
Other [Sponsor's SP2 Form for Change of Supervisor]	SA1	27 April 2020
Participant consent form [Consent Form]	V7	27 April 2020
Participant information sheet (PIS) [Participant Information Sheet Colne House]	V7	27 April 2020
Participant information sheet (PIS) [Participant Information Sheet Cygnet House]	V7	27 April 2020
Summary CV for Chief Investigator (CI) [Brief CV: Chief Investigator (Dr Keith Sullivan)]	1	09 May 2020

Appendix 24. Non-substantial Amendment 1 (NSA01)

UNIVERSITY OF HERTFORDSHIRE

FORM SP2: APPLICATION FOR APPROVAL TO SUBMIT AN AMENDMENT TO PROJECT WHERE THERE IS UNIVERSITY SPONSORSHIP*

* That is, when applying for an amendment to a study with Health Research Authority (HRA) approval, including NHS Research Ethics Committee (REC), Social Care REC (SREC) or other relevant regulatory body such as the Medicines and Healthcare Products Regulatory Agency (MHRA).

As a condition of receiving University of Hertfordshire sponsorship, it the responsibility of the Chief Investigator to inform the Sponsor of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations, from the protocol, which may require re-evaluation of the sponsorship arrangements before submission of the amendment to the REC and/or HRA.

(Note on student projects: Students must consult with their supervisor. Applications for sponsorship of student research projects, including doctoral level students, must be made in the name of the student's University-employed academic supervisor, as must any application to the HRA or REC.)

1. Health Research Authority NHS or Social Care Research Ethics Committee (REC) reference: 236003

2. UH Protocol number: [Awaiting confirmation].

3. Research study title: **How do individuals diagnosed with Emotionally Unstable or Borderline Personality Disorder experience their states of self?**

4. Contact details:

i. Chief (Principal) Investigator name (for student research projects this must be the University-employed academic supervisor): **Dr Helen Ellis-Caird**

Please note that during temporary sickness absence of PI I am signing as Research Supervisor (Dr Nick Hawkes) as per advice from Research Information and Governance Manager.

ii. Student name (if applicable): **Ms Laraine James**

5. State to which regulatory body/bodies the amendment request is being made (eg NHS REC, MHRA): **NHS Rec**

6. Specify if you consider this is a substantial or non-substantial amendment (see HRA website for [guidance](#)):

Substantial Non-substantial

7. Amendment number: **NSA01**

8. Specify the nature of the amendment being requested (that is, what is the amendment and what is the reason for it?):

The student researcher has taken on board final PPI consultation feedback which is reflected by minor changes on the 2 Participant Information Sheets. The Consent Form has subsequently been amended with the correct version number of the PIS'. The changes can be seen in blue (text) for ease of reviewing.

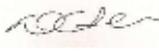
The non-substantial amendments (in red text) correspond to what the HRA has requested for the above documentation. Some final tweaks were suggested by the HRA, based upon discrepancies in what was written on the previous documentation (in purple text).

9. Detail any changes to the risk assessment (if applicable) due to the amendment:

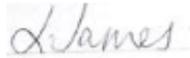
1 RESEARCH SPONSORSHIP SP2 March 2019 v2.1

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No changes to risk assessment.

Signature of Chief (Principal) Investigator: 

Date: 24 7 19



Signature of Student (if relevant):

Date: 28th June 2019

Once you have signed this form using an electronic signature(s), please email to research-sponsorship@herts.ac.uk with any revised documentation (ensure the changes from the original approved version are indicated clearly) and await email confirmation of approval to proceed.

Appendix 25. Research Sponsorship Approval Notification (NSA01)

From: Research Sponsorship <research-sponsorship@herts.ac.uk>

Sent: 31 July 2019 13:47

To: Laraine James [REDACTED] <[REDACTED]>; Helen Ellis-Caird <[REDACTED]>

Cc: Research Sponsorship <research-sponsorship@herts.ac.uk>

Subject: HEC_LJ NSA1

Dear Laraine and Helen,

Further to receipt of your completed SP2 form, this is to confirm approval for notification of the amendment. When you receive the necessary approvals from the REC/HRA we will be able to progress your sponsorship application.

