How the experience of being diagnosed with Borderline Personality Disorder affects relations with others and one's self-perception -an Existential Phenomenological Study.

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AUTHORSHIP

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ABBREVIATIONS

BPD - Borderline Personality disorder

CNA – Critical Narrative Analysis

DSM IV - Diagnostic and Statistical Manual of Mental Disorders.

TARA – Treatment and Research Advancements National Association for Personality
Disorder

TRANSCRIPT SYMBOLS

The following symbols were adopted in the study to preserve participant anonymity and
confidentiality.

(...) - Material omitted

(Lines in the Spanish transcript) – refers to lines in the original transcript in Spanish

CHAPTER 1

INTRODUCTION

Having worked as a psychologist in both the UK and Lima, Peru, working with patients who present a variety of conditions ranging from a depression to severe cases of schizophrenia, I became concerned by the way in which patients reacted to their diagnoses and in particular by the negative response of patients diagnosed with Borderline Personality Disorder (BPD). I also perceived that the lack of a clear and accepted diagnosis caused significant confusion regarding the condition for patients, carers and professionals. This led me to question the value of the diagnoses in the process of understanding and helping people with emotional distress or psychological problems. This study is a response to my experience and the experience participants expressed through me.

Borderline Personality Disorder (BPD) is a complex phenomenon as it involves several factors including physiological, psychological and environmental. It is one of the seven personality disorders included in the *Diagnostic and Statistical Manual of Mental Disorder* (DSM), which serves as a guide to the clinical practice in this area. The traditionally accepted diagnosis of BPD is defined in the DSM IV (2000) as: "A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning in early adulthood and present in a variety of contexts, as indicated by five or more of the following:

1. Frantic efforts to avoid real or imagined abandonment.

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance.

4. Impulsivity in at least two areas that are potentially self-damaging.

5. Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour.

6. Affective instability due to a marked reactivity of mood.

7. Chronic feelings of emptiness.

8. Inappropriate, intense anger.

9. Transient, stress-related paranoid ideation (DSM IV, 1968: 790-794).

Although the DSM is widely used in the fields of psychiatry, psychology and counselling, other research studies, as well as theoretical frameworks, therapeutic approaches and perspectives have been proposed and implemented in order to understand the causes, diagnosis and treatment of patients with BPD (Millon, 1995; Fommer, 1997; Batcheler, 2003; Koldobsky, 2005; Triebwasse, 2008) Leichesering 2011

For the purposes of consistency of the study I will refer to the person that had received a psychiatric diagnosis as "patients".

Investigations published (using the medical model as a reference to guide them) in several countries including England, France, Portugal and the United States (USA) have shown an increased prevalence of BPD in the general population. Although it is not possible to create a map of prevalence in any given country, studies in the United States have shown BPD as a mental pathology with prevalence close to 1.8%, which is similar to that of schizophrenia (Widiger, 2002; Leichesenring, 2011). Investigations in Europe have traced its development in England, Germany, Holland, France, Norway, Finland, Austria, Belgium and Portugal (Gunderson, 2009).

Psychiatric epidemiological studies, such the ones conducted by Torgensen (2001), have argued that between 1% and 2% of the general population in the USA have

been diagnosed with BPD while 11% of people who sought psychological attention suffered from BPD (Koldobsky, 2005). In Europe, recent studies have shown that BPD is a predominant diagnosis in the forensic population; the data analysed showed that between 75% and 90% of this population had a personality disorder of which some two thirds was BPD (Hildebrand and Ruiter, 2004; Ruiter and Greeven, 2004; Young-Tineo, 2005; 2007).

Despite all the information that has been published on BPD and its prevalence there has been little epidemiological research done into the disorder. Three methodologically rigorous surveys have examined the community prevalence of BPD. Coid et al. (2009) showed that the prevalence of BPD in a random sample of 626 British householders was 0.7%, while Samuels et al. (2002) found that in a random sample of 742 American householders the prevalence of BPD was 0.5%. In primary care, the prevalence of BPD ranges from 4% to 6% of primary attenders (Moran, D 2000; Gross et al., 2002). Compared to those with no personality disorder, people diagnosed with BPD are more likely to visit their GP frequently and to report psychosocial impairment. However, the prevalence of a disorder or a group of symptoms does not necessarily imply the existence of a psychiatric diagnosis as the group of patients could be presenting only a group of difficulties that with some self-control skills and good psychological treatment could improve after time, as this study explained (presented in the Literature Review).

While there is a case being made, therefore, that the prevalence of BPD is increasing, this may well signify a prevalence of diagnosis. It does nothing to show that BPD actually exists as a neurobiological disorder.

These studies have also shown a prevalence which is generally higher in females and largely invariant across cultures (Allik, 2005). Other reports show that 80% of

patients who received treatment for this diagnosis are women, a factor that has contributed to the idea that this diagnosis is more common in women (Gunderson, 2009). Koldobsky (2005) puts the differential between women and men at 2:1 or 3:1, which suggests that gender could play an important role in the gender prevalence of this disorder. Many researchers have shown important differences between male and female patients with respect to serotoninergic function but to date, no firm explanations of this phenomenon have been offered (Treatment and Research Advancements National Association for Personality Disorder (TRANAPD), 2007).

However, is also noticed in other studies, such as the one conducted by Wright and Owen in 2001, that the lower prevalence of antisocial personality disorder in women might be due to intense social control of women's activity. Similarly, BPD is also seen by other researchers as a gendered construct suggesting no clear existence of it as a psychiatric diagnosis.

In recent years, biologists studying the psychological and neurological causes of BPD in depth have claimed that certain regions of the brain (the anterior cingulate cortex and the intraparetical sulci areas) that help to guide people through social situations seem to malfunction in BPD sufferers. This could provide some explanations over some of the extreme behaviours and lack of impulse BPD patients present. These findings would classify the BPD diagnosis as a medical disease, but there is as yet no consensus on the causes of BPD (Reichbor-Kjennerud, 2011).

Regarding BPD diagnosis it is important to mention that the DSM classification of psychiatric disorders has been very controversial, as groups of professionals believe that the DSM diagnosis could create confusion in patients who receive a diagnosis. This confusion is compounded by the fact that these patients are called 'borderline', "because they were sicker than neurotic but not sick enough to be classified psychotic" (Millon,

2000), which could lead patients to feel categorised and labelled, and the rejection of the diagnosis.

Professionals that are not in agreement with DSM diagnosis have expressed their concerns about the tendency to group symptoms and then define them as major psychiatric diagnosis, something frequently done by the DSM. This group of professionals is inclined to reflect on the degree to which we want to accept and permit this tendency to follow psychiatric diagnosis. It is important that counselling psychologists and psychotherapists try not just to assume the classification of mental disease in a passive way but also to try to make sense of it; in case it has to be used it could help the professional to understand the patient´s situation without giving them a sensation of being labelled.

The DSM has responded to these criticisms by suggesting that when one classifies a disorder it is not the same as classifying a person. However, is it not the same when a BPD diagnosis is given to a person then professionals refer as that person as a BPD patient? From that moment, friends and family will see most of these people as a BPD patient. This "label" could impact negatively on their identities.

Regarding this last idea, this study will present the personal experience a group of BPD patients had with respect to their diagnosis. And the argument they all present regarding that the medical model used by professionals in the mental health field does not allow a dynamic perspective of the person who seeks help. On the other hand this model has a tendency to see the entire personality as a group of "malfunctions traits" that are a permanent condition in the person who presents it.

Although there is general agreement that personality traits influence BPD development, how these factors interact remains largely unknown. Furthermore, how these factors exacerbate existing personality traits is also unknown (Cohen et al., 2005).

Another important point regarding DSM is the determination to present specific treatment plans for each diagnosis thereby ignoring the individual differences that even two individuals with the same diagnosis could have, and which should be taken into consideration in order to structure a therapeutic plan. This point will be present in the stories of the participants.

Aim and Objectives of the study

The aim of this study is to add to the British Psychological Society's (BPS) ongoing exploration and understanding of Borderline Personality Disorder and in particular the impact on the clients´ experience of receiving a diagnosis, by examining and describing how a person's perception of himself/herself, the world and others can change after being diagnosed with BPD. In addition, this study attempts to contribute to the conceptual understanding of the term BPD by building theory from a holistic description and analysis of the sample while maintaining the uniqueness of each participant. This study also focuses on the impact of stigmatization that a BPD diagnosis could potentially have on patients and the way participating patients perceived treatment. Droskin (2002) perceived that the term BPD often results in sub-standard treatment because some professionals consider that all of the behaviours presented by BPD patients are *manipulative*. This situation is exacerbated when the professional reacts to the diagnosis by assuming the likelihood of poor end results. He or she then responds negatively, even to the extent of refusing to work with those so diagnosed. This study will argue that being diagnosed with BPD can further harm the patient as it generates a sense of alienation and loneliness in them. People who are diagnosed with BPD tend to experience devaluation in relationships, patterns of idealization, affective instability, and attendant risks of suicide and self-harm (Critchfield et al., 2007).

This study will, however, attempt to demonstrate that those people diagnosed with BPD can make good progress. While prior investigations in the field have helped to better understand BPD, there still remains the need for a comprehensive and holistic understanding of a person who suffers from this diagnosis. Thus, it is important to know how this person feels and thinks about the situation and about the possible stigmatization when the diagnosis is received (Aviram, 2006; Hoffman, 2007; Salters-Pedneault, 2009). Studies have shown the significance of empathy on the part of the psychotherapist or counselling psychologist within the therapeutic setting, as well as the importance of building a trustworthy relationship (Sherwood, 2001; Lorda, 2007; Gabbard, 2009). In this respect, existential psychotherapy has made a valuable contribution with some other approaches such as a person-centred or humanistic one to the fields of psychology, psychotherapy and counselling.

In the existential approach, it is essential for the therapist to understand the client's inner world and to try to comprehend the way this person perceives and feels the world (May, 1986; Mearns and Cooper, 2005). This approach is based on the general understanding of existentialism that considers that the *existence* of a human being precedes his or her *essence* (Sartre, 1943). In his book *Existence* (May, 1994), Straus emphasized the importance of understanding each patient's world or in other words, the actual life of each human being and how she or he defines it. This is what constitutes a human being's individual true essence rather than the attributes used by others to define him or her. Straus' argument is applicable to any patient with an emotional or psychological disorder, as it is to the understanding of human beings in general. This is a significant departure from other medical models. The existential perspective intends to know and understand the person in a holistic way without categorizing their experiences or seeing them as symptoms and will take that person

towards a psychiatric diagnosis. It is the level of understanding the world-life of the person that allows the therapist to help him to understand his own symptoms and to work on them.

For this qualitative study I took an existential conceptualization of the terms related directly to the "existential dimensions" – physical, psychological, social and spiritual – to gain a holistic understanding of the phenomenon being described (Binswanger, 1963; van Deurzen, 1997). This study will also attempt to demonstrate that the diagnosis of BPD has not been universally accepted and that explanations for the disorder are incomplete and inconclusive. It will further argue that this diagnosis should not be seen as a psychiatric diagnosis, because of the negative implications of it for the people who receive it.

Research Methodology

To achieve the aims of the study, a qualitative methodological approach was chosen using a hermeneutical phenomenological research design to gather and analyse data. A total of five patients that were diagnosed with BPD were interviewed regarding their experiences of being diagnosed with BPD to gain an in-depth and rich understanding of the phenomenon and the possible changes this can bring about in the way they perceived themselves and their relationships with others and the world. Three females and two males ranging from 18 to 33 years old volunteered for this study. A professional in mental health diagnosed all five participants with BPD and they were provided with psychological and counselling services during the study.

Data collection was conducted by interviewing participants. All interviews were open-ended and lasted approximately ninety minutes, in which time the participants could talk freely about their experiences with minimum interruptions from the

researcher. An in-depth, semi-structured interview with an open-ended question was created to obtain information regarding participants' experiences and characteristics. Interviews were audio-recorded and transcribed. For data analysis, Critical Narrative Analysis (CNA) was used (Langdridge, 2007).

Organization of the dissertation

This dissertation is presented in five chapters. Chapter 1 provides an introduction to the research study. In Chapter 2, existing research and literature on the subject of Borderline Personality Disorder and aspects contributing to stigmatization are reviewed. A review of the literature on Borderline Personality Disorder and different positions in relation to psychiatric diagnosis, including the existential view of these concepts, is examined. In addition, the present situation regarding the BPD diagnosis and the discussions currently taking place regarding the possibility of changing its name with a view to achieving a clarification of the disorder, are presented. The methods and procedures used in this study for data collection and analysis are discussed in Chapters 3 and 4.

Chapter 5 presents the results of the core categories of data analysis from the perspective of the participating BPD patients. This chapter has been divided into a narrative structure and the different identities and tones found on all participants' stories. In addition, extracts from interview transcripts are included. Three themes have been separated from the interview analysis as they were repeated in all participants' narratives; they have been described in the results to enable clear exposition of the journey from participant statements to themes to discussion and conclusion. Finally, Chapter 6 presents the discussion of the results, the implications of this research, suggestions for future research and main conclusions.

CHAPTER 2

LITERATURE REVIEW

In this chapter I will review the literature existent on BPD and I will try to demonstrate the different perspectives of this diagnosis as well as how incomplete, inconclusive and controversial this diagnosis could be seen.

To begin with Plato was one of the first philosophers to propose a human mental health paradigm. He described many of the conflicts occurring within an individual's psyche and posited that social factors could influence the developmental course of individual children in any number of ways. Later, following this idea, many theorists wrote about how society's imbalance and challenges contribute to a marked societal pathology that in turn contributed to mental health *epidemics*, such a depression, addictions or Borderline Personality (Millon, 1995). This idea presents the possibility of understanding how social aspects can positively or negatively affect personalities. A series of research studies have been undertaken but they vary widely from analyses of biological aspects to the study of childhood development.

A personality disorder is characterized by a permanent and inflexible pattern of perception, behaviour and thought which causes anxiety and prevents or obstructs the person from having a complete and satisfactory relationship with their environment (Beck and Freeman, 2006; Young, 2007; Benjamin, 1996). BPD often begins in adolescence and the condition remains constant throughout life. People who suffer from personality disorders have difficult adapting to tensions in life. They have a tendency to be inflexible, rigid and incapable of coping with day-to-day changes and demands (Clarkin and Lenzenweger, 2005).

It is possible to agree with this definition to a certain point but the idea of an inflexible pattern generates the idea of a permanent difficulty in the person who receives

this diagnosis. As researches have shown personality is a complex construct and until now we there are many and different perspectives to try to explain it (biological, socials, genetic). It is also a dogmatic and condemnatory idea to say that a personality disorder will prevent or even obstruct a person to have a satisfactory relationship with his environment, when researches such the ones conducted by Links et al., 1990, and Stone, 1993 establishing that in the long term, the "prognosis" for example of BPD patients is a better one than is often assumed and a person could have a satisfactory relationship with his environment.

Borderline Personality Disorder (BPD)

Among the most known personality disorders is Borderline Personality Disorder (herein referred to a BPD), a "serious personality disorder" (Lieb, Zanarini, Schmahl, Linehan and Bohus, 2007). The development of the concept has always been related to challenges in diagnosis and treatment of patients.

Stern (1938) was the first scientist who used the word "borderline" to identify a group of patients who did not fit into the psychotic or neurotic categories. He described the borderline client as a narcissistic person with marked resistance to psychoanalytic treatment. In his opinion, the borderline condition was characterized by 10 symptoms: narcissism, psychic bleeding, hypersensitivity, psychic stiffness, a negative reaction to therapy, inferiority feelings, masochism, self-harm, somatic anxiety, projection mechanisms and difficulty evaluating reality (Millon, 2005).

Following Stern's work, the desire to understand the borderline condition continued and was given different names such as "latent psychosis" (Frosch, 1964) and "pseudoneurotic schizophrenia" (Hoch and Cattel, 1962) among others. The term *borderline personality organization* was coined by Kernberg (1967), which strictly

separates bad and good objects in the client experience, and this is still used in psychoanalytic-oriented psychotherapy.

Later, in 1968, Grinker, Werble and Drye made an effort to give a description of the syndrome using empirical studies. In 1975 Kernberg, with contributions from many other practitioners, presented an integration and synthesis of the different and earlier studies of BPD that described and defined the diagnosis. Over time, Kernberg modified these ideas but his basic structure remained the same (Kernberg, 1985; 1989) while his ideas are based on psychoanalytic structural configuration – structural configuration which implies a different type of ego and superego functioning in BPD patients, a configuration that is stable and resistant to change (Beres, 1956). In addition, these patients also suffer from primitive ego defences such as splitting, idealization and projection, among others yet, these defences are observed to be pathognomonic (Kernberg, 1985).

All of these past explanations and clarifications are clearly following the medical model that was the only one presented at that time with the religious explanation. Those were then used during that period to categorize and understand mental disorder or problematic behaviours in a person.

The medical model is still being used to conceptualize and explain mental health; however, great improvements have been made in the way we are seeing mental illness. Examples of that could be seen in an article published in Perspectives of Psychological Science (2011), where Dr. Kazdin and Dr. Blase suggested "that in order to relieve the burden of mental illness, the medical community needs to come up with more effective models of treatment delivery that are more practical, humane and accessible for the majority of those in need."

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by

the American Psychiatric Association (APA) provided common and standards criteria to classify mental disorders. The DSM classified BPD under Axis II as a disorder characterized by a "pervasive pattern of instability" (APA, 1994, p.654). One issue being addressed by the DSM V researchers group for personality disorders is the possibility of changing from a categorical to a dimensional model of classification (Clark, 2007). The dimensional model is based on the Five Factors Model (FFM) of personality, first developed by Tupe and Christal in 1961 and later on expanded by Cattel in 1957, and Costa and McCrae in 1987 (Widiger and Frances, 2002). It consists of five broad dimensions that are used to describe personality features such as openness, conscientiousness, extraversion, agreeableness and neuroticism. The idea is that a personality disorder diagnosis is challenging and cannot be provided without the knowledge of maladaptive personality traits. One criticism of this proposal, which is still under debate, is that it fails to show any normal personality traits (Skodol, 2009; Leising and Zimmermann, 2011).

In the DSM V, only five personality disorders have been accepted, viz, antisocial, avoidant, borderline, obsessive-compulsive and schizotypal (Pincus, 2011; Skodol, 2012). However, the majority of the researchers and practitioners from mental health agreed that the intensity and variability of mood states were the primary characteristics of BPD. In other words, patients' symptoms shift rapidly from hysteria to psychotic anxiety followed by periods of rational and "normal" behaviour. They experience short periods of sadness or boredom, which easily give way to periods of aggressiveness and self-destructiveness (Schwartz-Salant, 1989; Linehan, 1993).

Heller (2008) believed that the term BPD is inaccurate and that this label in itself implies that the whole person is flawed. He based this view on BPD research which shows biological brain disorder as the possible cause. On the other hand, Linehan

(1993) proposed that the BPD condition is a problem of emotional dysregulation and that the name should be changed to a more accurate one such *Emotional Dysregulation Disorder*.

Droskin (2009) agreed that something has to be done to remove the stigma of the BPD diagnosis; he believed that the term BPD often results in sub-standard treatment as this behaviour tends to be perceived as manipulative by practioners. . Although it is undeniable that manipulation could certainly happen on the part of the patient, we cannot overlook the fact that, as Droskin (2009) explains, it could also come from the therapist's point of perception.

For the *Treatment and Research Advancements Association* (TARA), the term BPD should be renamed following the core symptoms: impulsivity and emotional dysregulation. *Emotional Dysregulation Disorder* or *Emotional Regulation Disorder* are the proposed options (Linehan et al., 1994). Also, in the report *Worthless or Wonderful*: *The Social Stereotyping of Persons with Disabilities*: *Status of Disabled Persons Secretariat Department of the Secretary of State Canada* (1988), it is recommended that,

> "Language which suggests negative or judgmental confrontations be changed to more objective terminology, the term BPD suggests the judgmental connotation that the personality of the patient is flawed. Since personality is viewed as the essence of who we are, the inference of a flawed personality is very insulting, therefore according to the latest recommendation on proper language use in referring to a person with disabilities, BPD does not meet current standards" (p. 30).

The use of negative language has been proved to play an important part in stigma and to significantly influence individual and public attitudes regarding mental illness. Dahl (1993) in *The Role of the Media in Promoting Images of Disability* asserts that this often constitutes "a major barrier for people with disabilities." However, even

with progress being made to use less stigmatizing terms, psychiatry has not kept up with these changes and the label of "Borderline Personality Disorder" is such an example.

Characteristics of Borderline Personality Disorder

Borderline Personality Disorder (BPD) diagnosis remains difficult and confusing. Further studies regarding aetiology and prognosis could contribute to making this disorder more understandable both for the professionals and for the person who suffers from it (Paris, 2007). The philosopher Gabriel Marcel (1956) gives a picture of a "broken world" where people see each other only through the actions or roles they perform in society and lose the close relationship with the human being itself. This creates high levels of emptiness and loneliness that could be seen as another possible explanation for the difficulties people can perceive in society. This was also substantiated with the research where the aspects of emptiness and loneliness are often indicated on people diagnosed with BPD (Salzman, 1998; Koldobsky, 2005). For instance, the recent study conducted by Leontieva and Gregory (2013) examined the characteristics of BPD patients in a hospital setting. The patients significantly had multiple short-term hospitalization, severe self-harm and impulsive behaviour and required crisis intervention. The study showed that BPD patients are associated with more frequent admissions and numerous management challenges, suggesting the need for comprehensive screening, coordination of care, and specialized treatment programming to improve their social skills and self-control.

Considering the prognosis and how it is currently seen in relation to the BPD diagnosis, many studies have established that in the long term, the prognosis of BPD patients is a better one than is often assumed as the majority of patients have been seen to improve over time (Links et al., 1990; Stone, 1993). In a study, two thirds of BPD

patients treated at a New York psychiatric clinic were found, after a long follow-up, to be clinically well (Stone, 1993). Another study conducted in Holland by Giesen-Bloo et al. (2006) explored the use of schema therapy in the treatment of BPD. Results have shown that BPD symptoms decreased over time. Patients in their study functioned significantly better after the first year of the study and there was continued improvement in subsequent years (Giesen-Bloo et al., 2006).

A research study carried out at Pittsburgh University in the US has shown that BPD patients presented a high index of suicidal thoughts (3-10%) with 62% exhibiting some type of suicidal behaviour and almost 50% inflicting self-harm (Kelly et al., 2000). Research also indicated that BPD diagnosis could be considered chronic and may improve only slightly as life progresses; 60-70% of patients maintained the condition 2 to 3 years after diagnosis , 57-67% in 4 to 7 years and only 22-44% were able to maintain the BPD diagnosis after 15 years (Koldobsky, 2005).

Aetiology factors

Following the group of professionals and literature that accept the existence of Borderline Personality Disorder (BPD) there are many pathways to the development and explanation of the aetiology of the disorder. Firstly, the causative factors related to psychosocial functioning are: a history of sexual abuse; disturbed relationship with one or both parents (Waldinger, 1993; van der Kolk et al., 1994; Levy, 2005); early separation and losses; and insecure attachment (Zanarini and Frankenburg, 1997).

Furthermore, the severity of childhood sexual abuse (Zanarini et al., 2002) and early deprivation of sexual abuse by primary caretakers (Links, Steiner, Offord and Eppel, 1998) also linked with the disorder severity which eventually impairs psychosocial functioning. Although there is general agreement that these factors

influence BPD development, how these factors interact still remains largely unknown. How these factors exacerbate existing personality traits are also unknown (Cohen et al., 2005).

The second view was based on the largely accepted view that personalities are structured by complex interaction between characterological factors (life events and development) and temperamental factors (constitutional components, genetics) (Gabbard, 2099; Skodol et al., 2002; Livesley, 2002; Soloff, 2007; Specht 2009). Further, studies in general indicated that more or less than 50 percent are heritable while the rest are external factors (Livesley, 2002). Since genes required environmental factors to activate behavioural expression, it is still challenging to say which prominent factors are related to the personality development. Thus, development of BPD is multi-factorial based on such things as culture, upbringing, neurobiology and genetic influences, but all depending on the individual loading experience and complex ideographic combination. This implies that there are multiple pathways; neither psychoanalytic nor genetic views have given clear and valid explanations of BPD diagnosis and understanding of these factors has burgeoned in the last two decades (Cartwright, 2008).

On this point, Paris (1994) stated that social integration is a protective factor employed to mask BPD and social disintegration or big changes, especially if they are abrupt and risk its appearance. Oldham, in his article entitled *Guidelines for the Treatment of Borderline Personality Disorder* (2005) published by the American Psychiatric Association (APA), mentioned new studies of genetic neurobiological and psychosocial factors and examined different possible aetiologies of BPD. It is important to highlight that even though the heritability of BPD is thought to be important, until now no genetic risk factors specific to BPD have been found (Distel et al., 2009).

On the other hand, studies focusing on socio-emotional factors indicated a link between childhood abuse and neglect as common characteristics in borderline patients (Barnow et al., 2009). Some researchers in the US have shown that up to 87% of Borderline patients have suffered from some kind of childhood trauma (Gunderson, 2009), the most common ones being sexual abuse (30–70%) and physical abuse (25-71%) (Perry and Herman, 1993).

The majority of the research conducted on childhood abuse seems to concur with the idea that the severity of the consequences of the abuse depends on the stage of psychological development reached by the child when it occurred (Van der Kolk et al, 1994). For many professionals in the field of mental health, the immaturity at a cognitive level when the trauma occurred makes it almost impossible for the child to understand and process it. Any type of abuse not only gives us an idea of how this child could develop but also shows us the types of environment and relationships with an incapacity for care or protection to which the child was exposed (Herman, Perry and Kolk, 1989).

Trauma and neglect seen in Borderline patients are usually linked to their difficulties in modulating or regulating their emotions (van der Kolk et al., 1994). Studies have linked childhood sexual abuse with the appearance of self-harming behaviours in adults that suffer from BPD (Herman et al., 1989). For example, self-harming behaviours, such as cutting, are commonly described by Borderline patients as a painless experience. This has been interpreted by some studies as a dissociative state that, in combination with a severe childhood trauma, has led researchers to see Borderline Personality Disorder as related to post-traumatic stress disorder (Zanarini et al., 1989).

These findings are leading some researchers and practitioners to view BPD as a

form of "chronic post-traumatic" disorder (Ryle, 1997). However, no substantial evidence is available to confirm that childhood sexual abuse alone is sufficient for the development of this disorder; other childhood factors, especially difficulties in maintaining stable attachments have also been judged as important in the development of the disorder.

Patients with BPD often reported increased concern about the possibility of losing their primary attachment figure such as a parents or caregiver (TARA, 2009). The fact that there is a high incidence of childhood sexual abuse among BPD patients led the researchers to simplify the aetiology of this pathology (Zanarini et al., 1989). This is an example that points to the necessity of achieving a better and deeper understanding of this disorder. There is also a need to understand that personality features are not pathological *per se* but they tend to change from adaptive to maladaptive depending on the circumstances with which the person has to cope (Koldobsky, 2005).

Genetic factors

Several studies conducted previously have confirmed the relationship between a diagnosis of BPD and genetic predisposition. However, these studies did not provide clear biological markers. For instance the study by Zanarini et al. (1998) showed a direct heritable link with people diagnosed with BPD in their family studies. Similarly, a 35% concordance with monozygotic twins, but only 7% with dizygotic twins, was found in the study by Torgensen et al. (2001). A heritability of 0.69 was found in one of the best fitting models, which is one of the highest genetic indicators, while impulsivity (Skodol, 2009) and affective instability accounted for half of the variance (Paris, 2005). Impulsive aggression and emotional dysregulation are both predominant traits that contribute to the higher rate of mortality in people diagnosed with BPD (Siever, 2002;

Skodol, 2009). Such situations and behaviours are often characterized by emotional instability, *existential* dilemmas, uncertainty, anxiety, conflicts about sexual orientation, and social pressures (Leihener et al., 2003). Studies also supported that aggression in BPD is also due to the underlying genetic vulnerability (Siever, Torgensen, and Gunderson, 2002). Empirical studies have found a strong association between diagnosis of BPD and neuroticism. This led researchers to think that other dominant genetic effects may also influence BPD features (Widigier et al., 1994). Siever (2002) suggested the possibility of looking for underlying endophenotypes to help measure some of the characteristics that reflect underlying genotypes rather than the diagnosis itself.

Neurobiological factors

The diagnosis of BPD is a disabling disorder characterized by poor impulse control and effect regulation. Several studies have been conducted previously on genetic, neuroimaging and neuroendocrine relevant to the diagnosis of BPD. A recent study in the striatal activity subject by Perez-Rodriguez and others (2012) indicated that the mass of white and grey matter located at the front of the thalamus in each cerebral hemisphere might contribute to social aggression in BPD patients. Male, but not female, patients showed a reduced striatal relative to Glucose Metabolic Rate (rGMR) during an aggressive behavioural task.

The use of neuroimaging in the study of the diagnosis of BPD is a recent development and some studies linked BPD diagnosis to the amygdala and the limbic system of the brain (the centre of control of emotion and impulsive reaction). Investigations showed that the hippocampus and amygdala are 16% smaller in BPD patients suggesting that experiences of trauma might be the cause of this neuroanatomical change. The possibility of trauma correlates to the exhibition of

impulsive and dangerous behaviours in BPD patients (Lis et al., 2007).

Previous studies reported that 14% of BPD patients suffered a cranial trauma, encephalitis or epilepsy and 26% presented attention deficit syndrome (Andrulonis et al., 1984). Van Reekum et al. (1993) found that 44% of a sample of males with BPD diagnosis had a history of deficit in their development and 58% showed a trauma in the brain.

Functional magnetic resonance imaging was used to record activity in the brains of 19 BPD patients and 17 mentally healthy individuals. As the subjects examined photographs of people crying, smiling, acting violently and making sexual gestures, the researcher found that the unpleasant images elicited much more activity in several regions of the brain of BPD patients compared with those of healthy volunteers, with more blood flowing into the amygdala of the former than the latter (Koeningsberg, 2009). The areas involved included those implicated in basic virtual processing as well as the amygdala, which governs emotional reactivity. This pattern of activation suggests that BPD patients may react not only more strongly but also faster to disagreeable images giving them less time for rational reflection (Scientific American Mind, 2010).

Neuroscientist King-Casas et al. (2008) suggested that people with BPD often lack the brain activity that, in most people, interprets social gestures such as those that signal trust. He found that an area of the brain called the "Anterior Insula", which is highly responsive in healthy participants, is much less responsive in BPD patients. The "insula" generally monitors interactions with others, but BPD patients seem to lack this gauge. This could be used to understand or explain the difficulty people with BPD diagnosis have in perceiving actions in others as trustworthy. As a result, BPD patients may not feel that they can trust others, although there is not a conclusive argument of these ideas until now.

Positron Emission Tomography (PET) scans have generally shown that people with BPD present hypo-metabolism of glucose in their pre-frontal cortex and limbic system compared to people who do not have BPD. This suggests that BPD diagnosis might result from a failure of the pre-frontal cortex to regulate the limbic system (De la Fuente et al., 1997). Also, Zanarini (1994) found subtle abnormalities in the EEG of BPD patients. Structural Magnetic Resonance Imaging (MRI) studies helped the researchers to demonstrate the reduction of volume of cerebral regions related with affective regulations, like Anterior Cingulated Cortex (ACC), hippocampus and amygdale that perhaps constitute part of the neural substrate of BPD symptomology (Lyoo, Han and Cho, 1998, Elst, Besslinger, Thield, Geiger, Haegele and Lemiux, 2003;Carison K, Gaunsom K, Wood Sj, Yuen HP et al. 2008; Ruocco AC, Armirthavasagam S, Zakzanis KK; 2012). For instance the recent study by Thabat et al. (2014) showed significant cortical abnormalities in the fronto-limbic and paralimbic regions of both hemispheres among patients with BPD in comparison to controls (Arajo, et al, 2014). Magnetic Resonance Imaging (MRI) helped the researcher to study the volume of structures in the brain with a clear distinction between grey and white matter, and cerebro-spinal fluid (Montes et al., 2003). Lyoo (1998) compared images of the frontal and temporal lobes, and the lateral ventricles; overall cerebral hemispheres demonstrated that BPD patients showed significantly reduced (6.2 %) frontal lobe volume compared to a non-diagnosed group. With these results, he suggested that reduced frontal lobe volume in BPD patients may be related to difficulty controlling impulses. Some biochemical results showed that BPD patients have low serotoninergic activity, a deficit that could explain these patients' impulsivity problems (Coccaro et al., 1998). [1]

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[1] See appendix five (5) for more studies regarding biological aetiology of BPD.

In summary, research on BPD diagnosis has suggested a possible dysfunction in the brain (pre-frontal area, limbic system, hippocampus among others) in people diagnosed with BPD. A "frontal dysfunction" could cause a disinhibiting behavioural syndrome and lead to acting out of behaviours in these patients (van Reekum, 1993). This type of "frontal brain dysfunction" could generate impulsivity, and a reduced capacity to regulate emotions. It could also present cognitive difficulties and a clear possibility of a psychotic syndrome or episode, all of which are characteristics of BPD diagnosis (Bergvall, Nilsson and Hansen, 2003). Thus, impulsivity, aggression and dysregulation in emotions that lead to social and relationship problems could be caused by this brain dysfunction and be exacerbated by childhood experiences (Distel et al., 2009).

Gender Bias

The importances of cultural factors that underlie the difference in the prevalence of severe personality disorders have been suggested by Akhtar (1999). For instance, the lower prevalence of antisocial personality disorder might be due to intense social control of women's activity. Women are more emotional, relationship dependent and relationally defined than men and thus, eventually leading to their expression of mental illness (Wright and Owen, 2001). Further Horsfall (2001) argued that BPD is a gendered construct while the term "gender" is inconsistently used in health and illness literature. The post-feminist movements cited BPD diagnosis as a label of oppression, a contemporary equivalent to the "witchcraft" label for women who do not fit into the confines of society. There are also many social constructionist thinkers who dismiss the "existence" of BPD diagnosis entirely (Biorklund, 2006).

Furthermore, there is a bias in reporting BPD diagnosis which is noted in the study by Widiger (2011) where he differentiated different forms of sex bias including

biased diagnostic criteria, instruments of assessment and diagnosed constructs. However, studies concluded that there is modest support in methodological difference that would explain the difference in prevalence of BPD diagnosis based on gender but these studies showed that there is a possibility that sociocultural and biological factors may account for the difference in gender.

Socio-Cultural Factors

The majority of theories that seek to explain the cause of BPD diagnosis focus on psychoanalytical or biological ideas, but others believe that the cause originates within the social cultural arena (social constructionists).

According to Millon (2000) these factors explain the 'contemporary BPD epidemic. The social constructionists' approach, BPD diagnosis is not "real" in any objective sense but rather is created by the purposeful action of "social labellers and problem finders". Brown (1995) provided a framework of BPD diagnosis, which is constructed socially involving various social forces. His framework includes a condition that is real (disease entity or disorder) that is either accepted or not accepted as a biomedical category, and a biomedical definition that is either applied or not applied. In essence Brown noted the changing nature of diagnosis. However, his framework is helpful to understand the tension between biological psychiatry and psychoanalysis. Cultural factors also seem to influence the development of BPD. The values placed on being independent in western culture exacerbate feelings of emptiness, isolation and others related to identity disturbances (Alarcon and Leetz, 1998). However, some studies showed that this might act as a protective factor (Millon, 2000). Social factors may not be direct causes of BPD but could be instrumental in its development (Sullivan, 1964; Young, 1994). Paris (1994) argued that while social integration is a mitigating factor against the appearance of BPD, social disintegration or major social changes,

especially if they are shocking, are important factors in the appearance of BPD.

Linehan (1993) described BPD clients as emotionally imbalanced and explained the condition as resulting from emotional vulnerability and an incapacity for self-regulation. She explained that this could be a consequence of an invalidating childhood environment in which the child did not learn how to cope with high levels of frustration. Because his/her emotional responses were not validated the child does not know how to feel in his/her external environment (Linehan, 2007). High social demands and lack of opportunities for generating relationships could increase this emotional instability. In addition, Linehan (1993) stressed that in an integrated social environment genetic vulnerability, traumatic experiences and dysfunctional families could be neutralized by actions in the community.

For Millon (1995) the anomy that characterizes contemporary society has a significant influence on young people and could be a crucial factor for the appearance of BPD. Another important factor for Millon (1995) is related to rapid social changes that interfere with the influence of extended families in the community. He argued that the lack of identity exhibited by BPD patients is the result of bio-psycho-social factors that do not allow for the normal development of an identity. This could explain both BPD patients' dependence on others in order to feel protected, and their high levels of anxiety about possible abandonment. Paris (1994) proposed to understand BPD by considering social risks as central elements in its appearance.

Although social aspects may not be direct causes of BPD, they could, however, be an important factor in its appearance. The lack of structure in society, changes in the role of women, the loss of contact with our past and the development of technology are all observed as possible factors that could contribute greatly to the development of BPD (Marcel, 1956; Masterson, 1981; Straus, 1989; Kreisman, 1991; Lipovetsky, 2003).

There are different theories regarding BPD aetiology and each of them lends importance to some aspects of a person's development. However, in order to have a better and more comprehensive understanding of the BPD aetiology, Zanarini (1989; 1993) suggested for each theory and/or model's main contribution(s) to be considered and reviewed as part of a bigger picture of the BPD aetiology.

Theories of BPD: Diagnosis, Assessment and Treatment

There are many theoretical approaches that have tried to explain the psychological difficulties, traumas or problems that could affect or contribute to the appearance of Borderline Personality Disorder (BPD). Studies from the past decade have given importance to childhood and traumatic experiences in particular as the possible cause for the development of Borderline Personality disorder. Two of the distinctive and significant theories and/or perspectives recognized by both researchers and practitioners in mental health are psychoanalysis and existential psychotherapy. Both will be explained and described below.

1. Psychoanalytic Perspective

Several theories with a psychoanalytic perspective related to Borderline Personality Disorder could be found in the literature. In this research, psychoanalytic theories, in particular the ones of Bowlby, Fonagy, Kernberg, Mahler and Adler have been chosen because of their important contribution to the understanding of the relation between mother/carer and child and the developmental implications.

a.   Attachment Theory: Bowlby's Theory

The attachment theory provides an excellent framework to understand both emotional dysregulation and interpersonal relationships in BPD diagnosis. This theory

offers a developmental perspective and according to Bowlby, styles of attachment are: relatively stable relational pattern; expectancies about self; belief; and others that are rooted in early experiences with caregivers and that act as model for later interpersonal interaction. Thus, the theory was explained with the relevance of the interrelation between the child and mother to the development of personality (Bowlby, 1973; 1988). Bowlby explained that in the early years of a child, when the child is trying to achieve self-regulation, the mother functions as his/her ego and superego. During childhood the capacity to self-regulate is still in process, so at this stage, the child is dependent on his/her mother for help. The mother has an important role helping the child to be orientated in space and time and fulfilling some instincts while repressing others. For this reason, Bowlby defines the mother's role as the ego and superego of the child. With "normal" development in childhood, it is expected, at some point, that the parents will let the child to play these roles for him or herself. It is a process that every child needs to go through not only in order to achieve self-regulation but also for the coping skills with regard to relationships.

For Bowlby, in order to grow up mentally healthy the child should have experienced intimate and affective relationships with his mother or close carer, where both have experienced deep enjoyment and satisfaction in the relationship (Bowlby, 1951). Further through the use of strategies such as self-soothing, problem solving and reappraisal, secure attachment promotes the ability to regulate one's emotional effectiveness (Shaver and Mikulincer, 2007). It is then logical to think that any type of trauma, abuse or neglect in childhood could affect the "normal" development of a child and generate different types of disorders including Borderline Personality. Although insecure attachment does not appear to be any single category, several studies supported a strong association between attachment anxiety (particularly hyperactivation) and BPD

(Levyu, 2005; Meyer and Pilkonis, 2005; Selby, Ward and Joiner, 2010)

Despite this relationship, controversy still exists on this relationship as emotional dysregulation represents a central characteristic of all personality disorder thus creating overlap among PD diagnoses (Zimmerman, Rothschild and Chelminiski, 2005; Scot et al., 2013).

However, this theory yielded mixed findings due to the overrepresentation of preoccupied and unresolved issues seem to be overrepresented in other clinical groups. Moreover, attachment theory was developed based on the personality development (Bowlby, 1980) that links with adult attachment. The studies revealed aggressiveness and impulsivity as core features of BPD (Links et al., 1999). However, the application of these theories (features) to children and infants showed significantly higher aggressive behaviour than those with secure attachment. Based on these findings Fonagy (1991) assumed that the capacity for mental representation of the psychological functioning of others and self is closely related to the subject's attachment style. Previous studies that tested the association between BPD with adult attachment patterns revealed a significant predictor of BPD especially among adults (Fonagy and Higgitt, 1989; Fossati, Feeney, Carretta et al., 2005).

b. Kernberg's Theory

For Kernberg (1975) there is an inability to maintain libidinal object constancy that gives rise to a difficulty to integrate the good and bad aspects of the object. This is the basic problem for BPD patients. Libidinal object constancy is the capacity to maintain an emotional image of the mother as being basically good, but as having both good and bad qualities. It is an emotional image that changes little under frustration or during a mother's absences (McDevitt, 1975). If a child experiences a high level of frustration in the early years of life, significant aggressive impulses that inhibit the

child's separation-individuation process will be generated. These will, in turn, produce a need to split the feelings towards the object preventing the achievement of a healthy child-object relationship. Kernberg argued that the child tends to organize his/her experiences according to the way he/she perceives them - positive or negative influences. This leads the child to perceive *good* or *bad* in a rigid way (Kernberg, 1975).

For Kernberg (1975; 1984) the possible cause of BPD could be explained by an excess of anger in the child caused by the mother's abandonment (real or imaginary). From a pathological point of view, the difficulty of object internalization and the use of defence mechanisms, such as splitting, would cause adult relationships to be seen as good or bad. This difficulty in being able to integrate good with bad could generate a lack of self-sense. This is something that is seen as an important feature of the psychopathology of BPD.

c. Mahler's Theory

Mahler's theory of separation-individuation contributed to the understanding of the first three years of a child's life and their effect on his/her later development (Greenberg, 1983). It not only explains the interrelation between mother and child or object relations, but also describes the importance of affective experiences for the development of our psychic organization. In the individuation phase, the child does not present "constancy of the object" (where 'object' means the significant person that is the object or target of another's feelings) so he/she cannot integrate the good and bad aspects of himself/herself and the mother. The concept of object constancy refers to the capacity of maintaining a lasting relationship with a specific object (mother or carer), to tolerate both loving and hostile feelings toward that same object. Also, to keep feelings centred on a specific object and the capacity to value an object for attributes other than its function of satisfying needs.

Mahler (1972) proposed that at the same time as the child is achieving autonomy from the mother, he/she is challenging the "good mother" who is trying to maintain intimacy. The child therefore develops ambivalence towards the mother, veers between intimacy and distance and tries both to maintain the security of the mother and his/her autonomy.

Mahler (1975) also expressed interest in some similarities he detected between the psychological vulnerabilities of BPD and issues regarding the separation stage in childhood. He hypothesised that a possible cause of the Borderline personality structure could be psychological difficulties in the rapprochement sub-phase of the separation-individuation process. This situation makes it almost impossible for the person to modulate or control his/her emotions - especially anger -or to be able to integrate the good and the bad in others and himself/herself. However, further research using this model has not proved that such circumstances will necessarily give rise to a BPD diagnosis in all children (Saunders and Arnold, 1990).

d. Adler's Theory

Adler (1985) explained BPD using a model of the *Deficit* model. He argued that inconsistency in the mother's behaviour and her variable availability could give rise to the difficulties in developing the internalization of an object that BPD patients present. This generates feelings of emptiness and a tendency to depression and anger. Adler agreed with Kernberg´s observation that BPD patients have difficulty integrating good and bad aspects of the self and the objects around them (Clarkin and Lenzenweger 2005).

But Adler diverged from Kernberg´s view as he considered that this difficulty originates during a later stage of development. He also disagreed with the notion that this difficulty is the basic problem for BPD patients. He argued instead that instability

of function in relation to specific introjections is the fundamental difficulty for these patients (Adler, 1982). These specific "holding introjections" help the person to find something to hold onto and relieve him/her of the necessity to be constantly approved or reinforced. For Adler, Borderline patients cannot develop a stable level of holding introjection, thus they depend on others to give them holding and security (Ewen, 1993).

To sum, most of the psychoanalytic theories that have attempted to explain the origins or causes of BPD focused on the relationship between the child and the person who cared for him/her during the first years of life and development. One of the most studied periods is that from the 18th to the 30th month, when the child is trying to find his/her own individuality (Mahler, 1958; Bowlby, 1969). In cases where the parent-child relationship is disturbed by parental loss or traumatic separation, BPD is seen as a possible result (Millon, 1995). Waldinger (1993) pointed to the compatibilities between the Adler's and Kernberg's theories and suggested that both highlight the two most common problems in BPD patients: 1. the inability to hold on to something to achieve stability and security, and 2. the difficulty in integrating good and bad aspects of objects.

2. Biosocial theory

The main theory dominated in the diagnosis, assessment and treatment of BPD is the biosocial theory proposed by Linehan (1993). This theory suggests that emotional deregulation is the core feature of BPD, which is developed based on a physiological vulnerability to hyperarousal and hyperactivity, in combination with poor childhood circumstances such as being ignored or punished for emotional expression. Several studies validated this theory from self-reported measures (Sookam and Parim, 2007;

Links, Eyan, Heisel and Nisenbaum, 2008) but due to the limitation of self-reported measures there is a high possibility that results obtained can be skewed to multiple biases such as impression management, accuracy of memories and mood state (Podsakoff et al., 2008; Cavazzi and Becerra, 2014)

Anthony Bateman and Peter Fonagy developed Mentalization Based Treatment (MBT) for BPD. The process of mentalization is "by which we understand ourselves and others with reference to subjective states such as feelings, thoughts and wishes and close links between these and our behaviours". However, such ability is not innate; it must develop in a secure attachment context" (Quintero and Vega, 2012). Bateman and Fonagy (1999) examined the effectiveness of Mentalization model and found the model proved to be effective in decreasing self-mutilating behaviour and suicidal tendencies.

On the other hand Cognitive Analytic Therapy (CAT) sees attachment security as a necessary but not sufficient condition for normal development while at the same time attachment has a function far beyond the provision of safety. The model focuses on the Reciprocal Role Procedure (RRP), which is acquired in early relationships; especially those with care takers but also with other children and siblings. The concept of the procedure unites actions, communications, effects, cognitions and dialogue. However, studying these elements limits the diagnosis and treatment of BPD, as BPD is characterized by the narrow and predominantly negative range of RRPs.

3. Existential Approach

One of the most important contributions of the existential therapeutic approach is the comprehension of the person in his or her world (Kierkegaard, 1954; Marcel, 1956). This approach is based on the general understanding of existentialism that considers that the *existence* of a human being precedes his or her *essence* (Sartre, 1943).

In his book *Existence* Straus (1994) emphasized the importance of understanding each patient's world. In other words, the actual life of each human being and how she or he defines it is what constitutes a human being's individual true essence rather than attributes used by others to define him or her. Straus's argument is applicable to any patient with an emotional or psychological disorder, even so to the understanding of human beings in general.

Furthermore, Binswanger (1963), an existential psychiatrist, argued that professionals have tried to describe and analyse patients' difficulties in relation to their lives in the world, instead of focusing the attention on the patient's world. The therapy used is not a specific technical approach; rather it defines a new set of rules that asks deep questions such as the nature of anomy, isolation, loneliness, grief, despair and anxiety. Further, it also deals with the questions of love and creativity and endeavours to be this "deeper and more discerning" type of therapy. The dynamic existential approach retains the basic dynamic structure proposed by Freud but with a radically different context.

Both existential and psychoanalytic approaches emphasise anxiety at the centre of the dynamic structure while it fuels psychopathology where both unconscious and conscious psychic operations, developed to deal with anxiety which provide safety, at the same time restrict growth. Freud focuses on drive while existential begins with awareness and views the individual as fearful rather than driven. The following section describes Binswanger's (1972) existential perspective, including three dimensions - physical, psychological and social - in an attempt to describe and understand patients' experiences with BPD, including associated challenges and controversies.

Binswanger Psychopathology Perspective

For Binswanger, a scientific conception of human behaviour could result in the depersonalization of the human being. It is the perceived notion of the human being as an object that can be broken up in parts, rather than a whole being and his/her whole existence (Frie, 1997). Binswanger's phenomenological ontology identified three modes of being-in-the-world. These are: (a) the *Umwelt*, which constitutes the environment in which an individual exists, (b) the *Mitwelt*, which is the world of social relations, and (c) the *Eigenwelt*, which is the private and intra-psychic element of being-in-the-world (Binswanger, 1972; Frie, 2000; Mills, 2004).

Although the three modes are interrelated, each presents its own purposes and challenges (van Deurzen, 1997). As Binswanger (1963) explained, consciousness (existence) is neither separated nor isolated from the physical world; we are our body and our body is us; we perceive, think, feel and act with and through it. It is important to understand that a man's world is more than the description of his environment; that is only a part of his whole world (Binswanger, 1972).

Binswanger insisted that the person and world exist as one entity, so the aim should be to understand the human existence by analyzing the person and world as a whole, *Gestalt*, as one unique existence. Thus, in psychopathology, researchers and practitioners with an existential approach focus on the understanding of the human being as it is presented by Binswanger's three modes of being-in-the-world (Ramsland, 1989; Frie, 2004):

a. The Umwelt:

This dimension explains how the body interacts with the world, and with the environment. All human beings have an *Umwelt*, the world of natural laws, where the instincts, necessities and vital cycles are located. As Sartre (1957) and Heidegger (1951) explained, human beings are thrown into this physical world and have to adapt to it.