Kind regards,

Stephanie

Stephanie Dixon

Research Office Administrator

Research Office

Extension 5794

Appendix 26. Participant Payment Form, Both Sites (Version 1)

PARTICIPANT PAYMENT FORM

Researcher: Ms Laraine James

This is to certify that I participated as a research participant in the following study:
How do Individuals diagnosed with Emotionally Unstable or Borderline Personality Disorder experience their states of self? and I have been reimbursed for my participation upon completion as follows:

Total Payment: £10

Name: _____

Signature
of Participant: _____ Date:

Signature
of Researcher: _____ Date:

Appendix 27. Transcription Notation System

Feature	Notation / Explanation
Identity of Person Speaking	Bold type used for the Interviewer, with standard type for the Interviewee. The first word of each new turn of speaking signified with a capital letter. A new line used every time a new speaker begins.
Brief Interjections / Interruptions**	If a person interjects when another person is speaking, this is denoted by < > e.g., “Can you say a bit more about <”no problem”> this?”
Utterances and Vocalisations**	Denoted by their phonetic qualities, e.g., “mmm”, “err”, “ah-huh”, “ahh”.
Inaudible Speech**	Square parentheses signify the timing on the tape, e.g. [0.63] for sounds that are inaudible, including instances of emotional speech. When some aspects are heard, single parenthesis indicate the best possible guess, e.g. (felt left out).
Filler / Connective Words**	Transcribed verbatim.
Interviewer Prompts / Clarification-Seeking**	Transcribed verbatim.
Pauses**	Denoted by [] for lengthy pauses.
Identifying Information	Substituted with appropriate pseudonymised information or an X.
Reported Speech	When an Interviewee provides a seemingly verbatim version of another person or their own previous speech. Signified using inverted commas, e.g., X said ‘I wish you’d listen’.
Use of Punctuation	Used carefully and where necessary as this can change the meaning of speech.

Adapted from Braun and Clarke, 2013

**All denoted by ‘...’ in the thesis write-up for brevity.

Appendix 28: Extract of a Coded Interview Transcript for Participant 4

Line No's (from original transcript)	Initial codes	Text	Annotations
213-216	Feeling uncomfortable Unable to take compliment	I don't know, it made me really uncomfortable. Like the boy about the XXXXX, he once called me "beautiful" and I looked at him and went "hah, no!" And he was just like "okay." I felt a bit rude, but I'm not that person. Do you know what I mean? I don't always look like this. Most of the time I've got hair extensions in and makeup. Do you know what I mean? I make a lot of effort sometimes.	Low self-esteem?
217-223	Automatic response Don't take compliments from anyone	It sounds like there's a bit of self-attack going on? Yes, but that's what I do. It's autopilot for me just to... What is autopilot like? Tell me a bit more if you can. I don't know. It's like I don't take compliments, even if it's from my mum. So my autopilot is just like anything that's said, whether it's good or bad, I kind of just hit it away, whether it's good or bad.	Hard to hear feedback about the self
224-230	Unable to hear good or bad things	So my autopilot is I just have to get through the day, I don't want to hear good things, I don't want to hear bad things. Does that autopilot feel like anything, apart from just getting through the day? Are there any particular feelings attached to autopilot, or an absence of feeling?	
	Avoidance Anticipatory anxiety	Because of my feelings in general, I can't... like anything complicating or making me feeling anything other than the feelings I've already got to deal with. So it's like I wake up and it's like I've got to go out, and my anxiety is already there because I've got to go out, so I don't need someone throwing like a look at me. So I don't look at people in the street. Do you know what I mean? I deal with so much in a day, feeling wise, it's exhausting, so anything else I just can't deal with.	Avoiding complicated feelings
231-239	Overwhelmed and exhausted	So, a compliment feels like what to you? It just feels like a hassle, I don't want to hear it, because I think they're lying as well, so that causes me stress that I think they're	