They find meaning through a sense of efficacy in this dimension. Some developmental theories explained an early aim in children to achieve a level of independence and a sensation of integration with the world (Mahler, 1975). This achievement also shows us the limit of our existence, something that people can find difficult to accept.

When the physical dimension is observed, the body requires substances from the physical world which, when found, provide pleasure. However, before this satisfaction is achieved, a sensation of need can produce anxiety. A person who has accepted his or her physical being can understand anxiety simply as a warning that the body is in need of something to restore balance (Cooper, 2003).

BPD patients do not perceive anxiety as a temporary state (Gratz, Rosenthal et al., 2006). They do not believe that balance will be recovered as soon as the body receives the substances needed; this causes high levels of anxiety (Bohus, Limberger et al., 2000). Based on this perspective, if a BPD patient decides to move into a path of searching for balance and erasing anxiety, he or she then moves into the social dimension (*Mitwelt*).

b. The Mitwelt:

This is the world of our relationships. The most important or relevant thing about this world is that, in any human relationship, the interactions between its members determine the personal meaning in the group. The meaning that a group has for that person depends on the attitude he or she has in the group (Binswanger, 1963). Just as human beings exist in a physical world, so too, they live, for the most part, in constant relationship with other human beings.

In the *Umwelt,* the necessary adjustments are related to their adaptation to physical changes in the environment, while in the *Mitwelt,* the necessary adjustments are concerned with "relationships". Human beings cannot expect others to adapt to them

or change in order to have a relationship with them. It is shared work and they need to adapt in order to co-create a relationship that will affect them all (May, Angel and Ellenberger, 1994).

Based on this perspective, it could be interpreted that often, many BPD patients struggle to achieve this level of acceptance. Perceptions commonly remain at the level of good or bad leading to volatile types of interactions and expressions of affection towards others (Gunderson, 1996; Levine, Deborah et al., 1997). Studies have indicated that most BPD patients present difficulties creating stable patterns of social abilities, in other words, they lack the ability to create equal relationships with others because they see others as objects rather than independent subjects of love and support (Blizard, 2003; Domes, Weidler et al., 2008).

As a result of their anxiety and fear of abandonment, BPD patients are constantly seeking new relationships to fulfil them (Linehan, 1993; Benjamin, 1996). Knight and Bradfield (2003) observed that many BPD patients manifest extreme feelings; everyone is either good or bad, and as a result, it is quite a challenge for them to learn new ways of interaction.

c. The Eigenwelt:

This dimension is a world that implies self-consciousness and self-relationship. It is through relationships that human beings differentiate from others and recognize their own existence and consciousness (Binswanger, 1972). This need for recognition has been compared to Freud's narcissistic stage in which the child needs to be *the only one* and where there is nothing outside the child that he or she cannot control (Neu, 2003). It is a developmental process in which the child ends up recognising that his or her carers have emotions and feelings similar to what he or she experiences but the carer has a separate being and mind. The child also begins to realise that the carer is not

necessarily in agreement with him or her all the time, creating the first breakdown or conflict between *self* and *others* (Linehan, 1993)

Considering this mode could help to understand why many BPD patients remain at the initial stage and struggle with separation. Many reach adulthood without fully developing their independence, thus exists a challenge in their lives to relate with others and consequently the need to receive attention and acceptance (Bretherton and Munholland, 1999).

Because of their extreme feelings, BPD patients could manifest insecurity in their relationships. Thus, they detach from others to protect themselves, or they could express devotion to others, accepting to do things for others so they could keep that person in their lives (Kodolbsky, 2005). Both extreme behaviours demonstrate the need for others in order to feel secured and loved, as well as achieve a sense of acceptance (Masterson, 2005).

Existential Psychotherapy and Personality Disorder

The existential psychotherapy approach to personality disorder attempts an ontological explanation of the disorder as opposed to the psychoanalytic perspective that could be seen as an ontic analysis of the disorder. Existential psychotherapy tries to use inter-psychic or inter-relational ideas to explain the personality, and sees it as a dialectic concept (Amorim and Montenegro, 2013). Dreyfus (1983) argued that *character problems* occur when some aspects of a person's way of relating to objects in the world become part of the context the person is involved with. When this happens, the person's world becomes restricted or rigid.

A patient with a group of difficulties that could be seen by psychiatrists as a personality disorder could be trying to avoid existential anxiety related with the existence of being and his or her relationship with others. Patients with personality

disorders tend to see their personality traits as inflexible and rigid, which they cannot change through experience (Young, 1999). These rigid patterns are reflected in the way patients relate with the world and could generate difficulties in each of the existential dimensions presented by Binswanger (1963).

Research has indicated that people who have been diagnosed with a personality disorder often express a lack of meaning in life, difficulties in relating with others, and a lack of a sense of being part of the world (Gunderson, 1984; Linehan, 1993). BPD patients in particular are susceptible to suffering from anxiety and struggle to let the life process flow as they need to control everything in order to feel secure (Koldobsky, 2005). Most BPD patients also see others as objects that fulfil them on some emotional or physical level (Drapeau and Perry, 2004). Often, relationships are therefore based on necessity and are not a reciprocal exchange of emotions; consequently they generate a sense of isolation and separation from others (Buber, 1923; Luijpen, 1969; O´Donohue, 2007).

The existential psychotherapy approach suggests that human existence comprises more of the various relationships a person could have with the world in all its dimensions to achieve a deeper understanding of the way he or she experiences the world (Laing, 1960; van Deurzen, 1997; Spinelli, 2005;). As human beings, we are not isolated in the world. In order to survive in it, we need to fulfil environmental needs and we also need to be capable of being with other human beings (van Deurzen, 1997). Therefore, it is important to observe the ways in which we relate to the world, how we relate internally and how we create ourselves as interdependent beings (Binswanger, 1972).

Heidegger (1957) stated that it is only through the observation of ourselves as part of the world that we exist. Heidegger (1957) also pointed out that it is important

that any person interested in researching human beings preserves the existence of the man, the subject being studied. A patient's experiences, subjectivity, ways of reacting, as well as the understanding of situations should be always considered important dimensions when studying the human existence (May, Engel and Ellenberger, 1967).

Psychiatric Diagnosis and Stigmatization

As a discipline, psychiatry appeared in the 19th century and was critically attacked in the 20th century because of the political processes that were involved in the discipline (Szasz, 1961, 1973; Laing, 1967, 1982; Goffman, 1968; Rosen, 1968). Psychiatric diagnosis received criticism for diverse reasons, including ethical, clinical and socio-emotional (Geekie and Read, 2009). Since then, humanizing mental health treatment has long been an important aim for many professionals in the field.

The predominant framework for studying mental disorders in psychiatry is known as "the medical model, the biomedical model or the disease model" (Kiesler, 1999). The medical foundation puts mental and physical illness as equivalent in all respects. In this sense, mental illness is formulated in terms of a functional psychosis, most likely the consequence of a neurophysiological disorder, and therefore conceived of, and classified in terms of, a physical disease (Szazs, 1987; Bradfield, 2006). Thus, terminologies that have been supported by professionals in mental health have been involved in great controversy.

The psychiatrist Thomas Szazs (1961) challenged the concept of mental illness expressing his position regarding the use of a medical model to the explanation and conceptualization of behavioural problems, as well as the implications for the person who received a diagnosis, including the lack of freedom and the possibility of stigmatization (Szazs, 1961; Kiesler, 1999; Bradfield, 2002).

There are many studies in the field that have tried to explain or describe this

controversy. Abundant literature in this matter could be found in relation to schizophrenia and psychosis (Bannister, 1968; Boyle, 1993; Bentall, 2003; Staring, 2009). Gergen and McNamee (2001) mentioned the importance of determining the benefits to the client, for example the relief that a patient could experience knowing that the problem has been identified and the sense of hope this could bring to him or her. They concluded that it is important for professionals to reflect on the benefits and hindrances of mental illness classification before a diagnosis is given to a patient (Aviram and Brodsky et al., 2006). Thus, psychotherapists and counselling psychologists often face the challenge of dealing with difficult clients and putting aside their own assumptions and feelings in order to build productive and positive relationships with their clients and understand the clients' worlds.

Frances (2009, p.1) pointed out, "the incredible recent advances in neuroscience, molecular biology and brain imaging that have taught us so much about normal brain functioning are still not relevant to the clinical practicalities of everyday psychiatric diagnosis". Medical or psychological labels or classifications are concerned with what is explicit, substantial and concrete. The diagnostics of symptoms based on the biomedical model try to identify and classify mental illnesses as defined disease entities, similar to that of physical diseases' classifications (Bradfield, 2002).

A physical condition could be found in a specific area of the brain or body and this type of diagnosis is adequate to explain an illness. The difficulty appears when this type of labelling or classification is used to explain illnesses that do not present the same kind of physical specificity (Wakefield 1992).

The existential approach tries to understand how a diagnosis could impact in a person's world and analyse the phenomenological experience of being diagnosed from that person's point of view. Feelings of being labeled or stigmatized are common

experiences for people suffering from a mental illness (Ingleby, 1981; Knight and Bradfield, 2003 Geekie and Read, 2009). This stigmatization can be subtle or more direct – as in someone assuming you could be unstable or dangerous because of your condition.

The stigma leads to the person receiving it having to face consequences, such as discrimination at work and being bullied for example. In society, mental illness generates prejudice and fear (Commonwealth of Australia, 2005). This feeling has been expressed from participants in a Knight and Bradfield (2003) study in which the authors explained that for the participants, the experience of being diagnosed with a psychiatric disorder felt as if part of them was replaced by the diagnosis, which functioned as a new description of themselves. In the UK, the ICD 10 refers to BPD as 'Emotionally Unstable Personality Disorder'.

For Binswanger, narrowing human behaviour to a purely scientific concept results in the depersonalization of the human being (Frie, 1997); therefore a human being has to be seen as a whole and not as a collection of independent parts. Binswanger's studies, developed in 1930, contrasted with the psychiatry of that time that treated the patient as an object; he argued instead for the necessity of understanding patients in their entirety (Ghaemi, 2001). Based on the existential psychotherapy approach, any division of the mind into individual spheres fails to provide an accurate representation of human subjectivity (Laing, 1960; Binswanger, 1963; Yalom, 1980; Frie, 2000; Bracket and Thomas, 2010).

Currently, the work of Bracken and Thomas (2001) supports Binswanger's conception of mental illness and the role of psychotherapy. For these authors, there is no such thing as physical suffering without a mental connection; physical and mental aspects are both parts of our whole human existence (Bracken, Thomas, Timimi et al.,

2012). Thus, it is important to develop a way of seeing psychological problems through the lens of both the medical position and the meaning they could have for the sufferer, the patient (Bracken and Thomas, 2010).

In addition, the medicalization of deviant behaviours has generated an over-controlling attitude from medical professionals and institutions regarding tolerance, acceptance and defining what is "normal or abnormal" (Bentall, 2009). Studies in the field have suggested that levels of normality in our society are currently gauged by the responses a human being could have in relation to work and the capacity to generate profits for the society in which he is immersed (Szasz, 1961; Moncrieff, 2008; Bracken, 2010). For example, in the United States, changes have been introduced to the *Mental Health Act* (1983) allowing for patients to lead independent lives outside of mental institutions with a legally supervised discharge. The aim of this Act is not to impose medical treatment but to work on prevention and facilitate the use of mental health treatments that will provide recipients with the possibility of preventing relapses (Bracken and Thomas, 2010).

In our modern society, studies have found that people suffer from physical and mental health issues, some of which are related to existential concerns and challenges that contribute to the rapid growth of the inability to identify their being-in-the-world (Marcel, 1953, 1956; Rosen, 1986; Moreno, 2010). Foucault (1961, 2006) described modern society as a technological culture, in which psychological problems are seen as difficulties that have to be solved or fixed in a rational or technological way.

In mental health, researchers and practitioners such as Whitaker (2010) and Summerfield (2008) believed that this modern perspective reduces the possibility of exploring different positions and alternative ways of thinking about mental distress. When a diagnosis is being imposed on a group of "symptoms" or problems it is difficult

or almost impossible to think of a different way of coping or dealing with those problems (Feyerabend, 1975; Schwartz, 2002). This contributes to the continuity of seeing mental disorders as somatic diseases, the physical causes of which are waiting to be discovered (Szasz, 1970; Rogers, 2010).

In the United States, *House Resolution #1005* (United States House of Representatives, 2005) mentions that it is important to increase awareness of BPD in the general population and to promote treatments and research into this disorder. While BPD continues to be a stigmatizing diagnosis, some professionals avoid BPD patients or even dislike working with this segment of the population (Siever et al., 2002).

There is a long history of people putting distance between themselves and mental illness sufferers; this distance takes the form of social isolation and institutionalization and this is making it difficult for the general population to become familiar with the actual experiences of those with mental illness. Goffman (1963, p.60) states that, "The difference between a normal and a stigmatized person was a question of perspective, not reality. Stigma lies in the eyes of the beholder and a body of evidence supports the concept of stereotypes of mental illness".

Byrne (2000) refers to the fact that people with mental illness are frequently seen as victims. Reducing stigma requires education for community members, providing them with the knowledge that mental illness is quite common and recovery and management are possible. There is also a need for psychotherapists, counselling psychologists and mental health workers to understand that there is not a "them" and an "us", and for them to revise the way they refer to patients, how they treat them and the way services are structured and delivered (Zanarini, 2009).

Many efforts have taken place in the field of medicine and mental health (e.g., psychology, psychotherapy and counselling) to define, describe and understand BPD.

From biological to psychosocial perspectives, and all combinations in between, the term BPD has been related to genetics and environmental factors. More importantly, what BPD implies for a diagnosis of a patient with this illness is yet to be fully described and comprehended. In this effort, this study focused on the characteristics and conditions of BPD from the point of view of the patients and their lived experiences in relation to the way they perceive themselves, the world, and their relations with others.

To summarize, the above review critically analysed BPD and various factors that influenced it, and although there are several definitions and diagnosis guidelines, there are still several challenges faced by researchers and physicians. Hence, with this gap and following all these ideas and difficulties to perceive clients with BPD diagnosis in a holistic and humane way the research question of this study had the intention to help researchers to understand the life world of these participants since they received the BPD diagnosis.

Research Questions asked:

RQ: How did the BPD diagnosis change the way participants perceive themselves, the world and relation with others?

RQ2: Did the participants experience stigmatization following their diagnosis, and its impact?

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CHAPTER 3

METHODOLOGY

Theoretical Foundations

The present chapter examines the research methodology process applied in this study. However, choosing appropriate research methodology is influenced by its underlying epistemological and ontological position (Greenbank, 2003). This chapter will shed light on the ontological and epistemological positions of the thesis. This section explains the chosen approach with appropriate justification and the chosen method of data analysis appropriately and with a consideration of the alternatives and critical reflections of decisions regarding procedure.

Phenomenology is a method of investigating the essence or essential meanings of phenomena. Phenomenology is also defined as "the study of essences" (Merleau-Ponty, 1962). The word 'essence' denotes the significant meanings for phenomenon, which makes a thing what it is (van Manen, 1997). Heidegger (1977) illustrates the essence of a phenomenon as, "the way in which it remains through time as what it is".

Phenomenological research includes other essentially qualitative methods such as hermeneutics, ethnography and symbolic interactionism. There are different approaches in phenomenology, each of them differentiates from the others in the importance to interpretation or description of the phenomenon. For this study an interpretative approach was considered the more relevant as the study was not looking

for the essence of the experience, rather the meaning of the participants lived experience.

This research adopted a phenomenological-hermeneutic methodology to explore the participants' experience of being diagnosed with BPD to gain an in-depth and rich understanding of the phenomenon, and the possible changes this can bring about in the way they perceived themselves, their relationships with others and the world. Since hermeneutic phenomenology focuses primarily on personal experience, and as this study is attempting to understand how patients experience being diagnosed with BPD, it will take an epistemological position focusing on reality and the phenomenon themselves, thereby avoiding the pitfalls inherent in scientific epistemology.

Moreover, hermeneutic phenomenology attempts to go beyond description so as to determine meanings which are not immediately apparent (Merleau-Ponty, 1962). Additionally, it tries to reveal the world as experienced by the individual via their life stories. Cohen (2005) suggested that hermeneutic phenomenology deals with understanding of texts. Applying this approach and through using intuition, the researcher aims to produce a brief description of a phenomenon, by concentrating on uncovering instead of accuracy of previous knowledge. This approach underpins both phenomenology and hermeneutics (van Manen, 1990b) aimed at producing rich textual description of the experiencing of selected phenomena in the real world of individuals that are able to connect with the experience of all of us collectively (Smith, 2004).

In this study, a scientific approach would not be appropriate when interested in understanding phenomena relevant to being human. The main reason is that it is an investigation into phenomena with an epistemology founded on a philosophy of mind that decontextualizes the lived world and detached from its referential context of meaning and significance from a human experiential view point. This approach is

described as follows: "A rigorous human science is prepared to be soft, soulful, subtle and sensitive in its effort to bring the range of meanings of life's phenomena to our reflective awareness... is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the life world, and yet to remain aware that lived life is always more complex than any explication of meaning can reveal...full or final descriptions are unattainable" (van Manen, 1990, p.18). Thus, this approach requires: (1) a hermeneutic ability to make interpretive sense of the phenomena, (2) a phenomenological sensitivity to life experiences, and (3) a way with language to facilitate the research process to contribute to one's thoughtfulness and tact. This section discusses these three requirements for the research of phenomenological-hermeneutic, as well as the validity and reliability of this methodology.

Moustakas (1994) illustrated that psychological or transcendental phenomenology paid less attention on the interpretations of the researcher. Therefore, in order to understand the real life world, there is a need to explore the stories as they share their experiences, often through some method of hermeneutic way of interpretation (Langdridge, 2007).

Hermeneutic Phenomenological Research Paradigm

Ontology is concerned with reality and the study of being and Heidegger's phenomenology studies the phenomenon of being human and being in the world. In this approach, the reality can be produced by individual consciousness (Cohen, Manion and Morrison, 2000). In the case of hermeneutic phenomenological research, reality is perceived as an individual construct dependent on different situations, while epistemology refers to the notion that the research work is supposed to make a contribution to knowledge itself (Harley, 2006). Under epistemology, the adopted approach is grounded in subjective experience and insights. "Reflexivity enables the

researcher to untangle personal and theoretical commitments and scrutinize ethics and epistemology" (Kleinaasser, 2000). Values give the standard for the estimation of ontological and epistemological claims. In this association hermeneutic phenomenology regulates with the scheme of practical form of knowledge creation that moves beyond the enumeration of mathematical properties. This phenomenology is ontology as it distinguishes between its appearances (optically) and essence it produced (ontological). This paradigm sheds light on the human relationship, place and time as it is lived.

Thus, this study proposes a qualitative methodology based on the approach of hermeneutic phenomenology as it opens to redefinition, new meaning and takes an inductive approach (Willig, 2001). Furthermore, it argues that a scientific method of investigation is not appropriate when attempting to shed light on what it is to be human. The main justification for this is that investigating into epistemology-based phenomena is founded on mind decontextualized the lived world. Furthermore, the phenomenon is detached from significance from a human experiential point of view and its referential context of meaning (Heidegger 1962). According to Dreyfus (1991, p.81), "scientifically relevant facts are merely removed from their context of selective seeing: they are theory laden"

In summary, the principles of a hermeneutical phenomenological approach are considered appropriate for understanding the personality disorder between sample ages from 18 to 33-year-old patients, and also to investigate further how patients diagnosed with BPD feel, understand, and interpret their lives.

Some other approaches such a IPA or Narrative approach were considered for this study but as the aim of this study was to understand and know the phenomenon each of the participants experiences after the BPD diagnosis, CNA was selected as the most appropriate to achieve this aim. Approaches such as grounded theory, and

narrative research have in common some process that usually begins with a research problem, continues with a question, the data analysis and research reports. In these approaches the data collection uses documents, interviews and audio material but the most important difference is in relation with what they are trying to accomplish. A narrative about an individual's life forms a narrative research. A description of the essence of the experience of the phenomenon becomes a phenomenology. A theory, often portrayed in a visual model, emerges in grounded theory and a holistic view of how a culture sharing group works results in ethnography.

In this study the focus was on the phenomenon each of the participant's experiences so the epistemology behind the method corresponds to phenomenological research, but as this method also generates interpretations of the stories participants gave in the interviews, it is a hermeneutical-phenomenological study. Thus, this research approach enlightens the study design and choice of methods.

To achieve a better understanding of the procedure it is important to clarify that the Critical Narrative Analysis method is based on Ricoeur's ideas. Ricoeur (1981) tried to rectify and clarify the idea of Gadamer's (1976) hermeneutics to engage with critique using four critical features of text: (1) distanciation as a necessary and positive aspect of text, (2) the need for explanation and understanding in interpretation, (3) the role of opening new worlds in the referential moment of the text, and (4) a critique of the illusions of subjectivity. These four ideas of text in turn demonstrate the possibility of a critical moment for hermeneutics (Langdridge, 2004)

Thus, CNA method of analysis following these ideas focuses on the description of the participants' world and then the interpretation of the ideas they present. For doing this it uses a theory to help the researcher to maintain distanciation of the stories he is analysing. The essential feature of text gives the possibility of a critical distance in

interpretation, a critical distance between appropriation and distanciation of meaning. A reader does not seek to capture the original intentions of the author but instead to expand their own horizons by actualising the meaning of a text. A reader seeks to appropriate a world from the text but in front of it through expanding his or her own way of seeing the world. (Langdridge, 2004) It was the reason why I decided to use CNA as a method for this study as I was distancing the text from the participants' intentions and helping me to understand the world and the experience of them.

Finally, this method gives me the opportunity for a critique of the illusions of subjectivity. It also recognises potential errors of interpretation and provides a corrective within his framework.

Reliability and Validity

In the phenomenological hermeneutic research, there is a need to determine the accuracy and trustworthiness of research. According to van Manen (1990a, p.29) "this is a methodology that tries to ward off any tendency toward constructing a predetermined set of fixed procedures, techniques and concept that would rule govern the research project". Phenomenology uses the scientific principle that investigation should be absent from the researcher's prejudice and assumptions regarding the subject being studied (Husserl, 1977), also called *horizontalization* (Spinelli, 2005). This aspect suggests that the researcher avoids the imposition of his or her meanings to the data to provide a more faithful description of the phenomenon being studied (Spinelli, 2005).

Reliability and validity are used to ensure the credibility of research by attending to the stories of research participants in a sensitive manner and strive for utmost quality (Nixon, 1990). Since phenomenology is a descriptive, reliability was always bound to the context (Osborne, 1990). However, in order to overcome any bias, there is a need to

develop several strategies. For instance, while recording and transcribing, we need to ensure accuracy (Perakyla, 1997) and procedures need to be described meticulously (Osborne, 1990). In this approach, trustworthiness of the data interpretation is referred to as validity (Priest, 2002).

Thus, the true value is determined through the themes that emerge during the research and its impact on the reader and its influence on future research. The researcher in this type of study recognized that there is a need for an "air of humility and helplessness" (Nixon, 1990).

CHAPTER 4

CNA METHOD

Critical Narrative analysis (CNA) method was chosen for this study for the possibility to analysis presented by the participant's narratives. The ideas focuses on the description of the participants' world and then the interpretation of the ideas they present. The essential feature of text gives the possibility of a critical distance in interpretation, a critical distance between appropriation and distance of meaning.

1. Participants

Five participants took part in this study: three women and two men. All five participants had been diagnosed with BPD using *The Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) system of classification by a clinical psychologist, counselling psychologist or psychiatrist. They were all under therapeutic treatment and under psychiatric medication. The aim of this research was to explore BPD and how this diagnosis affected the way participants perceived themselves, their relationships with others and the world.

Although the researcher does not agree with the medical framework, it is important to point out that the medical framework is the principal model used in Peru. For that reason it was necessary to use a single criterion to classify participants. The DSM IV was used for several reasons: first, it was the version available at the time of doing the study; second, it is until today the manual that it is used in Peru to categorise symptoms and do psychiatric diagnosis; and third, it describes specific symptoms that could be presenting in a person suffering from BPD. Some of the symptoms described in the DSM IV are: a pervasive pattern of instability of interpersonal relationships, self-image and effects, and distinguished impulsivity in early adulthood. All of these

presented in and were mentioned for the participants during their interviews.

All the participants were over 18 because, according to DSM IV, it is not possible to diagnose someone with personality disorders before this age. All participants were interviewed in Spanish, and each interview was transcribed verbatim also in Spanish.

Data analysis was conducted in Spanish and results and findings were translated and reported in English. Findings include most literal quotes in both English and Spanish. The intention was to preserve participants' authentic expressions using their native language, Spanish. Following Ricoeur's (1976) ideas regarding language and the construction of an identity through the language we speak, it was important to keep the interviews and analysis in the mother tongue of the participants allowing them to present their identity through it. The way participants explained the phenomena in their native language allowed for idiomatic expressions and tones in the narrative to be fully captured and described. The quoted translations were undertaken by a qualified translator who tried, as closely as possible, to achieve the meaning of the original Spanish quote.