<p>240-250</p> <p>Difficult to trust compliments / others</p> <p>How could anyone like me</p> <p>Stress on top of everything else</p> <p>Hard to trust people</p> <p>Tried hard, disappointed self</p> <p>Daydreaming, couldn't concentrate</p> <p>Didn't try hard enough</p>	<p>lying. So someone said they had feelings for me the other day and instead of going "oh he's got feelings, that's really sweet, that's really nice," I went "oh, stress, he's lying, he can't possibly have feelings for me," if that makes sense.</p> <p>Yes, and that causes you to feel stress?</p> <p>Stress and anxiety and it's even more in my day that I have to deal with.</p> <p>And what goes through your mind? So other people lying, is that a common thought for you?</p> <p>Yes, I think everyone is lying, and my trust isn't great so...</p> <p>Yes, so you find it very hard to trust. And then there are times when, in the absence of people saying nice things to you that you attack yourself, so if you feel you've not done something to a certain standard. Do you have any examples?</p> <p>I remember my exams at school, even though I knew I'd tried my hardest on my exams, I didn't get as well as I hoped I would get. I mean, some of them I knew I wouldn't do well in, so I spent half the exam daydreaming, because the boy I fancied was sitting in front of me. So I was like just daydreaming about him for most of it. But I kind of knew I was going to fail that exam, but the other ones I was like I should have tried harder, I was ashamed to tell anyone what my results were so I hid it for a while before my mum found it and said "why didn't you tell about your exams?" I was like "I didn't do very well."</p>	<p>Low self-esteem</p>
<p>251-253</p> <p>Shame / Hid results</p> <p>Default mode: shame</p>	<p>So it sounds like shame was part of it?</p> <p>Yes. I think another one of my default modes is shame, I feel quite a lot of shame. I do things as well, I'll be happy doing it and then the shame kicks in after.</p>	<p>Lost the will / berating the self?</p> <p>Not thinking of consequences – Regret?</p>

Appendix 29. Illustrative List of Identified Codes for Abandoned Child Mode: Deductive Themes

Code: Abandoned Child Mode
P1: Abandoned
P1: Rejected
P2: Feel neglected / invisible
P2: Fear rejection
P3: Sense of abandonment originated in childhood
P3: Abandonment is triggering
P3: "Abandoned child"
P3: Needing rescue
P3: Needing reassurance
P3: Not held in mind / forgotten
P4: Fear of abandonment
P4: Breakups are hard
P4: Rejection is debilitating and painful
P4: Abandonment fears are specific to men
P4: Short-lived depression after relationship ended
P6: Abandoned
P7: Fear of abandonment
P7: Abandonment fears are situation specific
P7: Fear of losing relationship
P7: Inanimate objects can't reject me (teddies)
P7: AC fears can last for hours
P7: Sometimes AC feelings go away on their own
P1: Feel childlike; not coping

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P1: Inferior, not good enough
P1: Showing distress (took overdose)
P1: Victimised; helpless
P1: Unable to vocalise what I need
P1: Suicidal, desperate thoughts
P1: Feeling lost
P2: Helpless
P2: Not cared for
P2: Needing reassurance
P2: Feeling to blame
P2: Hopelessness
P2: Embarrassed and ashamed
P2: Hopeless
P2: Sensitive
P2: Dramatic, over the top
P2: Worrying and overthinking
P2: As a child, clingy and reassurance-seeing
P2: Unable to verbalise distress
P2: Sadness and anxiety often felt
P2: Low, in a bad place
P2: Disproportionately upset
P3: My childhood state is very prominent
P3: Vulnerable and scared
P3: Sadness / Defaulting to sadness
P3: Overwhelming embarrassment and shame
P4: Anxiety always present

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P4: Afraid to be alone
P4: Happiness switches to sadness
P4: Sadness is the worst feeling in the world
P4: Overwhelmed and exhausted
P4: Default mode is shame
P4: Need for validation
P5: Sense of feeling small and childlike
P5: Reconciliation calms intense feelings down
P5: Scolding leads to feeling hurt
P5: Stomach cramps (linked to negative feelings)
P5: Self-infantilisation
P5: Despair; lack of hope
P5: Humiliating to regress to being a child
P5: Sadness
P5: Uncertainty is triggering
P5: AC Mode can last for days
P6: "Felt like an orphan"
P6: Insecure
P6: Victimised and abused
P6: Seeking rescue
P6: Constant sense of being childlike
P6: Suicidal ideation (desperate)
P6: Yearning for closeness / can't be alone
P6: Desire for closeness
P6: Sadness, shame, guilt and remorse
P6: Rumination about loss leads to sadness