2. Purposeful Sampling

As this study follows a qualitative methodology, the sample used was a purposive one, with the aim to generate insight and understanding of the experiences regarding BPD diagnosis in each of the participants. Participants in this research were selected on the basis that they will be able to provide information for the analysis, so the strategy that was used was a convenience sampling (Braun, 2013).

This research was conducted in Lima, Peru. For the recruitment process the researcher personally contacted psychiatrists and counsellors working in private practice

or private hospitals. She asked them to invite identified BPD clients to be part of this study. To maintain control and consistency in the selection process of participants, the researcher gave psychiatrists and counsellors an identical written invitation to give to their clients.

The invitation stated: "*I am a psychologist conducting some research for my doctorate thesis. The research concerns the subjective experience of being diagnosed with BPD. I would like to invite you to take part in the research. If you participate in the research you will be required to attend an interview with me, which will last between 60 and 90 minutes. You will not be required to go anywhere or do anything except talk to me about your experience of being diagnosed with Borderline Personality Disorder (BPD). If you feel you would like to participate, I will arrange an initial meeting with you so that I can explain personally the aims of the research; after this meeting you can think about the invitation and I will contact you after a couple of days to find out your answer to the invitation*".

One clinical psychologist and two psychiatrists invited patients diagnosed with BPD; each one invited between 2-3 patients and participants that were part of the study were the ones that freely agreed to participate in it. After a month the researcher contacted the counsellors and psychiatrist who gave them the names of the patients that accepted the invitation to participate in the study. The researcher personally contacted each of the possible participants and scheduled a first meeting with each of them with the purpose of a clarification and description of the study and process. Ample time was provided to clarify and explain the research, as well as to respond to any questions and doubts to each one of the participants. Following this, if the participant agreed to continue, the researcher sent them a letter explaining in detail the purpose and process of this study. Participation in this study was entirely voluntary and participants were

free to withdraw their participation at any time.

After the acceptance the participants received a document (acceptance document and invitation letter are presented in Appendix 4 and 5, explaining the process of the study, and they arranged a possible date for the interview.

3. Participants' Characteristics

Participants in this study varied in age from 18 to 33 years old; three were single and two married. With regard to gender, three females and two males participated in the study. Participants' religions included two practicing Catholics and three who were raised Catholics but did not follow that religion. Their level of education included three professionals and two technicians. To protect anonymity and confidentiality of participants, pseudonyms were used. Participants included two males, named Mateo (19) and Henry (33), and three females, named Marcela (27), Sandra (30) and Catalina (20). Some participants' personal characteristics were as follows:

1. *Mateo* was a young adult who lived with his family (parents and two younger sisters). He finished high school and was trying to find a career. He presented difficulties in his relationships, with mood changes therefrom, anxiety with some episodes of panic attacks and low control of his impulses that led him to present aggressive episodes. There was a permanent feeling of "not being part of" the world. He had a previous experience of being hospitalised at the age of 13 for a suicide gesture. He expressed it was his way to ask for help as he felt incapable of dealing with his life. He also had received previous diagnoses such as depression and generalised anxiety disorder.

2. *Henry* was married and had two children. He worked as an administrator in

his father's company. He suffered from mood changes and panic attacks, had difficulties in his family relationships and a constant sense of isolation and alienation. Henry started presenting difficulties when he was at university. He remembered having difficulties in dealing with social activities.

3. *Marcela* was single. She was finishing cuisine school and was living with her family. She expressed difficulties relating with people, anxiety in any social interaction and a constant sense of alienation, as well as mood changes and self-injury. Marcela also had previous diagnosis and went to several treatments without any change in her condition.

4. *Sandra* was married and had recently given birth. She was enjoying her new role as a mother. She presented mood changes, feelings of isolation, difficulties in her relationships, and a high level of anxiety and negative thoughts.

5. *Catalina* was a young woman, in her last year of architectural study, living with her family, but experiencing severe difficulties in her relationship with them. She also presented feelings of isolation and alienation, mood changes and impulsivity that led her to aggressive behaviours and self-harm. As a result of her mood changes she had to stop her studies as an architectural student and at the time of the interview she was looking for new career options.

3. Ethical Considerations

For this study ethical considerations were put in place to reassure the confidentiality of the data and the security of all the participants as well as the researcher. As the research was done in Lima, Peru, the researcher also followed the

Peruvian Code of Ethics. It was ascertained that the British Psychological Society (BPS) Code of Ethics is similar to the Peruvian Code. Furthermore, since the research was carried out under the supervision of the New School of Psychotherapy and Counselling (NSPC), BPS principles were applied where Peruvian principles differed. Before starting the research, a pilot interview was conducted with one participant to test the interview protocol, determine safety cautions, and change or clarify any situation that could create difficulty to participants or researcher.

There are differences between the health systems in Lima, Peru and those in the United Kingdom. Most of the Peruvian health system is private, and for this reason all the participants were private clients who were completely responsible for their treatments. This gave them more control over decisions regarding their treatment.

With regard to expenses, it was the researcher's intention not to generate any as a result of the participation in this study. If, however, the participant felt that a cost would be incurred, the researcher discussed the matter with them prior to their acceptance of participation. In order to facilitate the interviews, the researcher conducted them in the practices where the participants saw their counsellors. The researcher was also flexible with regard to the scheduling of interviews to suit participants' needs and accessibility. After each interview, the researcher debriefed the participant and checked that the interview fulfilled participants' expectations, as well as explaining any doubts or concerns which arose during the interview.

Participants had the opportunity to discuss any aspect of the study with their counsellor or psychiatrist at any time. Participants received a consent form that guaranteed their right to withdraw from their interview at any point without having to explain their reasons for doing so, together with an explanation of confidentiality and anonymity issues such as how the confidentiality would be taken into consideration

during and after the research.

During the interview, the researcher took into consideration that participants might feel overwhelmed by the experience of going through their life histories. Should this happen, the researcher would offer to stop the interview for a few minutes and pause the recording to give the participant time to review their thoughts and feelings. During such pauses, the researcher would not act as a therapist but would offer some supportive words if necessary and would point out that it would be good for the participant to discuss these topics with their current therapist. The researcher would then ask them whether they felt able to continue with the interview. In cases where they said no, the researcher would give them the opportunity to continue with the interview on another day or to withdraw from the research completely. During the current study none of the participants presented difficulties during the interview. They all talked freely and without the necessity for the researcher to participate other than to ask for some clarifications.

Possible risks inherent in interviews with BPD clients were taken into consideration, so all the interviews were done in the office of a counsellor or psychiatrist who was working with a participant. Potential physical risks to the researcher were also taken into consideration, so interviews were done in a private psychiatric unit.

After the interview, the researcher asked each participant whether they wanted to receive a copy of the transcript of their interview, all of the 5 participants agreed to receive a copy. This allowed the interviewee to correct any misunderstanding or idea that might have been wrongly explained. The researcher also explained that the transcripts and tapes would be kept in a locked cabinet where they would stay for a period of two years after which time they would be destroyed. Should the researcher

publish all or part of the research, she would let them know and their anonymity would be guaranteed. Researcher offered participants the opportunity to learn about the outcome of the research and asked them whether they would like to be sent the completed research.

All the participants also agreed to receive all the study as soon as it was finished and accepted by the University. The explanation they gave to the researcher was that they would like to know what other participants felt and how others dealt with similar symptoms.

4. Procedures:

In this study a semi-structured interview was used, given space to participants to explain their own life stories before and after the BPD diagnosis was given to them. Semi-structured interviewing is one of the most popular methods of data collection in qualitative research (Willig, 2001). This type of interview allows the participant to express freely and openly areas of his experience. Although semi-structured interviews are non-directive, they still allow the researcher to ask the participant for clarification. This allows the researcher to establish a relationship in which participant and researcher engage in a relation with equal power positions (Giorgi, 1995).

In the case of the Critical Narrative Analysis method, the semi-structured interview can take the form of a biographical interview or a life history. The idea is to help and encourage the participant to create narratives that will later be analysed (Langdridge, 2007). There are different ways to start the interview; a good approach in some cases is to present the client with a short, specific question about a specific event. One example of this could be: "Tell me the story of your life in relation to (event for analysis)". Another way to start could be to use a more structured opening statement as

was done by McAdams (2006). He suggested that there are 8 important events in the life of an individual, including peak experience, nadir experience, turning point, earliest memory, important childhood memory, important adolescent memory, important adult memory and other important memories. This approach would not be appropriate if the researcher wanted to analyse a specific moment or event in the participant's life; in these cases, it would be more accurate to concentrate on asking about the specific event.

In the present study as the aim was to understand a personal life experience in relation to the BPD diagnosis event, the researcher used one specific question about this event. The necessity to focus on a specific moment of the participants` life was the basic ground on which to build the question.

The question that was asked to each participant was: *Tell me the story of your life since you were diagnosed with BPD. How do the ways you perceive yourself, the way others perceive you, and the way you now relate to others change, if it did, due to the diagnosis of BPD?*

This question allows the participants to choose how to build their stories regarding this event in their lives. As the interview was not a structured one, the interview gave the opportunity to the researcher to ask for clarifications or explanations with regard to the participants` stories. The researcher also followed a set of ideas that were important to talk about with each participant. (Appendix)

During interviews where participants expressed that they had nothing more to say, the researcher asked for some clarification of the story or for more information about some part of the story. To capture participants' stories and ask for clarification or expansion of their thoughts, the Socratic dialogue was employed (Kvale, 1996). This dialogue allowed for participants' reflection and explanation of meaning.

5. Analysis

Following the semi-structured interviews the recorded tapes were transcribed for analysis purpose. The researcher listened to each of the interviews several times; these had the aim of correcting any mistake or error in the transcripts and also to make initial descriptive notes on each participant's narrative. After this the proper analysis began.

CNA method consists of 6 stages, none of which should be seen separate from the other. The aim of each stage is to work with the data and add new perceptions to the phenomenon under investigation (Langdridge, 2009). This method gave the researcher the opportunity to decide if he will be engaging in the first stage (A critique of the illusions of subjectivity) and stage 6 (A critical synthesis), depending on the help they could give to the study, (Langdridge, 2009) thus for organizational purposes I decided to add those stages with the discussion in Chapter 6.

The analysis was done in all the lines of the transcript (one transcript example is included in Appendix 1 with line numbers used for the analysis) and notes taken of the general and specific ideas of each participant regarding the BPD experience. Most of these notes and comments were firstly descriptive, describing what the participant was saying. After several readings of the transcripts and feeling more familiar with each of them, the researcher started to add some interpretative notes and some queries that appear regarding the stories. Finally with the help of the transcripts and the notes of participant's ideas the researcher started to search for themes that emerged from the stories.

Going through more details of the analysis method the following ideas explain the stages that the researcher went through in detail. In the second stage (as the first was not included for organizational purposes in this part of the study), the researcher began looking for the **narrative identity** in each participant's transcript. The aim of this stage

is to capture participants' stories and identify different sub-stories in the narrative (Langdridge, 2009). It is also important to find any change in the tones that could appear on the transcripts for a better understanding of participants' stories. After the analysis of each transcript regarding narrative structure, identity and tone changes the researcher compared if any of the identities found in each participant where common to the others.

For this work each transcript and interview was read and listened to several times focusing on the self-being of the narrative, trying to gain a clear idea of the person and how they relates to their story. Participants constructed their identities on the ground of their explanations they gave to their difficulties; some explained their difficulties as a phase of anger in their lives or as a necessity to be "perfect" or to feel "normal". These identities started to shift after major events occurred in their lives, such as hospitalization. They began to think that maybe they had a serious mental problem and not just an anger management issue or insecurities, which generate a sense of separation from others and the world. (See table 1 below for an example). As one participant expressed: "The idea of always being different from others upsets me and to think that I will not want to do many things because people are going to distance from me because I have a mental problem concerns me".

Table 1

Participant # 1	Narrative identity	Changes in tone	Descriptive note	Interpretative note	Critique position
	1. **"Angry young man"** Before BPD diagnosis he saw himself as a difficult kid with a complicated relationship with his parents. This justified his	Predominant tone was anger	"Explained all his problems as consequences of his relation with his parents and his difficulty controlling his temper".	He tried to give some logical explanation to all his difficulties **Queries**: (Rationalizing his situation)	

	difficulties without seeing him with a "mental problem" **2**. **Victim of the BPD diagnosis** After the diagnosis was given to him, he shifted from seeing himself as an angry young man to a victim of the BPD diagnosis	Change from anger to despair and hopelessness	"The diagnosis is perceived as the cause of all the changes in his life. He felt that people don´t love him in the same way… " "When they gave him the diagnosis, he perceived it as a limitation and a loss of control… " "Psychiatrist gave it so is the doctor who can say when he is cured…"	The shifts in the way he saw himself could be as a result of a medical intervention and diagnosis. **Queries** How much control he had over this shift??	
Participant #3	1. **"Perfect daughter":** …the ideas and feelings of sadness and desperation were so strong that I went to therapy…Before that I always presented myself as a perfect daughter, with a successful career and always following the rules of my family.	During the narratives the tone change between sadness, emptiness and hopelessness to acceptance of her situation. This acceptance brought some calm to her	She tried for a long period of time to hide all her insecurities and sadness so people couldn't see them.	This hiding of her real emotions and feelings, helped her to feel accepted and part of her family and "normal people"	

As can be seen in the table above, the descriptive comments remain close to what the participant said, paraphrasing or summing up what they said. The interpretative comments are more speculative and include more of what the researcher felt was being said, her reactions and thoughts.

After the analysis of the different identities presented in each narrative and the comparison between all of the participant's narratives, the researcher started to review each interview again, taking notes and identifying the emergent themes in the stories and the relationships between them. Having completed this process with a participant, I would then print out the emergent themes and try to cluster them into groups. Some of these emergent themes fell in importance, being either weak or indeed being subsumed under other stronger themes. It was necessary to decide whether they fitted into a single category or several categories. Common core categories were identified in this study, and are presented in the findings chapter of this study. Having established this understanding of a participant, the researcher would then move on to the next transcript, repeating the process. The criterion for whether an emergent theme should remain was with reference to its importance for the "participants' attempts to make sense of their experiences.

Three predominant themes were identified in these participants' story that clarified and explained the experience of these participants after the BPD diagnosis was given to them. Some themes had gained in importance during the analysis, an importance that wasn't fully reflected in the original verbatim.

The last part of the analysis consisted of the critical review of all the themes that emerged. To do this the researcher engaged with critical psychopathology, anti-psychiatry theories regarding mental health psychiatric diagnosis. These theories helped her to perceive these ideas from a critical perspective, trying to understand the ideology behind the stories presented by participants to the researcher.

For the coherence and consistency of this study, the critique and destabilizing stages were added in the Results and Discussion chapters. However, some critiques and theoretical concepts were also included in the analysis of each participant's narrative.

In summary, in this research study all interviews were analysed following the CNA stages structure and an example is presented in the Appendix. The same areas of analysis were used to maintain the coherence of the entire investigation. Findings of this study are presented in the following chapter.

Chapter 5

Findings

The aim of this study was to gain a better understanding of the psychosocial phenomenon a person might experience when he or she is diagnosed with Borderline Personality Disorder (BPD), and how this experience might change his or her relationship with others, the world, and the way the self is perceived.

Five participants took part in this qualitative study in which open-ended, semi-structured interviews were undertaken for data collection. Each interview lasted approximately two hours. Data gathered from this study was analysed using Critical Narrative Analysis (CNA), a method predominantly concerned with understanding the participant's personal history (Langdridge, 2007; Ricoeur, 1981). The participants' interviews were conducted in Spanish. This chapter includes the translated version of the participants' quotes.

In pursuing the aim of this study three main themes were developed and issues identified. These themes were (i) the participants' relationships with others and themselves, (ii) their relationship with the world and their diagnosis, and (iii) the participants' response to possible stigmatization. The information was compiled from the participants' experiences in relation to being diagnosed with Borderline Personality Disorder and changes in their perceptions of their relationships with others, the world and themselves. Special attention was given to the level of stigmatization a mental health diagnosis such as BPD could have on participants, as this idea appeared in all of the participants' narratives as an important issue to deal with.

This study tried to understand the experience of five participants who went through the BPD diagnosis. Each participant had a personal explanation for his or her experiences and difficulties that contributed to the understanding of their personal phenomenon.

Every experience and feeling that the participants presented such as sadness, loneliness, fear of relationships, anxiety and anger, are seen in medical literature as some characteristics of a 'mental disease'. However, each of the participants had a personal explanation for their experiences such as difficulties with parents, inability to control anger, being too rebellious, suffering from extreme sadness, isolation, emptiness, as normal problems that everyone faces in life. This idea of being 'similar' and sharing 'similar' experiences with others gave them a sense of relief.

In each of the narratives participants described how they all tried to generate meanings from their experiences that allowed them to not only interpret the situation but also the world in which they lived. For some of them the world was a hostile place where they couldn't fit in or feel part of it.

As Catalina said; ***"In art school people do not treat me as a normal person. If I do something 'strange or different' they say, take your pills. They see me as a 'crazy person' and I do not want to be labelled like that".*** (Transcript: Line 175)

For others, although they had an image of someone who feels part of the world, this false situation generated high levels of anxiety in them as they realized that even when they faked their 'adjustment' following social rules, they could not achieve the sensation of being part of the world.

Sandra explained this saying***: "I couldn't fit into the world... I did all the right things, all the things you're supposed to do in life to be a happy person, but I was not happy***

and I was in pain all the time" (Transcript: Line 116)

To better organise the findings of the study they have been divided into the following themes:

1. History and difficulty finding meaning to their situation
2. Thoughts regarding BPD diagnosis
3. Impact on their lives and on their relations with others after the BPD diagnosis

1. **History and difficulty finding meaning to their situations**:

All the participants in the study expressed a necessity to explain and find meaning to and causes of their difficulties. Each participant gave different explanations. All of them had different ideas regarding possible causes of their problems. The range of these ideas went from genetics to social and family difficulties. All of these explanations were not taken into consideration by the medical diagnosis all the participants explained or tended to explain their problems through personal experiences such a being a rebel or problems in the relationship with authority.

This necessity to understand was going hand-in-hand with their necessity to share their ideas, fears and thoughts with others. Participants felt that they had to fight with the way others saw them, that they were always categorised by others, and their own explanations regarding their difficulties were not taken into consideration by almost all the people around them, including the professionals.

As Sandra said, *"I always had to deal with the expectations family and people have from me. This pressure made me to act in a way that I was not being myself"*

The BPD diagnosis, as with any other psychiatric diagnosis, had a medical explanation so they felt that a suggestion of a mental disease was implied in the diagnosis; this led them to reject the diagnosis at the beginning. Their necessity to make sense or create meaning of their difficulties was expressed all through their narratives in this study. This interpretation leads all participants to achieve a personal meaning and understanding of the BPD diagnosis. Each participant's narrative was full of personal explanations allowing the researcher to perceive some personal elements of the inner world of each participant. The personal perspective presented by all the participants regarding development of their problem clashed in many aspects with the 'medical' ones. The medical explanation of the diagnosis that left the subjective experience of all of them out of context and did not allow them to be part of or have control of their own meaning, was an important point described by all participants.

Some of the explanations patients applied to their difficulties were:

   a) Social causes

   b) Psychological causes

   c) Lack of control

a) Social causes

All the participants expressed a variety of social circumstances that they used to explain their difficulties. For example Mateo explained all their symptoms through his difficulty in his relationship with his parents.

For Mateo his problematic situation started because of the difficulty in his relationship with his father. He explained that they were always fighting and he felt

he was being judged by him all the time and not trying to be understood or listened to by him. This generated in him a feeling of anger that increased with time. This anger started to affect him at school and outside it until he presented a difficulty with any rule or social boundaries.

Mateo: ¨*Since I remembered I was a rebel, never follow the rules at my home and that generated a difficult relationship between my parents and me. They tried to be more and more strict but I was trying to look for approval and love as I never felt that I fit in in any part. It was a horrible and scary feeling that I was scared of being aggressive." (transcript: Line 67)*

Another participant explained how difficult it was for her to be authentic as she was always trying to present a 'perfect face', doing what others wanted her to do. All these ideas explained why she was so sad and anxious all the time, she believed.

For Sandra one of her explanations for her symptoms was how her 'perfect family' expected her to be. She was trying since she was a child to achieve all the expectations her parents had for her and she started to felt overwhelmed with all those ideas. She thought it was important to hide any negative feeling such as sadness or anxiety so she struggled to cope with them alone.

Sandra: *"I have always been for my family "the perfect child" at school. I had honours and also I was good at sports so I achieved all that the family expected. But I never was authentic with myself, always feeling that I have to work harder, incapable of enjoying things, only focusing in the results so I started feeling anxious and sad all the time and started to critique myself a lot that made my anxiety even worse"*

(transcript: Line 89)

In the case of Henry he explained all his problems because of his difficult childhood. His parents were always fighting and neglected him so he felt alone and started to develop some anxiety that increased when he went to university.

Henry: *"Since I was a child I remembered my parents fighting and being angry all the time, so they never had time for me. They never even asked me if I felt ok with all the fighting. I grew up alone and with problems to have friends. I was a shy and timid kid always feeling that people were looking at me and laughing at me." (transcript: Line 105)*

One problem that participants in this study describe as important regarding social relationships was the difficulty of being understood by others. They felt that even the professionals did not understand them or their difficulties. Many of the participants have presented in their narratives different symptoms that could be seen as a mental disease developing in them. This fear of being perceived as crazy led participants to not revealing anything regarding their symptoms and therefore putting their health at risk.

Some of the participants intended to talk about their necessities or difficulties to their parents, but the reaction they received was of being rejected. In cases like Mateo´s, they regarded him as crazy and he therefore felt stigmatized by their perception. The fear of a possible incorrect interpretation led all the participants to isolate themselves, to feel lonely and more confused regarding their experiences. The fear of being labelled meant that the participants did not seek or receive help or treatment thereby compounding their difficulties and creating a vicious circle. An important experience shared by all the participants was the feeling of isolation; they explained their emptiness as a result of being isolated and rejected by others.

These feelings of separation from others and the world gave participants a sense of not

being similar to others and emotions such as frustration, anger, sadness and hopelessness dominated.

Mateo felt that ***"Others labelled me or judged me and that made me feel sad***. (Transcript: Line 75)

For one participant the diagnosis gave relief and a sense of knowing what would happen next. An idea that I will come to again to in following areas of the chapter.

Sandra said: "***My doctor told me that my problem is like suffering from asthma, you can climb the Himalayas but it would take a bigger effort; with BPD I would need to make a big effort to relate to others and to myself***." (Transcript: Line 20-25)

To summarize this social explanation of their difficulties, we can say that of the five participants in this study who experienced BPD symptoms it was important to try to understand and give personal explanation and to have the opportunity to share this with other people significant to them. The explanation given to their experience and the reaction from others will have an impact on the participants and in their future treatment.

b) **Psychological causes:**

Patients identified different emotions that they had before the BPD diagnosis was given to them. These feelings and emotions were other possible explanations of what was happening to them. Some patients expressed that anxiety and sadness could have been the causes for all their difficulties; for others the feelings were not the problem but rather their incapacity to deal with them.

The feeling of not being part of the world or not fitting in groups were also important psychological points for all of the participants. This sensation of not being able to fit in also generated low self-esteem, irrational thoughts and a change in how they perceived

and interpreted others behaviours. They tended to see in others' behaviours things that they used to reaffirm their own irrational thoughts. They also expressed their incapacity to relate to or understand others' feelings, misreading them as aggression toward them or feeling their parents are not attuned with their feelings

Catalina: *"Sometimes when my parents said something regarding my behaviour I took it as a critical comment and that switched on in my brain many irrational thoughts regarding how bad I was as a human being, in those moments my parents were incapable of helping me to see things in real way" (transcript); Lines 55-609*

One aspect that all participants shared in relation to their difficulties is the conflict in relation to their own explanations of them and reality. The participants described with clarity their fear of being seen as crazy. They all think that accepting the idea of being crazy (accepting the BPD diagnosis) as a negative one and a stigmatized situation. However, for the participants the idea of not being stigmatised as crazy means being seen by others only through their difficulties and allowed them to live their problematic experiences in a more positive way and motivated them to seek help. The way participants described their own experiences was relevant in their narratives. When they tried to explain in their narratives their experiences they used to compare them with normal process.

Mateo explained this when he said: *"Before the BPD diagnosis I was aware of my difficulties but they were as similar as the one any other human being has. Sadness, frustration and difficult to deal with life"*

It was only after the participants received the BPD diagnosis that they started to think in terms of being mentally ill. This could be an important point to take into consideration for the future treatments or explanation of psychological difficulties to

patients.

c) Lack of Control

One idea that was shared by the five participants was regarding the feeling of lack of power or control. They felt that after the BPD diagnosis was given to them, they lost control of their situation. How professionals explained these difficulties and categorised it as a BPD diagnosis led participants to feel pushed away from their own world. They also pointed out that the diagnosis was beyond their control because a third person (psychiatrist) had given it and it was only that person who could retract it.

Catalina commented, *"I felt sad for me and angry at the same time... I don't know what is normal...I received this diagnosis and I was thinking how am I going to take it out or I will have to live with it always?"*

Marcela added, *"I identified with some ideas they told me regarding BPD but I was afraid of the label, thinking that it would not disappear and that I would have to live with it." (Transcript: line 77)*

Once the BPD diagnosis was assigned to these participants they felt that professionals took control of their life, seeing them and their situations in a medical way, taking the subjective experience of each participant out of it, and not taking into consideration the meaning that each of them ascribed to their problems. Their difficulties were living as a subjective experience and it was important for all the participants to be listened to and have their ideas taken into consideration instead of being pushed into one diagnosis or psychiatric stereotype.

As the result of the variety of diagnoses that all the participants received they lost trust in the professionals and in the possible help that they could give to them. This loss of

trust and the feeling of not being heard by professionals regarding their own experiences contradicted the process of giving a psychiatric diagnosis. It is the patients who explain and describe their symptoms to the psychiatrist and it is through all of these descriptions that the professionals arrived at a diagnosis. The participants struggle in accepting the diagnosis because while they provide the material for the diagnosis they feel that at the end they cannot contribute to the diagnosis itself.

In this study all the participants had the sensation of a loss of control of their own situation as soon as a diagnosis was given to them.

2. <u>Description of the experiences and the possible impact in their lives:</u>

All participants expressed a variety of causes that could be used to explain their difficulties. In this part I would like to explain how participants described the experience they lived and the possible impact on their lives.

The five of them explained how before the diagnosis they used different methods and mechanisms that helped them to stay in connection with others and the world and 'normalized' this sensation of ·'not being part of it'. One way of normalizing their problems was to perceive all the answers and explanations as a physical malfunction and not as a mental illness, hoping that a medication or physical treatment would give them instant relief from the pain and the sensation of isolation they had to deal with. Participants also referred to preferring to have a physical condition than a mental one, because the first one was more accepted by others and it was also easier to treat than a mental condition.

Mateo described his feelings of depression and panic attacks like difficulties anyone can experience. ***"For me, my sadness and my anger was always "normal", sometimes I***

saw it as extreme but I saw others feeling things like that. I was not different. Things changed after the diagnosis of BPD." (Transcript Lime: 95)

Descriptions of ways to try to relate with others and to understand themselves and others were common in all participants. This study presents examples expressed by participants, such as Sandra's description of how living in a family where education and success were highly valued pushed her to hide all her weaknesses and feelings in order to be part of her family and to feel competent and good enough in her parents' eyes. In this situation, Sandra portrayed herself as a person with a 'perfect' identity, with a good and respected life, job and success that everyone could envy. She perceived her situation and herself in the following way: ***"I was the perfect daughter, the family was proud of me, but socially I did not have friends. I could not maintain relationships because I did not want people to see my dark side"*** (Sandra: 20-25-Participant: translated from original transcript).

In the case of Sandra, being perfect appeared to be a good role-play that she acted out all the time in front of others to hide the dark areas or bad things such as sadness, frustration and negative thoughts in relation to herself, life and others. She dealt with these emotions in silence because of her fear of the negative reaction others might have if she expressed herself openly and freely. She thought that all people felt the same and she felt inadequate in not being strong enough to deal with these emotions.

In a way, they all tried to hide their negative feelings in order to be seen as normal in the eyes of others. As most participants explained, these feelings did not improve after they were diagnosed with BPD. For all participants it was a long process before they could arrive at acceptance and understanding of the BPD diagnosis.

It is important to take stock of these findings describing the impact these

experiences had on their lives. All participants expressed this impact as an important thing in their lives. They all expressed in their narratives the different ways these experiences impacted on their lives. Henry explained this idea in the following way: *"All these feelings of isolation and lack of control of my emotions made my life complicated. It was difficult to go out with others as I never knew how I could react to comments or others behaviours, so my social life was deteriorating rapidly until I couldn't go out any more."* (Transcript): Line 47)

During the time when they felt isolated or hopeless they all described the difficulty in seeing reality in a different way. They started to feel insecure regarding their own thoughts as people close to them usually explained that things were not like they saw them. Confusion and insecurity was common for all participants regarding the way they interpreted situations and perceived others' behaviours always as negative towards them.

"*I thought that my parents were not in the position to understand me because they saw life in a different way, so I thought I couldn't trust in them as they criticized all my feelings or thoughts saying I was exaggerating*" (Catalina)

After the BPD diagnosis was given to them, they all described the importance of working at being able to compare their own feelings to reality to be sure that reality was how they saw it.

"*I isolated myself because of my feelings of "not being normal"; people were only reacting to my rejections and anger to them*" (Mateo)

In the case of Catalina she expressed how difficult it was for her to recognize that, during the year that she had run away, her parents only tried to help her instead of

criticising her.

"*At the beginning of the treatment I was convinced that they were against me and happy not to deal with me but then I realised that all the time they were there trying to explain how reality was instead of criticising me*." (Catalina)

The impact that feelings of hopelessness and alienation had in the way participants see their own self was also an important issue that all described in their narratives. As a result of their social difficulties with family members or friends they started to be apart from them, and this auto-alienation help to generate more feelings of difficulties and sadness in participants.

Henry said: "*At some point in life I could not go out anymore. So I stayed in the house or in my room for hours. This isolation gave me lots of anxiety and sadness*"

This feeling of not being able to have a close relationship or to relate with others was a common theme in all the participants. Difficulties in expressing their feelings or explaining to others what all of them were feeling isolated them more and more until participants believed it was better to stay away from others.

Catalina said: "*I saw things and life as a TV programme, I could not feel any connection with life or others, it was a scary sensation so I stayed away*"

Another of the social consequence of the BPD diagnosis was the stigma that came with it; for participants this stigma also included the feeling of not being taken into consideration in several decisions, as they were not seen as capable to decide correctly. This aspect will be explained in depth in the BPD stigmatisation section.

Although all participants expressed the negative feelings of their experiences, some of them explained that some positive aspects came out of this situation.

Mateo commented: *"I am separate from the rest of people because of my feelings and reactions ... Sometimes I would like this to end and sometimes not, because at the same time as feeling different you also feel special. When I had hallucinations, I felt that I could see things that no one else could see, so you feel different but special at the same time. It is like everyone having a white label with their names and you have a red label with yours; you feel different and sometimes you feel good because of it. Feeling good gives you great happiness; it is like a sensation of being unique..."* *(Transcript: Line 78)*

Although some positive aspects were expressed and described by the participants, those were less important than the negative ones.

3. Thoughts regarding BPD Stigmatization

A relevant theme identified in the analysis of the participant's stories was in relation to the possible stigmatization that can come from the BPD diagnosis. All participants in this study were concerned about a mental health diagnosis such as the one they received, and how this diagnosis could change things in a positive or negative way for them and their lives.

Regarding this theme, two interrelated aspects were identified: one regarding the possible negative effects the BPD diagnosis could bring, and one regarding the fact that participants believed it was helpful in some way. The manner in which the professionals explained their symptoms to them, and the causes of their problems and suffering, impacted on the participants and on how they perceived the diagnosis.

All of the participants at the beginning of their stories described how the BPD diagnosis brought a sense of being labelled and a fear of being seen as crazy into their lives, which increased their experience of alienation and separation from the world and others. Marcela explained how difficult it was for her to accept all the labels doctors gave to her and the sense of frustration and hopelessness this generated in her. She felt she was trying to look for help and, instead of trying to help her to understand her symptoms and alienation regarding her own existence, doctors were only changing names and labels and were preoccupied with what name/ label to give her rather than trying to understand her.

For some of them the initial attitude towards the BPD diagnosis was to reject it because it was seen as a label imposed on them by another person such as a doctor, psychiatrist or psychologist - someone that they did not trust and did not take into consideration how they experienced their difficulties.

Mateo explained, *"...It was a label that someone had put on me, that removed me from the world and put me in a different position."* (Transcript, Line 45)

They perceived that this label called BPD was more difficult to accept than the symptoms they had lived with before. This label of BPD gave participants a sense of not being similar to others and emotions such as frustration, anger, sadness and hopelessness dominated them.

Catalina commented, *"I felt sad for me and angry at the same time... I didn't know what was normal..."* Marcela added, *"I identified with some of the ideas they told me regarding BPD but I was afraid of the label, thinking that it would not disappear and that I would have to live with it."* (Transcript : Line 104)

The initial rejection of the BPD diagnosis that participants described in their interviews was based on the possible stigma a psychiatric diagnosis was thought to bestow on someone's life and the inability to discard the label because it was not under their control.

Feelings of alienation or not fitting in the world increased and were confirmed by participants after they received their BPD diagnosis; however, their perception that the label put them into a category that was not accepted in society, or at least without a gesture of concern from others, increased their feelings of hopelessness in relation to their future treatment and life.

Mateo explained this idea clearly when he mentioned in his narrative that: "*the diagnosis put me into a small world, took me out of the mass...*" Most participants in this study had to deal with more than one diagnosis. (Transcript: Line 67)

The sensation of not being seen as a normal was also related to how they perceived others and did not take into consideration the interpretations or meaning that they had regarding their own experiences and feelings.

Catalina said that she felt she was rejected because of her difficulties and people saw her as a 'crazy' woman. *"It is difficult to accept that could be true that people are thinking that when they saw me."*

Participants also expressed these feelings of their explanations of the experiences not being taken into consideration, as well as a general feeling of not being recognised as a human being and instead people only seeing them as a 'psychiatric patient'.

Henry explained this idea as follow. *"The name of BPD or the diagnosis that they gave me was for me a way to reject me, which did not help me because it was more*

difficult to accept it and to feel as the people around me".

All participants described the importance that had for all of them to feel accepted as equal to others. To be able to recognise that others take their meaning or explanations of their thoughts, behaviours and feelings as a real experience was relevant to their 'normality'. The opportunity to describe and explain how they experienced things before the BPD diagnosis was important in the narratives they presented.

Their sense of trust and confidence in their treatment did not increase until they received a clearer and better explanation of their difficulties; an explanation that allowed them to reconcile with themselves and the world.

There are clear differences in the way participants received their diagnoses and how their psychiatrists handled these. Four of the five participants had to deal with more than one diagnosis. These ranged from bipolar disorder, to anxiety, depression and eventually BPD. These constant leaps into different explanations of their difficulties generated a sense of not being understood, leading to a negative reaction to the treatment and therapy they were offered. As expressed by participants, it was only after they achieved a deep understanding of the BPD diagnosis that most of them, through therapy and self-education, started to work on ways of coping with their problems.

The feeling of being understood by professionals and of perceiving that their feelings were being taken into consideration helped the participants to accept the treatment and therapy with a positive attitude. Not labelling them and explaining their symptoms, taking into consideration the meaning participants gave to them, was important for the future collaboration and mental progress of these five participants.

In the case of Sandra, she did not share the same experience in relation to the

BPD diagnosis as the other participants. Her narrative was more optimistic, as she was not diagnosed with a mental illness, or even treated as a crazy person. Instead, she referred to being treated by the professionals as a human being who was facing some difficulties. For Sandra, the way her doctor explained her situation gave her a sense of relief and she started to see all the 'bad characteristics' in her as only another part of herself and knowing that people have these two sides helped her to relate to others and to connect to people in an open way without hiding some areas of her personality for fear of being rejected or misunderstood. Sandra's psychiatrist and therapist explained that all her problems could be improved with psychological help and medication. The professionals who dealt with Sandra tried to be clear in their explanations about her feelings and problems so she could relate to them. They also took and used Sandra´s explanations of her own experiences to explain her problem to her, something that for Sandra was seen as a relief and which also finally helped her to achieve an understanding of her suffering. This gave her hope in relation to her future.

In this respect, Sandra reflected, ***"The diagnosis calmed me down, helped me to see all the help I needed and the support I will need in life. It helped me to understand that some things will be difficult for me to cope with – like motherhood – but with psychotherapy and treatment I would be in a condition to face them..."*** **(Transcript: Line 106)**

As the study states, stigmatisation in relation to mental illnesses and the medical framework used to understand any type of emotional or psychological difficulties is still predominant even though they are several studies explaining the possible negative consequences this could bring to the patients. In USA a similar study by Vellenga y Christendon (1994), where they interviewed 15 patients with mental diseases, stated that for all of them the sensation of stigmatisation and alienation was an important thought

and difficulty.

Participants in their narratives expressed and explained how important it was for acceptance of the BPD diagnosis, not only to feel that their explanations were taken into consideration by professionals but also the explanations and ways in how professionals communicate the diagnosis to them. In other words, each participant sought a professional that saw them as human beings with problems and difficulties common to all human beings, and not as a person with psychiatric symptoms that led them to a mental disease.

All of the participants explained that a sensation of alienation was part of them, before the BPD diagnosis was given to them but it increased after the BPD diagnosis. They found their BPD condition one that they would have to live with instead of a group of difficulties that anybody could experience during life. The BPD condition was seen as a condition that they would need to learn how to control and also with the possible stigma this type of diagnosis could bring into their lives.

Another important result or consequence that participants described they needed to deal with after the BPD diagnosis was the necessity to build a new self that helped them to move forward into their future

It is possible that participants feel that to receive a diagnosis of BPD would not help them to feel normal, as they have all been trying to adapt to the world and find meaning to their difficulties. The idea of giving a psychiatric diagnosis could be a trigger, which exacerbates their problems of fitting in and of feeling part of a social group as they have been explaining through their stories.

However, the separation also gave to some of them a new perception regarding their

social dimension and a capacity to relate to and understand others. Mateo expressed this feeling when he said, "***The diagnosis put me into a smaller world, took me out of the mass, made me differentiate myself; although it separated me from the world, sometimes I liked being out of it because I could see how superficial people were in that group".*** **(transcript: Line 70)**

In this study, a conflict between independence and dependence in the participants' narratives could be observed. The BPD diagnosis gave them a sense of superiority or differentiation from others, simultaneously enabling them to see themselves as separate from the mass as a consequence of the diagnosis and suffering because of this.

Marcela added, ***"...maybe with the 'BPD name' I felt more afraid and thought that I was different from others because of it; so when someone said something about me I always said, 'that it is because I am Borderline' in an attempt to justify all my acts".*** (Transcript: Line 89))

As this mechanism (seeing themselves as different) was not successful for the participants, they later on in their stories presented a change in the way they acted in relation to others, by seeing themselves as not interested in others. They said they were not good at maintaining relationships, or that they preferred to be alone as people were boring. They explained this through the idea that they were not empathetic and others were not important for them.

This could be interpreted as a way for them to move from the role of a sufferer from not feeling part of their social environment to one who kept themselves apart from others on an emotional level, acting almost with indifference.

Catalina said, "*I think I am not interested in others, I am not sympathetic, I do not feel empathy for others.*" (Transcript; Line 56)

Because of the feelings of rejection that she had suffered in the past, she used the distance from others as a defence mechanism, giving off the sense of indifference, although this separation from others also generated a sense of isolation.

The sense of being different from others, either positive or negative, as a result of the BPD diagnosis was a common theme in all the participants' narratives. The first feeling of being different generated a high level of pressure to hide their true personality, which created anxiety. The second dimension was related to the need for feedback and acceptance from others that human beings in general have, and the idea that if others interpret us in a negative way, it can lead to loneliness, pain and sadness

The necessity for recognition as equal to others implies a contradiction: in every moment of achieving our independent will, we are dependent upon others to recognise it. When we understand the meaning of *myself*, we also realise the limitations of that self.

Knowing that they were safe in their environment, and accepting that their difficulties were a combination of physical symptoms and emotional causes, they could move towards the possibility of establishing a new social life. They appeared to be able to build a bridge between themselves and others, achieving an intimate relationship that finally took some of them to long-term relationships and commitments, such as marriage. Eventually they began to recognise some of their emotional strengths and added them to their intellectual abilities generating a sense of being capable of dealing with life again. All this enabled them to express their vision of the future and their feelings of being part of the world.

CHAPTER 6

DISCUSSION, IMPLICATIONS & CONCLUSIONS

This chapter presents a discussion of the research findings emerging from this study in relation to participants' perceptions and experiences of being diagnosed with Borderline Personality Disorder (BPD), and in relation to the review of literature presented in Chapter Two. For clarity and organizational purposes, the chapter is divided into three sections. The first section provides a discussion of the study and comprises the main interrelated areas, including being with others and themselves, being in the world, and the therapeutic relationship, diagnosis and stigmatization. Several practical implications, as well as suggestions for future research in the field of psychotherapy and counselling are presented in the second section. The final section of this chapter provides the main conclusions.

Discussion

The literature regarding psychiatric disorders is based on the points of view of a group of professionals in the field, professionals that assumed their own personal perspective of psychiatric disorder as the correct and true way of seeing "mental illness".

In this study the position presented by the author does not agree with the medical position. It is not a pure opposition to psychiatric disorders, but presents a possibility to see and interpret psychiatric disorders and mental illness in a wider range of possibilities.

In the field of psychology and counselling, it is critical to consider the subjective experience of people who *suffer* from mental illnesses (Geekie and Read, 2012). In other words, people's narratives regarding personal experiences are essential in the

therapeutic process to better understand patients' *being* and their world, as well as their perspectives with regard to mental illness.

Both counselling and clinical psychologists have recognized this therapeutic approach as beneficial. It allows professionals to know patients' personal and social experiences in relation to their mental illness, especially before a diagnosis (Goldberg, 2000; Bradfield, 2006). As indicated in Chapter Two, also of importance in this type of approach is the way professionals explain a diagnosis to a patient. The aim is not to *label* him or her and, at the same time, avoid stigmatization. The aim is to explain and take into consideration the experiences patients live through to achieve a better understanding of their situation (Goldberg, 2000; Szasz, 2008). As Bracken (2007) explained, the problem is that professionals try to talk about emotional worlds, beliefs and experiences in the same way that they talk about physical things.

In this study, most of the participants described how they think psychiatrists, psychologists and counsellors saw them as objects rather than human beings or *normal people*. Participants were highly critical of this attitude of clinical professionals as they felt, for the most part, that their therapists did not understand them. They also felt separation from the *world* and others by being labelled "mentally ill", "crazy" or "abnormal". As mentioned in Chapter Two, regarding this point, the anti-psychiatry movement led by Laing (1960, 1961) and Szasz (2007, 2008) took a different position from that of critical psychiatry.

Because of the importance of understanding the subjective experience of people who receive a psychiatric diagnosis, the aim of this study was to explore and describe how the five participants might experience being diagnosed with Borderline Personality Disorder (BPD) and the changes this experience could bring to their existence. In

general, participants in this study expressed different types of difficulties, including high levels of anxiety, depression, anger and suicidal thoughts, isolation, and alienation.

In most cases, they also reported suffering from these difficulties for many years prior to the diagnosis of BPD. These symptoms manifested in clients prior to the BPD diagnosis, but they were not identified as clusters of symptoms of a particular mental problem, but rather as isolated emotional manifestations in response to participants' understanding and relationship with themselves, others, and being part of the world. After the diagnosis, most participants felt that someone external to them, a psychologist or counsellor, clustered their emotions with a "big title" and put *a label* on their self, not just on their symptoms. This situation greatly contributed to a personal sense of being *mentally ill* and stigmatized by others.

Some practitioners and researchers in the field of mental health see the difference between neurotic patients and patients with personality disorders as if the former is willing to accept some help and acknowledge their problem, but for patients with personality disorders to more often refuse psychiatric help (Crawford *et al*., 2001). Oftentimes, this leads patients with personality disorders to persist with their difficult behaviours, creating problems for family members and peers (Laing, 1960).

People who suffer from personality disorder often have difficulty adapting to the tensions in life such as in school, at home, or at work. Most have a tendency to be inflexible, rigid and incapable of coping with day-to-day changes and demands (Szasz, 1987). However, with assistance and adequate mental treatment, many of these patients can achieve a functional way of living.

Being with Others and Themselves

Participants expressed their difficulties not only in accepting that a mental disorder label such as Borderline Personality Disorder was put upon them but, more importantly, they struggled to conceptualize and describe what this meant to them. For the most part, they could cognitively comprehend how BPD was described to them by professionals, but they had a difficult time accepting the diagnosis as part of their self. In addition, they found it a challenge to communicate and relate to others as human beings suffering from a mental disorder than "being" the mental disorder itself. Thus, participants' relationships with others suffered changes and became more distant. This generated feelings of isolation and alienation in many of them.

Many studies have reported detrimental effects of these feelings in patients with BPD, but also found that coping mechanisms of these patients allowed them to function in society (Linehan, 1993; Clark, 2007; Dovski, 2009). In this respect, the findings in this investigation support these previous research studies. Participants described their lives as "functional" in some aspects, such as their occupations and employment situations. This capacity to continue living a "moderately functional life" generated mixed feelings. On several occasions during the interviews, participants gave examples of changes in their relationships with others, especially with close relatives, friends, and other meaningful people in their lives. Although they thought they were able to function in society, they also felt misunderstood and thought that others saw them differently because of their BPD diagnosis.

In other studies on this subject, it was reported that even though patients might be able to continue with a *functional* life, the psychological dimension (e.g. their feelings, thoughts and emotions), for the most part, is not appropriately functional (Stone, 1990). This situation generates a sense of "being different" and misunderstood by others, hindering positive and productive relationships (Bradfield and Knight, 2006).

As Buber (1970) explained, mutual and reciprocal relatedness between self and other is a condition, which enabled the emergence of the self. This self needs to be recognised and confirmed by others. It is through this recognition that identity is constructed and intersubjectivity is possible. Participants in the study such as Sandra, Mateo and Catalina described feelings of misunderstanding and criticism by others. They all identified the BPD diagnosis as the moment in their lives that these changes had the greatest meaning and impact. This generated a big difficulty for all of them in constructing a new identity after the BPD cluster.

These feelings appeared to be the main contributors to participants' vulnerability to confusion, loneliness, and separation from others and the world. The concept of alienation is explained by Olds and Schwartz (2000) as an experience of loneliness and separateness from the world and others in the world. Ultimately, this experience generates isolation. In other words, the incapacity to communicate with others generates a feeling of loneliness (Aviram *et al.*, 2006).

Isolation, alienation and separation from others have been discussed by researchers and practitioners as difficult, but common in modern society (Marcel, 1956; Buber, 1970; Boss, 1979; Lipovetsky, 1986). Some research also indicated that modern society tends to discourage people from thinking or being aware of their own existence (Marcel, 1956; Lipovetsky, 1986). A similar experience was described by BPD participants in this study corroborating prior findings on the topic. They expressed difficulties in understanding their own situation or in thinking about their existence.

Being in the World

For Heidegger (1962), "*being in the world*" could only be understood from a phenomenological point of view. The *World* represents an ontological aspect of

existence. Thus, as human beings, we have the need to understand others' perceptions and existence in order to interpret and describe the *World*. In the therapeutic setting, regardless of the particular mental disorder, it is important for the professional to recognize the patient, both as the subject and object in the relationship (Toombs, 1987).

The main ideas of Marcel (1953), Kierkegaard (1954), Heidegger (1962) and Bisnwanger (1962) were discussed in Chapter Two. These three authors discussed anxiety in the human existence as a result of the loss of connection with the *World*. Reisman (1993) explained that this feeling is currently common and we can observe it in the difficulties and struggles people have with relationships, emotions and the over-rationalization of everything. These feelings and struggles are not only characteristic of people with psychological and psychiatric problems but also exist for people without these types of problems. People are related to the world via the functions they perform in life and are not trying to understand or think about their own human existence (Marcel, 1956).

This study provided some findings supporting Marcel's ideas. For example, the description of separateness from the world was presented and described in detail by one of the participants. After the BPD diagnosis was given to him, he started to analyze his own being and his relationship with the world. He felt as if the BPD diagnosis took him out of the world to create a different one.

Being-in-the-world has been suggested to be a condition of human existence. Thus to be able to understand others, it is necessary to be aware of our own existence in order to recognize the one of the other (Goldberg, 2000; Bradfield, 2002). The issue to be highlighted in the professional-patient relationship is not the conflict or tension in itself, but rather the capacity or ability to find a balance in the relationship so that both

professional and patient can have control and acceptance of each other's *World*.