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P7: "Regressing to childlike state"
P7: "Feel like a child, navigating life"
P7: Enduring and overwhelming anxiety
P7: Sadness
P7: Sadness switches off other emotions
P7: Crying is a temporary release
P1: Afraid to get close to others
P1: Taken advantage of
P1: Trust betrayed
P1: People are untrustworthy
P1: Lonely, no friends
P2: Scared to be open
P2: Difficult friendships
P2: Preoccupied by friendships
P2: Push-pull dynamic in romantic relationship
P3: Unable to tolerate people being upset with me
P3: Fear of not being able to connect
P3: Lonely; distant from others
P3: Feel different from other people
P4: Attached to unavailable person
P4: Ruminating about past (difficult) relationships
P4: Relief when relationship ended (uncertainty ended)
P4: Fear others' negative judgement
P4: Scared to be in a relationship
P6: Feel vulnerable in the presence of others
P6: Cautious about getting close to others

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P6: "Don't belong"
P6: Attracted to unavailable men
P6: Taken advantage of
P6: Betrayed
P6: Let-down
P6: History repeating itself (relationships)
P7: Fear negative judgement

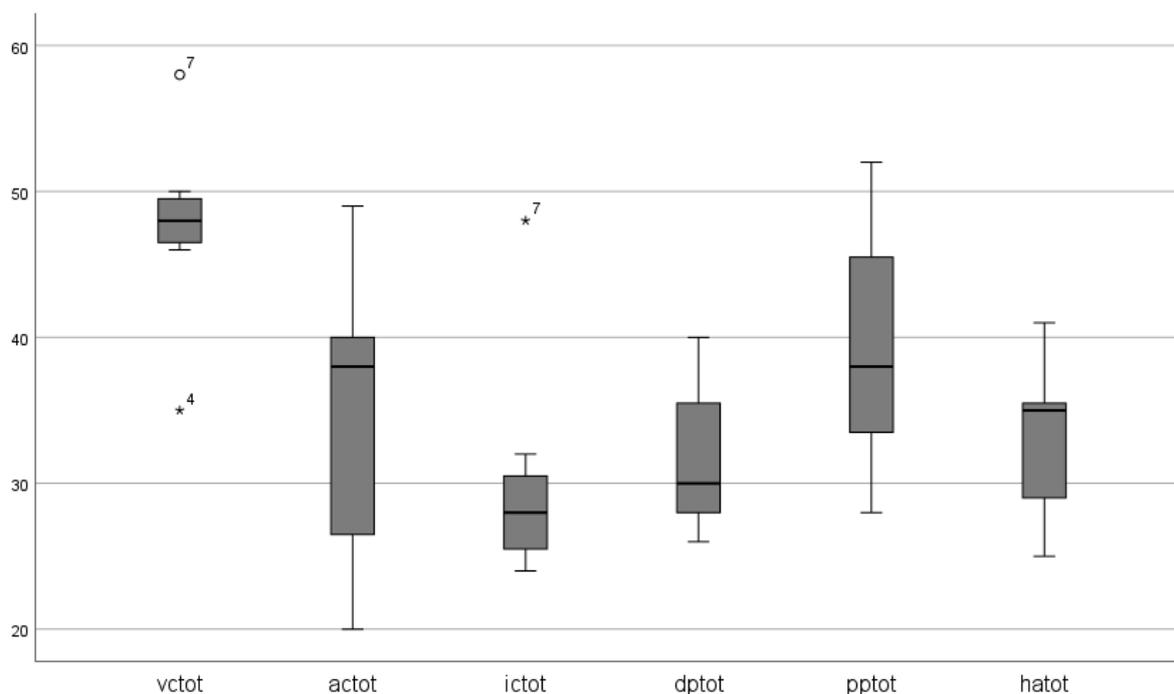
Appendix 30. Extract of Quotes and Codes for ‘Resilience’: ‘Struggling to Cope’ Sub-theme

Quotes	Codes	Mode
<p>P1 (33-34)</p> <p><i>“And then I was helping my mum and dad and my gran at the time, helping people and not me and when it came to growing up I couldn’t cope with being an adult because they’d taken all the bricks away from me to build, if you know what I mean”.</i></p>	<p>No opportunity to mature</p>	<p>(Un)Healthy Adult</p>
<p>P1 (344-348)</p> <p><i>“But I mean we’ve both got mental health problems, we’re just trying to do our best, and that’s why I think we should have a parenting programme for people with mental health, to give them a bit more guidance rather than...”</i></p>	<p>Lost without guidance</p>	
<p>P1 (514-521)</p> <p><i>“I suppose it’s giving me to say, to tell him I’ve had enough, you know, give me a break ... I feel like you’re pushing me, still pushing me, and I can’t go any further ... I just feel like I’m pushed to the limit all the time”.</i></p>	<p>Unable to cope</p>	
<p>P2 (648-654)</p> <p><i>“...when I was feeling like kind of all right I applied for this volunteer thing because I thought I’d be able to do it, and I even went to the interview and stuff, which I’ve never done anything like that before, this was last summer, but then it came to like nearly the time where I was going to start the training, and yes, I kind of...obviously, I was probably scared as well, I think because I realised I can literally like change so easily or the smallest thing can kind of affect me, I wasn’t really ready for that kind of thing. So I guess it does hold me back quite a lot, because I never know how I’m going to be, day to day...”</i></p>	<p>Hesitant to connect to Healthy Adult mode</p>	

<p>P2 (654-656)</p> <p><i>"...Obviously, you can't have a job or anything like that if you're going to be just like cancelling shifts and stuff like that, last minute".</i></p> <p>P3 (768-770)</p> <p><i>"Something bad happens, or something happens, something bad happens probably, but it doesn't necessarily have to be that bad, anything like mildly upsetting, being cancelled on or even plans have changed. Yes, I feel like anything can happen and just knock you out of the...I feel like this is my feeling every day, but at least once a day I'll have another feeling".</i></p> <p>P4 (621-627)</p> <p><i>"Yes, whereas this is kind of just like a levelled...I kind of feel you can do pretty much anything and not get bogged down by it, but obviously sometimes it doesn't actually last very long ... I think it kind of depends. I could be like fine, I might come out here and be like this down and then... I don't know. Everything just switches so quickly it's hard to...like I might get out of here and be really happy that I've done it but feel really overwhelmed that I've just done it, and then in the adult feeling kind of goes and I don't know what to do with myself.</i></p> <p>P5 (767-768)</p> <p><i>"I don't feel it as often as I'd like, but I'd say it lasts maybe... it can last for a few hours. Occasionally it lasts for a day but often the depression will kick in at some point".</i></p> <p>P5 (826-827)</p> <p><i>"The healthy adult one, it's kind of more sparingly, it's less frequent, so I guess that one doesn't fit me quite as well either".</i></p>	<p>Afraid to take responsibility</p> <p>Healthy adult mode stops when upset or something happens</p> <p>Hard to know what to do when Healthy Adult feeling goes</p> <p>Healthy Adult mode is more fleeting</p> <p>Healthy Adult mode is more fleeting</p>	<p>(un)Healthy Adult</p>
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<p>P6 (541-542)</p> <p><i>“But I just don’t have the energy to be able to do anything about it. I would need to do something, diet wise, and I’d walk the dog, but anything... you know, just living with this mental health is exhausting”.</i></p> <p>P7 (930-934)</p> <p><i>“I find that I’m overwhelmed, because also, like, obviously if it’s something to do with purely me and I have to do it, and I get that, but like for example, the flights and like the hotel and everything, because I was meant to fly out with X, I felt like it was always falling on me, because I had to fix the issue and I had to do this and that, and it’s like this is a shared activity between the both of us, why am I doing all the adulting?”</i></p> <p>P7 (963-968)</p> <p><i>“Well, once I’ve like accomplished the task, it [HA Mode] tends to go away ... Well, then I’ll get a bit frustrated and I’ll be like, “well, now I have more to do tomorrow.” ... I’ll like feel disappointed, I feel like, so I’ll be like very like upset with myself because you should have done it and you didn’t”.</i></p>	<p>No energy for self-care</p> <p>Responsibilities feel relentless</p> <p>Healthy Adult mode tends to cease when the task is done</p>	<p>(un)Healthy Adult</p>
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Appendix 31. Boxplots for the 5 Central Modes Illustrating the Distribution, Spread of Scores, Outliers, and Extreme Values of the Schema Mode Inventory Data for the Total Sample (N=7)



SMI Mode Severity Range: Very Low – Severe

Note the SMI separates Angry and Impulsive Child into 2 sub-scales and has a Vulnerable Child subscale which is the closest fit to the Abandoned Child mode.