Therapeutic Relation, Diagnosis and Stigmatization

Stigmatization appears to be one of the main findings of the current study. It is evident that all those who participated in the study expressed fear of being stigmatized by others as a result of their diagnosis with BPD. A good example is Catalina who explained how difficult it was for her to talk with others about her difficulties and situations as she thought people could misinterpret them and see her as a "crazy" person. Nonetheless, Sandra revealed that for many years she tried to hide her feelings from her family because of the fear that they would change the way they perceived her. In fact there are some participants who faced situations where family members, friends, colleagues and others labelled them as "crazy", weird", or "ill", making it more difficult for them to feel confident to be open about their BPD diagnosis. In this regard, the study by Heller (2008) provides an insight into the use of the term BPD. The study asserts that the term BPD is inaccurate and that this label in itself implies that the whole person is flawed. Heller (2008) based this view on BPD research which shows biological brain disorder as the possible cause. On the other hand, Linehan (1993) proposed that the BPD condition is a problem of emotional dysregulation and that the name should be changed to a more accurate one, such as *Emotional Dysregulation Disorder*. This is consistent with Droskin (2009) who asserts that there is need for change into the stigmatization after BPD diagnosis. He believes that the term leads to patients' ill-treatment as the behaviour tends to be manipulative. There seems to be almost unanimous agreement from reviewed literature on stigmatization that the term BDP be renamed as a result of the core symptoms, impulsivity and emotional dysregulation, and that the adoption of *Emotional Dysregulation Disorder* or *Emotional Regulation Disorder* are the options (Linehan *et al*., 1994). The report by Status of Disabled Persons Secretariat, Department

of the Secretary of State Canada (1988) recommended that, because the language used in diagnosis is negative it needs to be changed to a more objective term; the term BDP is a judgmental connotation that the patient personality is flawed. In addition, personality is widely seen as the essence of a person and that it is insulting to the patient. Therefore, for the term to meet the current standards, it must be changed (p. 30). However, the current study goes beyond stigmatization as seen in the current literature, since it provides further insight into the effect of stigmatization on treatment. There are those who responded claiming that the label never disappeared once diagnosis was made. Some of the respondents felt that professionals took control of their life, seeing them and their situations in a medical way, taking the subjective experience of each participant out of it, and not taking into consideration the meaning that each of them ascribed to their problems. The study reveals that all those who were subjected to a variety of diagnoses lost trust in the professionals and in the possible help that they could get from them. Consequently, the patients felt the psychiatric diagnosis was contradictory because they were not being heard by the professionals regarding their own experiences. This is in light of the fact that the professionals got all the symptoms for diagnosis and treatment from the patients' explanations and descriptions. The study further reveals that despite the labelling, the patients struggle in accepting the diagnosis because while they provide the material for the diagnosis they are unable to effectively contribute to the diagnosis of the condition.

The feelings of alienation and loneliness were predominant in most of them, especially in relation to the professionals' limited and unclear explanations of the BPD psychiatric diagnosis and its symptoms. In the few cases in which the counselling psychologist or medical professional took time to explain the diagnosis and difficulties, the patients' reactions were more positive toward treatment.

Implications

Several implications, both theoretical-research based and practical, emerged from this study in relation to the field of mental health, in particular regarding the significance of understanding and describing BPD from the patient's perception and experiences. The findings in this investigation and the limited research conducted with this focus provided a basis for recommendations for future areas of studies related to BPD. These areas will be further described at the end of this section.

A positivistic and medical-biological perspective remains influential in the practice of mental health around the world. It has influenced the definition and interpretation of symptoms of mental health disorders, including the BPD diagnosis, as well as the therapeutic practice. Findings in this study support the theoretical and research-based premise of the existential therapeutic approach that validates the opinion of the individual who receives the BPD diagnosis and gives importance to the understanding and experience of the patient.

Implications for Clinical Practice

This study provides a strong basis for the need to enhance services offered to such patients and most importantly the fact that practitioners need to be educated about stigmatization and their negative beliefs. The aim of the current study was to assist practitioners as well as those in the mental health field to gain a better understanding of the psychosocial phenomenon a person might experience when they are diagnosed with BPD, and how this experience might change their relationship with others, the world, and the way the self is perceived. It is evident from this study that stigmatization is a major hindrance of progress in both diagnosis and treatment and has a long lasting

effect on the patients. Therefore, regardless of the fact that the explanations and descriptions were not taken into consideration by the medical diagnosis, and that all the participants explained or tended to explain their problems through personal experiences, it is evident that education is needed for the practitioners as they pose a major hindrance right from the start. In this regard the practitioners as well as those in the field need to understand the importance of establishing rapport with patients, so as to bring about effective communication as an element of good practice in healthcare (Rhoades, McFarland, Finch, & Johonson, 2001). This connection between the practitioners and the patients is most likely to bring about an ideal situation that makes treatment better for patients and more so in consideration of the fact that BDP is perceived by practioners as manipulative and could lead to special challenges when it comes to practitioner-patient communication. The study clearly shows that there are complexities in practitioner-patient relations based on the stigmatization. There needs to be care in dealing with the emotions of patients as this is critical in diagnosis. That could affect the way the patient perceived their own self and how others perceive him too. Education, specifically on the communication techniques that include self-awareness, empathy and emotional intelligence, can help a practitioner improve patient interactions.

The current study also reveals that feelings as a result of stigmatization are a main contributor to participants' vulnerability to confusion, loneliness and separation from others and the world. The findings are reason enough for education specifically in self-awareness, empathy and emotional intelligence which can help practitioners improve patient interactions. Leary and Buttermore (2003) explain that the differrence between people and other animals is the fact that people have the ability to think consciously and in a manner that is deliberate, complex and abstract. In addition, Vorauer and Ross (1999) assert that human beings have a wealth of self-knowledge because of their past

experiences that include their thoughts, feelings, goals and intentions. This is much needed in dealing with BPD patients as dealing with them requires sensitivity and more importantly awareness on the part of the practitioners or caregivers. Self-awareness is one important way of mitigating stigmatization among practitioners and developing better ways of communication; its benefits outweigh the drawbacks, and can guarantee effective communication.

Practioners need to be trained and made aware of empathy and its importance and relevance to healthcare practice. Preston and de Waal (2000) explain empathy as the proximal level derived directly from another's behavioural condition onto a subject's behavioural effects. It is both cognitively and emotionally based. As seen from the study, some of the participants' initial attitude towards the BPD diagnosis was to reject it because it was seen as a label imposed on them by another person such as a doctor, psychiatrist or psychologist - someone that they did not trust and who did not take into consideration how they experienced their difficulties. There is a possible indication of lack of empathy on the part of the practitioners seen from their actions during the diagnosis and treatment. Preston and de Waal (2000) assert that there is a direct connection with the practitioner's situation because the patient's emotional state is indicative of the practitioner's emotional state. In this regard, empathy is being in an emotional state that makes possible a communication dyad giving insight into the other party's feeling. For someone who maintains a dialogue, we are constantly monitoring their state of mind to be able to respond fluidly to their emotions, which ensures us that our conversation flows (Bateman and Fonagy, 2002). This adopted into the BPD practice would restore the trust that seems to diminish due to lack of empathy, and is revealed in stigmatization. Mindfulness (Linehan, 1987) is another concept used in cognitive behavioural therapy, a concept related to Mentalization but a broader one that

reflects an attitude of openness also used in Mentalization. It is evident that there were challenges in living as a subjective experience and it was important for all the participants to be listened to and have their ideas taken into consideration, instead of being pushed into one diagnosis or psychiatric stereotype.

In addition, the training to patients needs to take into account the development of emotional intelligence. BPD patients tend to misread minds, not only others but theirs too, and this difficulty affects enormously their capacity to relate with others. Using Mentalization practitioners has helped BPD patients to recognise the experiences as real when its consequences are apparent to all, such as the example of the affection that is learned to be seen as true only when it is accompanied with some physical expression too (Salovey and Mayer, 1990; Bateman and Fonagy, 2002). It is the perception, assessment and expression of emotion, thought facilitated by feelings. This appears to be critical in care and especially in practice that is riddled with lack of trust and stigmatization as all the participants reveal the lack of emotional intelligence in the processes.

Limitations of the Study

The main limitation of the study was the low number of participants. This is an issue connected to generalizability that is not an aim in the methodology of this study. A study such as the current one is more dependent on the sampling narratives and personal experiences, rather than the number of research participants. The study used the ideal characteristics of the participants based on their selection and in this case BPD that reflects the diversity and breadth of the population. The number used was enough to aid in the observation of their experiences. Nonetheless, although the findings aren't generalizable as such, they do provide an interesting alternative perspective and may be

applicable to other people with BPD. However, these findings warrant further research in the area.

Conclusions

The aim of this study was to explore and describe the experience of being diagnosed with Borderline Personality Disorder (BPD) and the changes this brought about in the lives of those who received the diagnosis. This study tried to review the primary theories and conceptual understanding based on the literature available on BPD and examined the meaning and subjective experiences of five participants diagnosed with BPD.

An important aspect found in this study indicates that all participants labelled with a BPD diagnosis perceived themselves different from people around them. They experienced themselves as different or abnormal. As a consequence, they felt misunderstood by others and alienated from family, friends and society. This alienation made the process of accepting their difficulties even harder. For most of the participants, this process made them feel vulnerable, frustrated, and out of control.

One of the most critical aspects found in this study was patients feeling understanding, support and validation from their counselling psychologists and/or medical professionals. This lack of understanding and validation of their own experiences generated in participants a feeling of no trust and lack of power of their own situation that led them to a vicious circle of anger, frustration and depression. Thus, a humane, empathetic, and compassionate attitude toward BPD patients is of critical importance in the professional-patient relationship and the success of treatment.

Finally, it is relevant to acknowledge the fact that the analysis of participants' narratives

and the writing of this research have helped the researcher to find a balance between personal assumptions and prejudices. It has also given her the freedom and space to allow her familiarity with the topic to be applied to research.

In conclusion, findings in this study suggest the need for new theoretical as well as research and practical based paradigms with a focus on assessment, programming and evaluation procedures regarding BPD. Of significance is the need for future research studies to focus on the effects of existential psychotherapy interventions on BPD patients' diagnosis, treatment and possible recovery. A 21st century mental health community will greatly benefit from exploring and implementing innovative, holistic existential therapeutic approaches in the pursuit of the overall well-being of individuals with Borderline Personality Disorder.

REFERENCES

Adler, G. (1985) *Borderline psychopathology and its treatment*, Northvale, NJ,

Aronson Adler, G (1989) A source of information. In: American Psychiatry Review,

Araujo T, Araujo G (2014) Cortical morphology changes in women with borderline personality disorder : a multimodal approach. Revista Brasilera de Psiquiatria, ScIELO Brasil

Talsman A, Robert E. *Psychodynamic Therapies in Borderline Personality Disorde*r, Ch. 3, P: 49-57

Adler, A (1982) *The fundamental views of individual psychology*, Journal of Adlerian Theory& Research and practice, 38 (1): 3-6

Akhatar S (1999) Inmigration and identity: Turmoil, treatment and transformation. Jason aronson

Alarcón R, Leetz K (1998) Cultural intersections in the psychotherapy of borderline personality disorder. American journal of psychotherapy 1998

Albee, G.W, Joffe, J. (2004*) Mental illness is NOT an illness like any other*. The Journal of Primary Prevention 24(4):419-436

Allik J (2005) Borderline personality disorder: what do we know? Diagnosis, course aetiology. South african journal of psychology

American Psychiatric Association. (2000). DSM-*IV-TR: Diagnostic and Statistical Manual of Mental Disorders.* (4th Revised edition). Arlington: American Psychiatric Press.

American Psychiatric Association: *Practice guideline for the treatment of patients with borderline personality disorder* by J. M Oldham. (2005); 158: pp. 1–52

Anckarsäter, H. (2010) Beyond categorical diagnostics in psychiatry: Scientific and medico- legal implications. *International Journal of Law and Psychiatry*, 33(2):59–65

Andrulonis,P, Nogel, N (1984) *Comparison of borderline personality subcategories to schizophrenic and affective disorders,* The British Journal of Psychiatry, 144 pp: 358-363

Angus, L. & Gillies, L. A. (200) A source information. In: Comprehensive guide to interpersonal Psychotherapy, Myrna M, Weeisman J. Ch.3. Counselling the borderline client: an interpersonal approach.

Archer, J. (1987) bereavement studies of Grief an adult life *Journal of Social and Personal Relationships, .4(3):378-380*

Ashworth P D (2003) *An approach to phenomenological psychology: the contingencies of the lifeworld. Journal of Phenomenological Psychology* 34 (6):145–156.

Aviram, R, Brodsky, B et al (2006) *Borderline Personality Disorder, Stigma and treatment implications*, Harvard Review of psychiatry, 14 (5): 249-256

Bannister, D (1968) *The Logical requirements of Research into Schizophrenia*, British Journal of Psychiatry, 114: 181-188

Barkham, M. (2003) *Handbook of Counselling Psychology*, London, SAGE Publications Ltd

Barnow S, Stopsack M, Grabe H et al. (2009) Interpersonal evaluation bias in borderline personality disorder. *Behaviour Research and therapy*. 43(5): 359-365

Baron, M, Gruen, R, Asnis, L (1985) *Familial Transmissions of Schizotypal and Borderline personality disorder,* The American Journal of Psychiatry, 142(8): 927-934

Batcheler, M (2003) A management of Borderline personality disorder. British Journal of psychiatry 183:78-79

Beck A, Freeman, A (2006) Cognitive therapy of personality disorder. Guilford Press USA

Bell, J, Duff, P (2002) Narrative Inquiry: More than just telling stories, Tesol Quarterly, 6(2): 207-213

Benjamin, J. (1988) *Shadow of the Other,* USA, Routledge Benjamin, L. S. (1996) *Interpersonal Diagnosis and Treatment of Personality Disorders.* New York: Guilford Press.

Bentall, R. (2003) *Madness Explained: Psychosis and Human Nature.* Allen Lane, London

Bentall, R. (2009) *Doctoring the Mind: Why psychiatric treatments fail*. London: Peguin Books

Beres D (1956) Ego deviation and the concept of schizophrenia. *Psychoanalytical Study Child* 2: pp. 164-235.

Bervall, Nilson, Hansen (2003) Temperament and character correlates of neuropsychological performance. South African journal of psychology 2010

Binswanger L (1963) *Being in the World*, USA, Basic Books Inc, Publishers

Binswanger L (1972) *Tres Formas de la existencia frutrada*, España, Amorrurto

Blankenburg W (1980). *Phenomenology and psychopathology*. Journal of Phenomenological Psychology, 11, 50-78.

Bohus, M, Limberger, M, Ebner, U. Et al (2000) *Pain perception during self reported distress and calmeness in patients with BPD and self mutilating behaviou*r; Psychiatry research, 95 3): 251-260

Boschen M & Warner, J. (2009) Publication trends in individual DSM personality

disorders: 1971-2015. *Australian Psychologists* 44(2): 136-142

Boss, M (1979) *Existential foundations of medicine and psychology*, New Jersey, Jason

Aronson Inc.Bowlby, J. (1969) *Attachment and loss*, New York: Basic Books

Boyle, M. (1993) *Schizophrenia: a scientific delusion*. London, Routledge

Bracken, P. & Thomas, P. (2001) Postpsychiatry: A new direction for mental health. *British Medical Journal*, 322(7288): 724-727.

Bracken, P, Thomas, P, Timimi, S, et al (2012) *Psychiatry beyond the current paradigm*, British journal of psychiatry, 201(6): 430-434

Bracken, P, Thomas, P, (2010) *From Szasz to Foucault: On the role of critical psychiatry*, Philosophy, Guilford Press

Braun V (2013) Succesful qualitative research: A practical guide for beginners Ltd. Croydon

Brown g et al, (1995) Assessment of dysfunctional beliefs in borderline personality disorder. Behavioural research, Elsevier 2002

Buber, M. (1923) *I and Thou*, trans. W. Kaufman, Edinburgh: T. and T.

Burston, D (2000) The crucible of experience: R D Laing and the crisis of psychotherapy, Harvard college library,

 Bychowsky, G. (1953) The Problem of latent psychosis. *Journal of the American Psychoanalytic Association,* 4 (1): 484-503

Byrne, P. (2000) *Stigma of Mental Illness and ways of diminishing* it. Advances of Psychiatric Treatment, 6: 65-72

Cacioppo, J., Hawkley, L.C, Patrick, W. (2011) Lonely Planet. *RSA Journal, Autumn 2011*. Accessed at: http://thersa.org/fellowship/journal/archive/summer2012/features/lonely- plantet

Calverley, R. M., Fischer, K. W. & Ayoub, C. (1994) Complex splitting of self-representations in sexually abused adolescent girls. *Development and Psychopathology,* 6 (1): 195–213.

Carpenter, W.T (1997) The risk of medication. *Free research. Schizophrenia Bulletin.* 23 (1):11-18

Carison K, Gaunson K, Wood SJ, Yuen HP (2008) Orbifrontal, amygdala and hippocampal volumes in teenagers with first presentation of Borderline disorder. Psychiatry research journal Elsevier

Cattel RB (1957) Personality and motivation structure am measurement. Psycnet.apa.org

Clare, J (1980) *Psychiatry in dissent: Controversial issues in thought and practice* (2nd. Ed.) London: Routledge

Clark, L.M. (1993) Personality Disorder diagnosis: Limitations of the five factor model. *Psychological Inquiry*, 4, pp. 100-104

Clark, L. M. (2007) *Assessment and diagnosis of Personality Disorder: Perennial Issues and Emerging Conceptualization*. Annual Review of Psychology. 58: 227-257

Clarkin J F & Lenzenweger F. (2005) *Major Theories of personality Disorder*, New York, Guilford Press

Coccaro, E, Siever, L, Klar, H, Maurer, G (1989) *Serotonergic studies in patients with affective and personality disorders*, JAMA Psychiatry, Formerly Archives of general Psychiatry, 46(7) 587-599

Coccaro, E, Silverman, J, Klar, H, Horvarth, t , Siever, J (1994) *Familial Correlates of Reduced Central Serotonergic System Function in Patients with Personality Disorders*, JAMA Psychiatry, Formerly Archives of General Psychiatry, 51(4): 318-324

Cohen, D & Moncrieff, J (2005) Rethinking models of psychotropic drug action. *Psychotherapy and Psychosomatics*, 74(3):145-153

Coid et al, (2009) The American Psychiatric textbook of personality disorder, American psycjiatric Assocoaition USA

Cooper, D. (1967) *Psychiatry and anti-psychiatry*. London: Tavistock Publications.

Corney, R. (2003) *Handbook of Counselling Psychology*, London, SAGE Publications Ltd

Costa PT, McCrae RR (1987): Facet scales for agreeableness and conscientiousness: a revision of the NEO PI inventory. Journal of personality and social

Crawford, M., Hopkins, W., Thomas, P., Moncrieff, J., Bindman, J. & Gray, A. (2001) Most psychiatrists oppose plans for new Mental Health Act, British Medical Journal, 322, 866

Critchfield KL, Clarkin JF (2008) Organization of co-occurring Axis II features in borderline personality disorders. British Journal of psychiatry

Crossley N. (1996) *Intersubjectivity: The Fabric of Social Becoming*, London, SAGE Publications Ltd

Crossley N. (2006) *Reflexive Embodiment in Contemporary Society,* London, Open University Press.

Dahl, M (1993) *The Role of the Media in Promoting Images of Disability-Disability as a Metaphor: The Evil Crip*, ed. Eds. Kim Flachman, Alexandra

De la Fuente, J, Goldman, S, Stabus E, Morlan, I (1997) *Brain glucose metabolism in borderline personality disorder*, Journal of psychiatric Research, 31(5): 531-541

Distel M, Rebollo M, Willemsen G et al. Familial resemblance of Borderline Personality Disorder Features: Genetic or Cultural Transmission. *Plo One*. 2009, 4(4): 5334

Domes, G, Czieschnek, D, Weidler, F. et al (2013) *Recognition of facial affect in BPD, Journal of personality disorders,* 22 (2): 135-147

Drapeu, M, Perry, C (2004) *Interpersonal conflicts in BPD: exploratory study using CCRT-LU*, Swiss journal of psychology, 63 (1): 53-57

Dreyfus, H. (1991). *Being-in-the-world: A commentary on Heidegger's Being and Time.* Cambridge, MA: MIT Press.

Dvoskin J.A. (2002) Sticks and Stones – The abuse of psychiatric diagnosis in prisons, www.vachss.com/guest_dispatches/dvoskin.html.

Errington, M. & Murdin, L. (2004) *Handbook of Counselling and Psychotherapy*, London, SAGE Publications Ltd

Feighner, J.P., Robins, E., Guze, S.B., et al (1972) Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry,* 26(1) pp. 57-63.

Feyerabend, P (1975) *Against method: Outline of an anarchistic theory of knowledge.* London: NLB

Fire, R (2004) Understanding Experience: Psychotherapy and Postmodernism, Routledge New Y ork

Fischer, W. (1986). *On the phenomenological approach to psychopathology.* Journal of Phenomenological Psychology, 17(1): 65-76.

Fonagy, P., Leigh, T., Steele, M., et al (1996) The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology*, 64(1) :22–31

Foucault, M (1961) *History of Madness*, London, Routledge

Foucault, M (2006) *Psychiatric Power*: *Lectures at the college de France. 1973-1974,* ed. J. Lagrange, trans G. Burchell. New York: Palgrave Macmillan.

Frances, A (2009) *A warning sign on the road to the DSM-V: Beware of its unintendedconsequences*. Psychiatric Times. Accessed at: http://www.psychiatrictimes.com/dsm5/content/article)10168/1378

Freud, S. (1930) *El malestar de la cultura,* Trad. Ludovico Rosenthal, Argentina, Editorial EA

Frie, R. (1997) *Subjectivity and Intersubjectivity in Modern Philosophy and psychoanalysis.* New York, London, Rowman & Littlefield Publishers, INC

Frie, R. (2000). *The existential and the interpersonal: Ludwig Binswanger and Harry Stack Sullivan*. Journal of Humanistic Psychology, 40, 108-130.

Fromm, E. (1947) *El Miedo a la Libertad,* Barcelona, Ediciones Paidós Iberica

Frommer, J, Reissner, V (1997) New approaches for understanding borderline personality disorder, Klinisches Institut und Klinik fur, 65(1) : 34-40

Frosch, M. (1964) *The psychotic character: Clinical psychiatric considerations,* The Psychiatric Quarterly, 38(1-4).: 81-96

Gabbard, G, Mardi, J (2009) Insight, transference interpretation and therapeutic change in the dynamic psychotherapy of BPD, Am J Psychiatry,

Gadamer, H. (1976) *Philosophical Hermeneutics*, Los Angeles, University California Press

Gaskell, G. (2000) *Individual and Group Interviewing.* In Baue, M.W. and G. Gaskell (eds). Qualitative Researching with Text, Image and Sound: A Practical Handbook. London: SAGE.

Geekie, J, Read, J, (2009) *Making Sense of Madness: Contesting the meaning of Schizophrenia*, USA, Routledge

Gergen, J, McNamee, S, (2001) *Towards Transformative Dialogue,* International Journal of Public administration, 24(7-8): 679-707

Gergen, K. (1999*) An invitation to social construction*. London: Sage. Ghaemi, S (2001) rediscovering existential psychotherapy: the contributions of Ludwig

Binswanger, An J psychotherapy, 55 (1): 51-64

Giesen-Bloo, J, van Dyck, R, Spinhoven, P, van Tiburg,W, Kremers, I, Arntz, A (2006) *Outpatient Psychotherapy for Borderline Personality Disorder: Randomized Trial of Schema-Focused Therapy vs Transference-Focused Psychotherapy*. JAMA Psychiatry, Formerly Archives of General Psychiatry, 63(6): 649-658

Giorgi, C, T. Fischer, and Edward L. (1975) Phenomenological Research Methods (Eds.), Duquesne Studies in Phenomenological Psychology: 2: 82-103, Pittsburgh: Duquesne University Press.

Giorgi, A. (2010) Phenomenology and the practice of science. *Existential analysis*. 21 (1):3- 22.

Giorgi, A.P & Giorgi, B. (2008). Phenomenological Psychology. In C. Willig & W. Rogers (eds.). SAGE Handbook of Qualitative Research in Psychology (pp.165-178).

Glover N, Crego C, Widiger T. (2012) The clinical utility of the five factor model of personality disorder. *Personality Disorder: Theory, Research and Treatment.* 3(2): 176-184

Goffman, I. (1959) *The Presentations of Self in Everyday Life*, USA, Penguin Books

Goldberg. C. (2000). *Healing madness and despair through meeting*, USA, American Journal of psychotherapy

Goldstein WN (1985) *An Introduction to the Borderline Conditions*. Northvale, N.J.: Jason Aronson.

Goldstein WN (1989) An integration of the views of Kernberg and Adler on borderline pathology. *Bull Menninger Clin* 53(4): 300-309.

Goldstein WN (1996), *Dynamic Psychotherapy with the Borderline Patient.* Northvale, N.J.: Jason Aronson.

Goldstein WN (1998) *A Primer for Beginning Psychotherapy.* New York: Brunner/Mazel.

Greenberg, J, Mitchell, A (1983) *Object Relations in Psychoanalytic Theory*, USA Library of congress

Grinker, Weble, Dryer (1968) Follow up studies of borderline personality disorder: a critical review. Journal of personality disorder 1988 Guilford Press

Gross R, Olfson M (2002) Borderline Personality disorder in primary care. Jama internal medicine

Gunderson J. (1984), *Borderline Personality Disorder.* Washington: American Psychiatric Press.

Gunderson, J. (2009) Borderline Personality Disorder: Ontogeny of Diagnosis, *Am J Psychiatry* 166:530-539

Harley K (2006) On conceptual definitions and boundaries: The case of theory use. 56 (2) 289-306

Hankin B, Barrocas A, Jennes j et al. (2011) Association between 5-HTTLPR and Bordeline personality disorder trait among youth. *Frontier in psychiatry* 2(6):1-7

Harré,R. (1994) *The Discursive Mind*, London, Sage

Haslam, J. (1798) *Observations on Insanity*. London: Rivington.

Hegel, G. (1979) *The Phenomenology of Spirit*, Oxford, Clarendon

Heidegger, M. (1951) *El Ser y el Tiempo*, México, Fondo de Cultura Económico

Heidegger, M. (1962) *Being and Time*, Oxford, Blackwell Publishing

Heller, L (2008) "A possible new name for Borderline Personality Disorder", www.biologicalunhappiness.com.

Herman, J. L., Perry, C. & Kolk, B. (1989) *Childhood trauma in borderline personality disorder*. American Journal of Psychiatry, 146, 490–495.

Hildebrandt, M; Ruiter, C. (2004) *PCL-R psychopathy and its relation to DSM-IV Axis I and II disorders in a sample of male forensic psychiatric patients in the Netherlands.* International Journal of Law and Psychiatry, 27 (3): 233-248.

Hoch, P; Cattel, J; Ostrhal,M. (1962) *The Course and Outcome of Pseudoneurotic Schizophrenia.* The American Journal of psychiatry. 119 (2): 106-115

Hoffman, P. (2007) Borderline Personality disorder: A most misunderstood Illnesss, Eduaction alliance for BPD

Holmes J (2004) Disorganized attachment and borderline personality disorder: A clinical perspective. *Attachment & Human Development*, 6 (2):181-190

Honneth, A (2001) *The Pathologies of Individual Freedom*, London, Princeton and Oxford University Press

Husserl, E. (1977). *Cartesian meditations – an introduction to phenomenology.* The Hague: Martinus Nijhoff.

Ihde, D. (1986) *Experimental Phenomenological Introduction*, Albany, New York Sunny Press I

Ingleby, D. (1981) Understanding 'mental illness'. *In Critical Psychiatry: The Politics of Mental Health* (ed. D. Ingleby), pp. 23–71. Harmondsworth: Penguin.

Jaspers, K. (1941) *Way to Wisdom*, Connecticut, USA, The Carl Purington Rolling Printing- office of the Yale University Press

Jaspers, K. (1971) *Philosophy of Existence*, USA, Walter de Gruyter & Co.

Kelly, B, Bracken, P, Cavendish, H (2010) *The myth of mental illness: 50 years after publication: What does it mean today*, Journal Psych Med, 27 (1):35-43

Thomas M. Kelly, Paul H. Kevin G. Lynch Et al (2000*).* Recent Life Events, Social Adjustment, and Suicide Attempts in Patients with Major Depression and Borderline Personality Disorder. Journal of Personality Disorders*: USA 14(4): 316-326.*

Kelly, T, Soloff, P, Lynch, G, Haas, G. (2000) *Recent Life Events, Social adjustment and suicide attempts in patients with major Depression and Borderline Personality disorder*, Journal of Personality disorder, 14 (4): 316-326

Kernberg, O. (1975) *Borderline Condition and Pathological Narcissism*, New York, Jason Aronson

Kernberg, O (1984), *Severe Personality Disorders: Psychotherapeutic Strategies.* New Haven: Yale University Press.

Kernberg, O (1985b), *Internal World and External Reality: Object Relations Theory Applied.* New York: Jason Aronson.

Kernberg OF, Seltzer M, Koenigsberg H, Carr A et al. (1989), *Psychodynamic Psychotherapy of Borderline Patients*. New York: Basic Books.

Kernberg, O & Michaels, R. (2009) Borderline Personality Disorder, *American Journal of Psychiatry* 166: 505-508

Kierkegaard, S. (1954) *The Sickness unto Death*, New York, Doubleday & Co.

Kiesler, D (1999) *Beyond the disease model of mental disorder*s, USA, Praeger Publishers.

Kim, G, Rosenthal, Z, Tull, M. et al (2006) *An experimental investigation of emotion dysregulation in BPD, Journal of abnormal psychology*, 115 (4): 850-855

King-Casas, B, Sharp, C, Lomax-Beam, L (2008) The rupture and repair of cooperation in borderline personality disorder, Science magazine, 321(5890): 806-810

Knight, Z.G. & Bradfield, B.C. (2003). *The experience of being diagnosed with a psychiatric disorder: Living the label*. Indo-Pacific Journal of Phenomenology, 3 (1), 1-20.

Kodolbsky, N. (2005) *Trastorno Borderline de la Personalidad, un desafío clínico,* Buenos Aires, Editorial Polemos.

Koeningsberg, (2009) http:/forum.Psychlinks.ca/borderline-personality-disorder/23979-whenpassion-is.the.enemy-borderlinepersonality-disorder.htlm

Koerner, K. (2012) *Doing Dialectical Behaviour Therapy: A Practical guide,* New York, Guilford Press

Kohut, H. (1984) *How Does Analysis Cure?* Chicago, IL: University of Chicago Press.

Kojeve, A. (2006) *La Dialéctica del Amo y del Esclavo en Hegel*, Buenos Aires, Editorial Leviatán.

Krawitz, R (2004) Borderline Personality Disorder: Attitudinal Change Following Training, Australian and New Zeland Journal of Psichiatry, 38 (7): 554-559

Kreisman, J, Straus, H. (1991) *I hate you. Don't leave me*, New York, Avon Books.

Kvale, Steinar (1996) *Interviews: An Introduction to qualitative Research Interviewing.* London, Sage, Ch,7: The Interview Situation, p. 124-135

Lacan, J, (1971) *Escritos Vol 1 &2,* Argentina, Siglo veinte y uno ed.

Laing, R.D. (1960) *The Divided Self*, London, Tavistock Publications

Laing, R.D. (1961) *Self and Others*, London, Tavistock Publications.

Lally, S (1989) *Does being in here mean there is something wrong with me?*, Schizophrenia Bulletin, 15(2): 253-265

Lang S, Stopsack M, Kotchoubey B et al. (2011) Cortical inhibition in alexithymic patients with borderline personality disorder. *Biological Psychology*. 88(3) 227-232

Langdridge, D.(2007), *Phenomenological Psychology. Theory, Research and Method*. London, Pearson Prentice Hall

Leichsenrig F, Leibing E (2011) Borderline Personality Disorder. Pub Med gov. USA

Leihener F, Wagner A, Haaf B, Schmidt C, Lieb K, Stieglitz R, Bohus (2003) *Subtype differentiation of patients with borderline personality disorderusing a circumplex model of interpersonal behavior.* University of Freiburg Medical   School, Germany.

Leising, D, Zimmerman, J. (2011). *An Integrative conceptual framework for assessing personality and personality pathology,* Review of general psychology, 14(4): 317-330

Leontieva L, Gregory R (2013) Vharacteritics of patients with borderline personality disorder in a state psychiatriv hospital. Journal of personality disorder, Guilford press

Levine, D, Marziali, E, Hood, J (1997) *Emotion processing in BPD, Journal of nervous and mental disease,* 185 (4): 240-246

Levy, K (2005) The implications of attachment theory and research for understanding borderline personality disorder

Lieb,K, Linehan m; Bohus, M (2007) State affective instability in borderline personality disorder asses by ambulatory monitoring. Cambridge University Press

Linehan, M. M., Armstrong, H. E., Suarez, A., et al (1991) Cognitive-Behavioural treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48: 1060– 1064.

Linehan, M. (1993) *Cognitive Behavioral Treatment of Borderline Personality Disorder*, New York, Guilford Press

Linehan, M. M., Tutek, D., Heard, H., et al (1994) Interpersonal outcome of cognitive behavioural treatment of chronically suicidal borderline patients. *American Journal of Psychiatry*, 151: 1771–1776.

Links, P, Mitton, J, Steiner, M (1990) *Predicting outcome for borderline personality disorder*, Comprehensive Psychiatry, 31: 490-498

Links p, Offord D, Epper A (1988) Characteristics of borderline disorder: a Canadian study. Canadian journal of psychology

Lipovetsky, G (2003) *La Era del Vacío*, México, Ed. Anagrama

Lis E, Greenfield B, Henry M et al. (2007) Neuroimaging and genetics of borderline personality disorder: a review. *Journal of Psychiatry Neuroscience*. 32(3):162 173.

Lorda, S. (2007) Systemic work with clients with diagnosis of BPD, Journal of family therapy, 29 (3): 203-221

Luijpen, W (1969) *A First Introduction to Existential phenomenology*, USA, Duquesne University Press

Livesley T (2000) The borderline diagnosis II: Biology. Psychiatric clinic of North America

Lyoo, IK, Heen Han, M (1998) *A brain MRI study in subjects with borderline personality disorder*, Journal of Affective Disorders, 50(2-3): 235-243

Lyoo, IK, Stoll, A, Parow, A (2003) *Frontal Lobe gray matter density decreases in bipolar I disorder, Biological psychiatry*, 55(6): 648-651

Mahler, M (1972) *On the first three subphases of the separation-individuation process*, The International Journal of Psychoanalysis, 53(3): 333-338

Mahler, M, Pine, F & Bergman, A. (1975) *The psychological birth of the human infant*. New York: Basic Books.

Marcel, G. (1935) *Ser y Tener*, Traducción de Ana María Sanchez Lopez, Madrid, Caparros Editores S. L

Marcel, G. (1953) *El Misterio del Ser*, Buenos Aires, Editorial Sudamericana

Marcel, G. (1956) *The Philosophy of Existentialism* New York, Citadel Press

Masterson J (1976), *Psychotherapy of the Borderline Adult: A Developmental Approach*. New York: Brunner/Maze

Masterson, J (1981) The Narcissistic and Borderline Disorders Bruner/Mazel

Masterson, J (2005) *The Personality Disorders Through The Lens of Attachment Theory and the Neurobiologic Development of the Self* , Zeig, Tucker & Theisen

Maudsley, H (1878) *Responsibility in Mental disease*, New York, D. Appleton and Company, Re printed by Cornell University Library

May, R. (1986) *The Discovery of Being*, USA, Norton & Company Inc

May, R, Angel, E, Ellenberger, H (1994) *Existence*, USA, Rowman & Littlefied Publishers, INC

McAdams, D. P., & Logan, R. L. (2006). *Creative work, love, and the dialectic in selected life stories of academics. In D. P. McAdams, R. Josselson, & A. Lieblich (Eds.), Identity and story: Creating self in narrative* (pp. 89–108). Washington, DC: American Psychological Association.

McAdams, D. P., & Pals, J. L. (2006*). A new big five: Fundamental principles for an integrative science of personality.* American Psychologist, Vol. 61(3):204–217.

McDevitt, J (1975) *Separation -Individuation and object constancy,* Journal of the American Psychoanalytic Association, 23(4): 713-742

McEwan, H (1997) *The Functions of Narrative and research on teaching,* Teaching and Teacher education, 13(1): 85-92

McLeod, J. (2001) *Qualitative research in counselling and psychotherapy.* London: Sage.

McLeod, J. (2003), *Doing Counselling Research*, London SAGE Publications Ltd

Mead, G. (1934) *Mind, Self, & Society from the Standpoint of a Social Behaviorist*, Chicago, The University of Chicago Press

Mearns, D, Copper, M (2005) Working at relational depth in counselling and psychotherapy London, Sage.

Merleau-Ponty, M (1945) *Phenomenology of Perception* Routledge NY & London

Miller, W. (2003) Faking *it,* Cambridge, Cambridge University Press.

Millon, T (1995) *Disorders of Personality- DSM-IV and Beyond*, 2nd ed. New York, John Wiley & Sons

Mills, J. (2004) *Psychoanalysis at the limit: Epistemology, mind and the question of science*, State University New York

Mikulincer M, Shaver P (2013) An attachment perspective on therapeutic processes and outcomes. Journal of personality Wiley online library

Moncrieff, J; Cohen, D (2006) Do antidepressants cure or create abnormal brain states? *PloS Medicine*, 3(7). 240

Moncrieff, J. (2008) *The Myth of the Chemical Cure: A critique of Psychiatric Drug Treatment.* Basingstoke, Palgrave Macmillan

Montes, A, Tajima, K, Carrasco, J (2009) *Estudios de neuromagen en el trastorno límite de personalidad, Actas Psiquiátricas,* 37(3): 123-127

Moran, D. (2000*) Introduction to phenomenology*. London: Routledge. Moreno, J. (2010) *Ser humano: La Incosistencia, los vínculos, la crianza,* Argentina, Letra Viva.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage Publications.

Neu, J. (2003). *Guía de Freud*. Traducción Mario Santana. Madrid: Akal Cambridge New, a,

Triebwasser, J (2008) The case of shifting Borderline personality Disorder, Biol Psychiatry

Ni X, Bismil R, Chan K et al. (2006) Serotonin 2A receptor gene is associated with personality traits, but not to disorder, in patients with borderline personality disorder. *Journal of psychiatric research*. 40(5): 448-453

Nixon R (1998) Research and development performance measurement : a ca se study. Managament accounting research 1998 Elsevier

O´Donohue, W, Cicciare, M (2007) *Identifying and Treating psychological factors in medical settings, International*, Journal of clinical and health psychology, 7(3): 807-821

Olafson, F. (1995) *What is a Human Being?* Cambridge, Cambridge University Press.

Oldham, J. (2005) Practice guideline for the treatment of patients with borderline personality disorder, American Psychiatric Association, 293(20):51-57

O' Neil, (1996) *Hegel's Dialectic of Desire and Recognition,* USA, State University New York Press.

Owen, D (2009) *En el poder y la enfermedad*, Madrid, Ediciones Siruela

Paris, J. (1994) *Borderline Personality Disorder, A multidimensional approach,* Washington, DC, American Psychiatric Press

Paris, J (2007) Why psychiatrists are reluctant to diagnose Borderline personality disorder, MD psychiatry 4(1): 35-39

Perez-Rodrigues M, Hazlett E, Ripoll, L, Koenigsberg, H, (2012) *Striatal activity in borderline personality disorder with comorbid intermittent explosive disorder: Sex difference*s, *Journal of psychiatry research.* 2012, 46(6): 797-804

Perry, Herman (1993) *Borderline Personality Disorder: Aetiology and treatment*, USA, American psychiatric Press.

Pincus. A (2005) *Some comments on Nomology, Diagnostic process and Narcissistic personality disorder in the DSM 5 Proposal for Personality and Personality Disorder.* Personality disorder, Theory, Research and Treatment, 2: 41-53

Polkinghorne D (1983) *Methodology for the Human Sciences*. Albany: Suny Press.

Ramsland, K (1989) *Engaging the immediate, applying Kierkegaard's theory of indirect communication to the practice of psychotherapy*. Associated university Press London

Reichbor-Kjennerud, T. (2011) The Genetic epidemiology of personality disorder. *Dialogues in clinical neuroscience,* 12 (1):103-114

Ricoeur, P. (1981) *Hermeneutics & the Human Sciences*, translated by John Thompson, Cambridge, Cambridge University Press

Ricoeur, P. (1986) *Del Texto a la Acción*, Buenos Aires, Fondo de Cultura Económica de Argentina.

Ricoeur, P. (2007) *Vivo hasta la Muerte*, Buenos, Aires, Fondo de Cultura Económica

Riessman, C. K. (1993) *Narrative Analysis* Newbury Park, CA: Sage Publications.

Rogers, A (2010) *A sociology of mental health and illness*, Open university press, McGraw – Hill education, England.

Rogers, C. (1969) *Freedom to learn*. Columbus: Merrill. Rosen, G. (1968) *Madness in Society, Chapters in the Historical Sociology of Mental Illness*, Chicago, USA, The University of Chicago Press

Ruiter, C; Greeven, P (2004). *Personality Disorder in a Dutch forensic psychiatric sample : changes with treatment.* Criminal Behaviour and Mental Health, 14(4): 280-290

Ruocco A, Zakzanis K, Amirthavasagam S (2012) Amydala and hippocampal volume

reductions as candidate endophenotypes for borderline personality disorder: a meta analysis of magnetic renonace imaging. Psychiatry Research Journal Elsevier

Ryle, A. (1997) The structure and development of borderline personality disorder: a proposed model. *British Journal of Psychiatry*, 170: 82-87

Ryle, A., Leighton, T. & Pollock, P. (1997) *Cognitive Analytic Therapy of Borderline Personality Disorder.* Chichester: John Wiley

Sabo, A (1997). *Etiological Significance of Associations Between Childhood Trauma and Borderline Personality Disorder: Conceptual and Clinical Implications*. Journal of Personality Disorders: 11(1): 50-70.

Samuels et al, (2002) Treatment of Borderline disorder. Study conducted at one of the original ECA sites in Baltimore

Salters-Pedneault, K. (2009) Stigma and Personality Disorder : How stigma impacts people with BPD.

Sartre JP (1943) *Being and Nothingness An Essay on Phenomenological Ontology*, trans. H. Barner, New York

Sartre JP (1957). *The transcendence of the ego: An existentialist theory of consciousness*. New York: Noonday Press.

Sartre, JP. (1962) *Sketch for a Theory of the Emotions*, New York, Methuen & Co. Ltd

Sartre, J P. (1976) *Critique of dialectical reason, vol I, theory of practical ensembles*. London: New Left Review.

Salzman J. (1998) Etiology of Borderline Personality Disorder, American Journal of psychiatry, 155(11): 1626aa-1626

Saunders, E, Arnold, F (1990) Borderline Personality disorder and Childhood abuse: Revisions in clinical thinking and treatment approach,

Scheff, T. (1984*) Being Mentally Ill A sociological Theory*, New York, Aldine de Gruyter

Schulte, P (2000) *Holding in mind: Intersubjectivity, Subject relations and the group*, Group analysis, 33(4): 531-544

Schutz, A. (1967) *The Phenomenology of the Social World*, USA, Northwestern University Press.

Schwartz, M. Wiggins, O. (2002) *The hegemony of the DSMs.* In J.Z. Sadler (ed) Descriptions and prescription: Values, metal disorders and the DSMs. Baltimore: The John Hopkins University Press

Schwartz-Salant N (1989) *The Borderline Personality: Vision and Healing*, USA, Chiron Publications.

Scientific American Mind journal (2010), *Borderline Personality*, 21(3), July/August

Scott M.J. & Dryden, W (2003) *Handbook of Counselling Psychology*, London, SAGE Publications Ltd

Sherwood P (2001) Client experience in psychotherapy what heals what harms?, Indo-pacific journal of phenomenology 2:1-24

Shinebourne P (2011*)* The theoretical underpinnings of interpretative phenomenological analysis. *Existential Analysis*. 22, (1):16-31.

Siever, L, Torgersen, S, Gunderson, J, Livesley, W, Kendler, K, (2002) *The borderline diagnosis III: Identifying endophenotypes for genetic studies,* Biological Psychiatry, 51(12): 964-968

Skodol. A, Bender, D. (2009) *The Future of Personality Disorders in DSM-V?* The American Journal of Psychiatry, 166: 388-391

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative research in psychology*. 1(1):39-54.

Smith, J. A., Flowers, P., Larkin, M. (2009) *Interpretative phenomenological analysis. Theory, method and research.* London: Sage.

Soloff P, Price J, Meltzer C et al. (2007) 5HT 2A Receptor binding is increased in borderline personality disorder. *Biological psychiatry.* 62:580-587

Solomon, R*,* (1983) *In the Spirit of Hegel*, UK, Oxford University Press.

Specht, M, Chapman, A, Cellucci, T (2009) *Schemas and Personality disorder symptoms in women,* Journal of Behavior Therapy and Experimental Psychiatry, Vol 40 (2): 88-91

Spinelli, E. (2005) *The Interpreted World, an introduction to phenomenological psychology*, London, SAGE publications Ltd.

Sprague J, Javdani S, Saden N. (2011) Borderline personality disorder as a female phenotype expression of psychopathy? *Personality Disorder: Theory, Research and Treatment*, 3(2):127-139

Staring, A, Berge, M, Mulder, C (2009) *Stigma moderates the associations of insight with depressed mood, low self-esteem, and low quality of life in patients with schizophrenis spectrum disorders*, Schizophrenia Research, Vol. 115, pp: 363-369

Stern, A. (1938) Psychoanalytic investigation of and therapy in the border line group of neuroses. *Psychoanalytic Quarterly*, 7, pp. 468-470

Stevenson, J. & Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder. *American Journal of Psychiatry*, 149, 358

Stone MH (1993), *The Fate of Borderline Patients: Successful Outcome and*

Psychiatric Practice. New York: Guilford Press.

Strawbridge S. & Woolfe R (2003) *Handbook of Counselling Psychology*, London, SAGE Publications Ltd

Sugarman L (2003) *Handbook of Counselling Psychology*, London, SAGE Publications Ltd

Sullivan HS (1953) *The Interpersonal Theory of Psychiatry*, New York, H. S Perry and M. L Gawell

Sullivan HS (1964) *Schizophrenia as a human process.* New York: WW Norton & Co.

Summerfield D (2008) *How scientifically valid is the knowledge base of global mental health?*, British Medical journal, .336(7651): 992-994

Syme G (2004) *Handbook of Counselling and Psychotherapy*, London, SAGE Publications Ltd

Szasz T (1970) *Ideology and Insanity, Essays on the Psychiatric Dehumanization of Man,* USA, Syracusse University Press ed.

Szasz T (1974) *The Myth of Mental Illness,* New York, Perennial

Szasz T (1976) *Insanity: The Idea and its Consequences*, USA, J Willey & Sons

Szasz T (2007) The Medicalization of Everyday Life, USA, Syracusse University Press ed.

Szasz T (2008) *Psychiatry The Science of Lies,* USA, Syracusse University Press ed.

Thiel t, Geiger E, Haegale L, Lemieux L (2003) Frontolimbic brain abnormalities in patients with borderline personality: a volumetric magnetic resonance imaging study. Elsevier

Tillich P (1956) *The Courage to be,* Yale, Yale University Press.

Toombs S (1987) *The meaning of Illness: a phenomenological approach to the patient-physician relationship*, Journal of medicine and philosophy, J Med Philos, 12(3): 219-240

Torgensen S, Krimglen E, Carmer V. (2001) *The prevalence of Personality Disorders in a Community Sample.* Arch Gen Psychiatry.59(6): 590-596

Triebwasser J, Charney DS (2008) The case for shifting borderline personality disorder to Axis I National center for biotechnology information By AS News

Tupes & Crystal (1961) Valdation of the openness scale of the personality inventory. University of Johannesburg

Van Deurzen, E. (1997) *Everyday Mysteries: Existential Dimension of Psychotherapy*, London, Routledge

Van Manen, M. (1990). *Researching Lived Experience*. Albany: State University of New York Press.

Van der Kolk B. A., Hostetler A, Herron, N., et al (1994) Trauma and the development of borderline personality disorder. *Psychiatric Clinics of North America*, 17(14):715

Van Reekum R, Conway C, White R, Bachman, D (1993) *Neurobehavioral study of borderline personality disorder,* Journal of psychiatry and neurosciences, 18(3): 121-129

Wakefield J (1992) *The concept of mental disorder: On the boundary between biological facts and social values*, American psychologist, Vol. 47 (3), P. 373-388

Waldinger RJ (1993), The role of psychodynamic concepts in the diagnosis of borderline personality disorder. *Harvard Review of Psychiatry* 1: 158-167.

Wallon, H (1984) "*The role of the other in the Consciousness of the Ego*" in the World of Henry Wallon, Aaronson publisher.

Watson, K (1973) *A rhetorical and Sociolinguistic Model for the Analysis of Narrative*, American anthropologists, 75(1): 243-264

Webster, L, Mertova, P. (2007) *Using Narrative Inquiry as a research method*, New York, Routledge

Wertz, F (2005) *Phenomenological research methods for counselling psychology*, Journal of Counselling Psychology, 52(2), 167-177.