N.B. please refer to the Table of Norms in Appendix 13 for intensity thresholds.

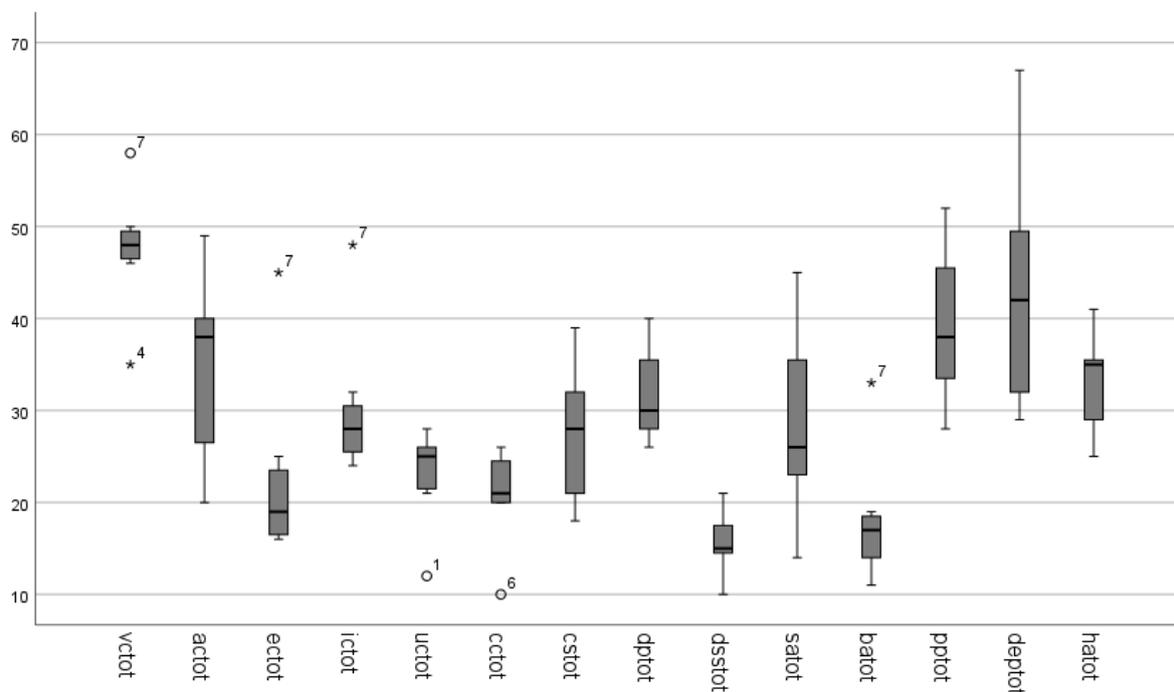
The above boxplots illustrate the distribution, spread of scores, outliers and extreme values of the SMI data for the five central modes and also for all SMI modes. Looking at the boxplots for the five central modes it can be seen that the median score is highest for the Vulnerable (Abandoned) Child mode and lowest for the Impulsive Child. The variation in scores is highest for the Angry Child mode and lowest for the Vulnerable (Abandoned) Child mode.

The Vulnerable (Abandoned) Child score overlaps with the score for Angry Child and Punitive Parent mode, suggesting there is no statistical difference. However, Vulnerable

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(Abandoned) Child does not overlap with the scores for the other three modes, suggesting they are statistically different. Leaving aside the Vulnerable (Abandoned) Child mode score, the distribution of scores for the other five modes clearly overlap.

Appendix 32. Boxplots for all Schema Modes Illustrating the Distribution, Spread of Scores, Outliers, and Extreme Values of the Schema Mode Inventory Data for the Total Sample



SMI Mode Severity Range: Very Low – Severe

Note the SMI separates Angry and Impulsive Child into 2 sub-scales and has a Vulnerable Child subscale which is the closest fit to the Abandoned Child mode.

N.B. please refer to the Table of Norms in Appendix 13 for intensity thresholds.

The above boxplots display the distributions, spread of scores and outliers of the total SMI modes for each group. Looking across the boxplots for all SMI modes, it can be seen that the score for Vulnerable (Abandoned) Child mode differs to all other modes except Angry Child, Punitive Parent and Demanding Parent, but retains its status as the mode (VC [AC]) with the lowest variability in scores.