Whitaker, R (2010) Mad in America, USA, Basic Books

Widiger, TJ Trull, JF Clarkin, C Sanderson (1994) Personality Disorder and the Five-factor model of personality. *American Psychological association Journal.* 68(1):69-85

Widiger, T, Frances, A (2002) Toward a dimensional model for the personality disorder*s, American Psychological Association*, 493: pp:23-44

Widiger, T, Weismann M. (2011) Epidemiology of Borderline personality Disorder, Psychiatric service*s, American psychiatric association*, 377 p: 74-84

Willig, C. (2001) *Introducing Qualitative Research in Psychology,* London, Open University Press

Woolfe, R., Dryden, W. & Strawbridge, S. (2003) *Handbook of Counselling Psychology*, London, SAGE Publications Ltd

"http://www.borderlinecentral.com/articles/stigmaofbpdlabel.php"www.borderlinecentr eal.com/ articles/stigmaofbpdlabel.php, last reviewed 31st August 2011)

World Health Organization (1992) *The ICD–10 Classifications of Mental and Behavioural Disorders. Clinical Descriptions and Diagnostic Guidelines*. Geneva: World Health Organization. *Worthless or Wonderful – The Social Stereotyping of Persons With Disabilities*.
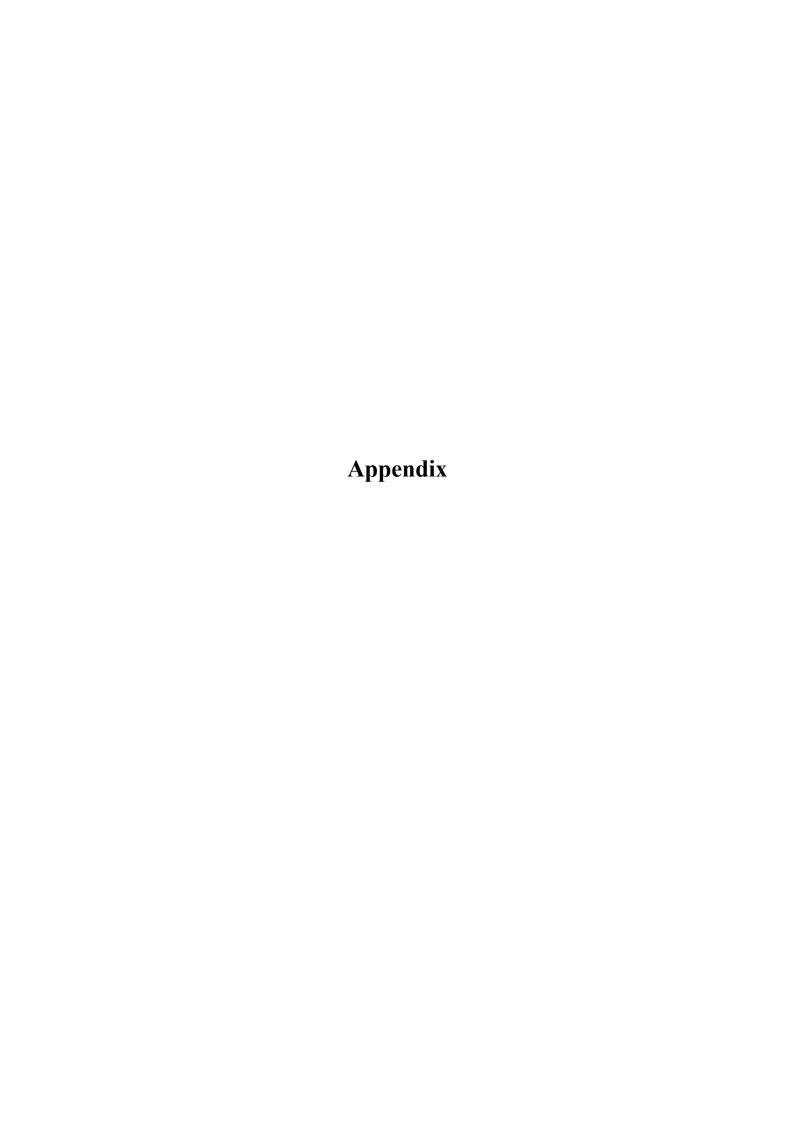
Wright &Owen (2001) No man´s land: gender bias and social constructivism in the diagnosis of borderline personality disorder. Issues in mental health Nursing

Status of Disabled Persons Secretariat Department of the Secretary of State, Canada, 1988. 30

Young, J. E. (1999) *Cognitive Therapy for Personality Disorders: A Schema-focussed Approach* (2nd ed.). Sarasota, FL: Professional Resource Press.

Young, J.E. (2007) Schema focused therapy appears effective for BPD treatment, Sarasota FL. Professional resources exchange

Zanarini MC, Gunderson JG, Marino MF et al (1989) *Child experiences of borderline patients. Compr Psychiatry* 30(1): pp. 18-25.

Appendix

Appendix 1:

PILOT INTERVIEW

Transcript in Spanish

Male 18 years old,

"Cuéntame la historia de tu vida antes y después de haber sido diagnosticado como TLP. Como esto ha cambiado la forma como te percibes, como otros te perciben a ti y la forma como te relaciones con el mundo y los otros"

P: Como cambia la percepción de mi ... nada, me sentí diferente al resto, este... sentía que tenía algo que no se si se iba a curarse, no era probable, no sabía si iba a vivir más, si iba a volver a tratar de suicidarme o si iba a poder soportarlo más, porque cuando me diagnosticaron estuve en la peor etapa, y no sé... me afecto un montón y como que cada vez que me sentía mal yo le echaba la culpa a la enfermedad.

Ósea más que todo, desde que me enteré como que cada vez que pasaba algo malo o algo fuera de lo normal, siempre le echaba culpa a lo que tenía, nunca me puse a pensar si realmente era yo el que tenía la culpa o si le echaba la culpa a los síntomas y diagnósticos que me habían puesto. Me culpaba y... y me costaba salir a flote... porque antes que me lo dijeran era: o.k. Pensaba "tengo un par de problemas pero puedo salir a flote" cuando me diagnosticaron, no sabía si iba salir a flote porque tenía algo se podía curar en 2 años, pero pasaron 2 años y dijeron 2 más, y pasaron ya 3 años y no sé cuándo se va a curar.

T: Al comienzo dices que te sentiste diferente a los demás diferentes ¿cómo? P: diferente...no sé cómo explicarlo, es algo raro, te sientes distinto nada más. Silencio por unos minutos P: Yo estuve 2 años con un psiquiatra y durante los 2 años, tuve meses por los que una de las características del trastorno sobresalía, por ejemplo intolerancia, irritabilidad, sensación de vacío crónico etc. y él al final saco el resultado de que tenía un trastorno Borderline de personalidad.

Yo solo había escuchado de esquizofrenia pero nunca escuche de esto, no conocía a nadie con esto, nunca he sabido, sabía si alguien había llegado a ser famoso o si había llegado a casarse teniendo este problema. Este... T: Suena como si fuera un misterio para ti... el no saber que podía pasar

P: Si, era como un misterio, no sabía, ahora sé que puedo mejorar porque creo en mí más que antes pero antes creí que no iba a tener curar. También he investigado un par de cosas en Internet y salen estas personas de 38 años o 27 años, que me lleva 10 o 20 años y que siguen en el mismo problema que yo estoy a pesar del tiempo, esto me hace pensar que no sé cómo puedo estar seguro de que saldré a flote

T: ¿Y antes del diagnóstico que pensabas de ti? P: ¿Yo? Hm.... pensaba que algo estaba mal, pero que algo estaba mal con mis papás y conmigo T: ¿en la relación con ellos te refieres? P: Tenía problemas con ellos, yo era rebelde no me gustaba hacerles caso ni a ellos ni a nadie. Si me daban una orden y no me gustaba, ni siquiera la escuchaba, y cuando venía de mis papás la orden, era peor, simplemente los ignoraba.

Yo creía que tenía problemas pero no que era loco, era agresivo, pero mucha gente es agresiva; lo que pensaba que eran alucinaciones pensaba que todos las tenían, porque yo las tenía y nunca había hablado con nadie sobre eso así que asumía que era algo común de sentir. Si me deprimía o era "bipolar" sentía y pensaba que mucha gente se deprime, hay gente que se ríe un rato y luego llora y es normal, en realidad yo me sentía igual que el resto, con la diferencia que a mí me gustaba ser el centro de atención, el hazme reír, no sé, era como un payaso siempre,

T: ¿cuándo te dan tu diagnóstico, el P: cambio todo, cambio mi idea de etiqueta puesta sobre mí. Como que Antes tenía algo pero no sabía que que sepan que hacer para ayudarme. Yo sabía que tenía que hacer pero no me sentía bien, antes los médicos creían que yo tenía este trastorno pero no lo habían afirmado, ya cuando un día me dijeron tienes esto: TBP, me etiqueté yo solo, se lo decía a la gente y si estaba con mis amigos en una conversación íntima y me preguntaban que tenía, se los decía, algunos pocos reaccionaban normal y los demás como que les chocaba...

Silencio P: Con referencia al mundo, sentía que era injusto, mis papás me decían que pensara que una persona sin piernas puede sentirse mal, pero se puede recuperar que lo mío era parecido, pero yo les decía que cualquier parte del cuerpo puede ser dañada pero que lo mío era diferente porque es el cerebro lo afectado, y obvio que es muy importante. El nombre de tu trastorno, que fue lo que cambió? lo que tenía un montón, fue diferente era como una ahora tenía algo diagnosticado tenía y ahora que los demás lo saben ha ayudado a

Sin brazo puedes hacer tu vida, pero una persona con problemas en la cabeza es mucho más difícil, como que yo siempre trataba de etiquetar lo que yo tenía como más problemático o difícil que otra cosa u otros problemas que se pueden superar mientras estés sano de salud mental. También pensaba porque a mí, pero al mismo tiempo me gustaba que me haya pasado esto a mí, porque yo creo que el que sufre es el que aprende, es muy difícil aprender un montón de cosas si no has sufrido, de los errores se aprende eso pensaba, pero llegó un momento que me obsesione con el sufrimiento y quería sufrir más para aprender más, quería ver cuánto podía resistir, y me auto dañaba con respecto al alcohol y a las drogas ehhh...

Silencio Para lograr aprender más rápido, en otros momentos tiraba la toalla, quería matarme sin suicidarme y consumía más drogas, porque quería desaparecer pero sin tener que suicidarme Silencio En verdad, yo creo que quería retroceder al momento en el cual no sabía que tenía, pero una vez que avanzas ya no puedes retroceder, y entonces lo que hice fue tratar de mejorar poco a poco T: El diagnóstico como diagnóstico, tu sientes que de alguna forma te ayuda o ayudó para algo? P: Que me etiqueten? no, ósea en lo que viene hacer recetar pastillas, es en lo único que me ayudó, pero que me hayan etiquetado no me ha ayudado en nada, suena feo tener una enfermedad mental, si te dicen: oye eres agresivo, depresivo, etc. ósea tienes problemas, pero no te dicen que estas enfermo, tú crees o sientes que tienes problemas como todos pero no estas enfermo. Estando sano de salud mental puedes lograr muchas cosas, la enfermedad mental es lo peor, porque la parte que dirige todo tu cuerpo está enfermo entonces no diriges tu cuerpo bien. Yo no sé si se puede curar todo esto que tengo, me parece difícil, curar la enfermedad en sí, ósea las 10 características que me han mencionado curarlas por completo, no me acuerdo de las 10, pero por ejemplo la ira incontrolada creo yo que ha mejorado, la intolerancia a la frustración que aún no manejo bien, el vacío crónico me pasa en una época pero creo que si vuelve lo manejaré mejor cada vez. Si los

estados paranoides se pueden mejorar con pastillas y aparecen en menos escala creo que puedo manejarlos y llegar a estar estable en todas las áreas. De todos los síntomas el que más me incomoda es la intolerancia a la frustración y eso es la única que creo yo que si llego a mejorar puedo salir adelante. La difícil es esa, si cambio esa controlaría mejor todo y me ayudaría a seguir P: Cuando yo tenía 7 años, me llevaban al psicólogo. Yo creía que el psicólogo era para los locos pero en verdad me llevaban porque era muy agresivo, fui 3 meses y de ahí yo pensé que era normal durante toda mi vida, hasta que hice algo que me arrepiento, hice 2 cosas, una que ya paso y otra que me sigue mortificando y seguirá mortificándome hasta que aprenda a superarla, es lo más feo que he hecho y me di cuenta que tenía un problema, ahí empecé a darme a cuenta y en 3ero media me di cuenta que tenía un problema cuando me llevaron a la clínica , me internaron y me empezaron a dar medicación ir psiquiatrita, ahí recién me di cuenta. Antes creía que podía pasar algo pero no necesariamente me sentía enfermo, me sentía...me sentía a veces raro, pero aun así llevaba mi vida social normal, a veces era tímido pero sentía que llevaba bien mi vida, desde que empezó mi tratamiento me sentí etiquetado y me cambiaron de colegio, tuve que...no se...fue incomodo cuando me dijeron que tenía TBP

T : Incómodo? P: Sentía que toda mi vida había estado enfermo que nunca había estado sano entonces, si toda mi vida estuve enfermo como me voy a curar, y si no me curo como vivo?. Sería estúpido que esto no se cure y solo se controle, porque qué pasa si un día se muere tu papá y tu mamá y vuelves a lo mismo ósea que... te recuperaras más rápido, nada más, pero de nada sirve toda la basura que me dicen que si se cura de acá a 2 años y cada 2 años me decía eso; me frustraría mucho si no se cura. Me molestaría ser siempre algo diferente y seguro no haría muchas cosas que quisiera hacer socialmente porque la gente se contaría entre ellos que tengo algo y me dejarían de hablar solo porque tengo esto. T: Eso te ha pasado, hay personas que te han dejado de hablar? P: Si, no exactamente pero cosas parecidas, como que no me cuentan cosas porque creen que yo soy de cierta forma que no soy realmente, no confían en mí, creen que no deben confiar en mí. A nivel social ha cambiado todo por mi diagnóstico, no sé si necesariamente el resto ha cambiado pero yo siento que el resto ya no me quiere igual. A nivel familiar por ejemplo mi mama como yo fui su primer hijo ella no sabía si los demás eran diferentes pero ellos ósea desde que empecé el tratamiento, ellos ya actuaban diferente, no me tratan como minusválido pero no me tratan como si estuviera bien bien bien. Cuando tengo mis "bajones" me apoyan y tratan de que mejore.

A mí me tratan diferente que a mis hermanas, a mí me tratan mucho mejor. A mi hermana del medio le exigen más a pesar que tiene muy buenas notas y le va bien, siempre le exigen más a ella. A mi hermana menor... se parece mucho a mí, pero es cierto que de los tres a quien más cariño dan y apoyan más ha sido a mí.

Cuando estoy intolerante yo grito mucho a mi hermana que me sigue, pero ahora creo que mejor con ella. Ella sabe de mi problema, y a la a la menor le hicieron un examen psicológico en el colegio y salió que ella creía que yo tenía algo, porque yo a veces reacciono feo y ella se asusta, entonces entiende que es porque algo malo tengo. Los demás se dan cuenta que algo raro me pasa, depende del día, de cómo hable que diga ese día.

T: Hace un rato mencionabas cuanto había cambiado la percepción sobre ti mismo, puedes explicarnos más esto? P: La percepción de mi cambio bastante y la parte social también cambio. Cuando me dan la noticia me sentí peor, me sentí "pucha" tengo una

enfermedad, es como que te digan que tienes cáncer, no necesariamente te vas a curar y a mí no me interesa solo controlar lo que tengo.

T: pero si te dicen que puedes controlar tu enfermedad y vivir bien no lo aceptaría como una buena opción? M: te limitas en ciertas formas, es similar a tener diabetes por ejemplo, pero la gran diferencia es que si te pasa algo en la diabetes se puede reponer, arreglar en cambio si te pasa algo en lo que yo tengo, yo siento, que uno va a demorarse en recuperarse y odio perder tiempo estando deprimido, metido en mi mundo, pero siempre me pasa. De cierta manera desde que me han dado el diagnóstico, desde que he empezado a tomar pastillas la parte psicológica, mi parte de salud mental ha mejorado, pero mi parte estudiantil ha estado empeorando, entonces eso me frustra mucho. Me frustra estar mejorando solo en un área, en el área estudiantil he bajado, pero en el área que es mejorar mis problemas he mejorado. Yo pensaba que la mejora tal vez sería por etapas y por eso me salí de la universidad para mejorar mi salud mental, y luego mejorar las otras áreas, pero mis papás no creían eso y ahora creo que si lo creen.

Antes del diagnóstico me sentía mal y no sabía porque era, entonces te cuestionas todo pero nunca llegas a una respuesta o conclusión, en cambio después de que me dan el diagnóstico me sentía mal y ya sabía porque era y me sentía peor; porque si te dicen "probablemente tengas algo" y te sientes mal, tú dices ah...me siento mal porque "probablemente" tenga algo, pero cuando te dicen que tienes algo, y te sientes mal ya sabes por qué te sientes mal y te da rabia, porque no necesariamente... por que antes de que te dieran el diagnóstico me dijeron que me iba a curar en 2 años, luego me dan el diagnóstico y me dicen que me voy a curar en 3 años, ósea 5 años en total, entonces no me ha mejorado nada, solo me ha empeorado de cierta manera.

T: tú crees que si no te hubieran dado un "nombre" y solo te hubieran explicado tus síntomas, hubiera sido mejorar para ti? M: si, por que mejorar uno por uno, ósea son etiquetas más chicas, en cambio cuando te dan una etiqueta más grande tienes que separarla, ósea... digamos que son 10 trastornos, de los cuales tienes que mejorar los 10 hasta controlarlos, pero cuando te dan el nombre ya son 11 y no 10, el nombre es uno más y encima el más grande y me cuesta trabajo quitármelo, esa etiqueta... solo se va hasta que el Dr. Dice "estas curado".

T: Pero estos otros 10 síntomas forman tu diagnóstico, porque el verlos separados es mejor o más fácil, puedes explicármelo mejor? M: Cuando te ponen el nombre no tienes los mismo que todos los demás, el nombre hace que te quiten de la realidad y te pongan en un mundo diferente. Ahora yo siento que estoy saliendo de ese mundo y entrando al de todos, pero me sentía así...Depresivo, todos se deprimen, agresivo, todos son agresivos, impulsivo, todos son impulsivos, que a veces se sienten vacíos, todos se sienten vacíos...que más, algunos han tratado de suicidarse no solamente los que están enfermos se han tratado de suicidar, hay gente que no está enferma y lo ha tratado, este...todo lo que se menciona o me han mencionado como síntomas les pasa a todos. Alucinaciones, hay gente que tiene y gente que no, como que eso si era medio raro, pero igual, ataques paranoides le pasa a mucha gente, entonces todos eran separados, lo ves, y no venían todos juntos tampoco. Ósea como que un síntoma siempre sobresale de los otros desde que he empezado mi tratamiento, entonces se me hacía más fácil pero desde que me dieron el nombre sentía que los 10 síntomas me atacaban diariamente, era como si me hubieran tirado una bolsa llena de piedras.

Silencio M: Yo me separé del resto de gente por enterarme de mi diagnóstico, obvio que

esto fue inconsciente. Hay veces que me gustaría que acabara y otras que no, porque al mismo tiempo que te sientes diferente y te separarás, yo me sentía especial de cierta manera. Al alucinar sentía que yo podía ver cosas que nadie podía, entonces de cierta forma te sientes diferente pero especial. Es como que todos tienen etiqueta blanca con su nombre y tú tienes etiqueta roja con el tuyo, entonces te sientes diferente, aunque a veces te sientas bien por ser así y a veces mal. Sentirte bien te da una sensación de felicidad muy fuerte, es como una sensación de ser único, sé que no soy el único con este diagnóstico pero si soy el único como persona con este diagnóstico.

T: parece ser una sensación complicada? M: El diagnóstico me mete a un mundo más chico, me saca de la masa común, me hace diferenciarme, aunque me separa del mundo, a veces me gustaba estarlo porque me daba cuenta lo superficial e hipócrita que era la gente en este grupo. La gente con la que empecé a parar que sí tenían problemas eran personas que valían más y por eso me gustó, pero sabía que no era para siempre esto, que no me iba a ayudar. Esta gente en mi mundo era más sincera, cuando alguien sufre es fácil darse cuenta de quien más está sufriendo, entonces antes de mi diagnóstico a mí me gustaba ayudar, porque siempre he sido una persona que se da cuenta es cada persona según su conducta, era una persona bien analítica y me daba cuenta que problema podían tener y sacar conclusiones tipo psicólogo y eso me gustaba. Estuve en esa burbuja de otro color...roja digamos, por un tiempo, pero ahora que ya estoy bien y tengo que volver a la burbuja grande me cuesta porque estoy fuera de costumbre. Sigo pensando que las personas en esta burbuja grande son superficiales, pero cuando las llegas a conocer no lo son tanto, la mayoría de personas no les gusta cuando les dices las cosas como son, se activan sus mecanismos de defensa, se incomodan. Yo creo que a veces yo no encajaba en ese mundo y era tal vez porque yo era muy directo, y a la gente le gusta ser directo pero diciendo cosas por separado, como la enfermedad casi casi lo mismo, en vez de decir una cosa por una cosa yo de frente mandaba todo, los 10 síntomas digamos, y eso incomodaba a las personas. Creo que es habilidades sociales, todas las personas con TBP son diferentes entre ellos aunque tengamos el mismo diagnóstico los síntomas se presentan de diferente forma eso hace que mi etiqueta sea igual a los de mi grupo pero el nombre no. Silencio No tengo nada más que decir.

Espero haberte ayudado Gracias

Translation of Pilot Interview

"Tell me the story of your life before and after you were diagnosed with BPD. How has it changed in relation to the way you perceive yourself, to the way others perceive you and in the way you relate to others now".

Par: How does my perception change about me... nothing. I felt different from others...I felt that I have something that would not be curable, I didn't know if I was going to live more or if I was going to commit suicide or even if I could tolerate it anymore, because when they gave me the diagnosis I was in a terrible state, don't know...it affected me a lot and it was like...every time I felt bad I blamed the illness. Like ...more like ...since I knew about my diagnosis, when something bad happened or something unusual, I always blamed it on my problem, I never thought that maybe it was me also.

I felt guilty all the time and ... em... it was difficult and a hard situation to come out of because before, they told me it was o.k...I knew that I had a couple of problems but I was going to survive, when they diagnosed me I didn't know if I was able to come out of it; they said this is curable in 2 years, then 2 years after they said 2 more years and 3 years have gone by and until now I don't know if this is going to finish.

Int: At the beginning of the interview you mentioned that you at some point felt different from others; could you clarify this idea for me?

Par: different...don´t know how to explain it , it is difficult to explain, you feel different after the diagnosis

Int: How did they give you your diagnosis?

P: I was 2 years with a psychiatrist. During these 2 years I had some periods where one or another of the characteristics of the BPD showed itself; perhaps intolerance, irritability or emptiness, so, after these 2 years the doctor concluded that I had Borderline personality disorder.

I had heard about schizophrenia but never heard about this diagnosis (BPD), had never known anyone one with this disease or heard about someone who had this and had get married or done something in life. So...

T: so you didn't know what could happen to you?

P. Now I think, I can get better, because I trust more in myself than before, but before I thought that I wasn't going to be fine again, I also did some research on the Internet and I read of cases where people in their 30s or 40s, people 10 or 20 years older than me still fighting with this, so how am I going to survive? I'm not sure

T: Before the diagnosis what did you think about yourself?

Par: I thought that something was wrong but something in relation with my parents and I.

Int: In the relationship you mean?

Par: I had problems - I was a rebel, I liked not to follow orders, if someone gave me an

order I didn't like it, so I didn't follow it, even my parents orders I didn't follow them.

Par: Before the diagnosis I thought that I had problems but I was not crazy, I was aggressive maybe, but lots of people are aggressive. I thought that hallucinations were common to everyone because I never talked about them with anyone. If I was depressive or bipolar I thought that many people felt depressed so I felt the same as other but I liked to be the centre of attention that's all - make people laugh, that was the difference between me and the others.

Int: And after your diagnosis what changed?

Par: Everything changed, my ideas about what I have, it was different, it was like a label that someone put to me

For example regarding others, my parents for example, before, they thought that I had something but they didn't know what, but after the diagnosis my parents started to know how to interact with me. They knew how to interact with me but I didn't feel better. Before the diagnosis, some doctors mentioned Borderline personality disorder as a possible diagnosis, but after they confirmed it I started to feel labelled, so I started to tell people about my diagnosis, so when I had a conversation with friends, intimate ones, I told them what I had. Some people reacted normally others felt shocked.

What else... regarding the world, I thought it was unfair because my parents used to tell me that a person without legs can get over it and move on, but I told them " any part of the body could be damaged but its completely different from a mental problem, because the brain is the most important part.

A person could be without an arm and still be able to continue with his life, a person with a mental problem is more difficult. I was always trying to label what I had, putting it as a more difficult problem than any other type of problem.

Sometimes I felt angry because I thought "why did this happen to me" but at the same time I quite liked it because that only they that suffer learn, it is difficult to learn a lot of things if you have not suffered because you learn from your mistakes, so I thought...but at some point I started to get obsessed about suffering so I wanted to suffer more so I could learn more, and I wanted to see how much I could resist so I self damaged with alcohol and drugs, but never suicide.

Some times I gave up and I wanted to kill myself, really I wanted to go back, to before the diagnosis but I you can never go back so I started to feel better... Silence

Int: Do you think that the diagnosis has helped you in any way?

Par: What the label, being labelled? No, only because of the medicines and prescriptions in that sense maybe but being labelled hasn't helped me in any way. To have a mental problem sounds awful, if they tell you, look you are aggressive, or depressive... you have problems but they are not telling you "you are ill".

When they tell you, you have an illness; it means, "you are ill".

If you are healthy mentally, you can do lots of things. Mental problems are awful because the brain or mind is what manages your body so if this part is not healthy you

are not going to manage your body correctly. I think to cure this illness is difficult... well, the 10 symptoms they gave me, like anger, I feel this some better now, intolerance, I still can't manage, the emptiness feeling happened to me for a period of time but if it appears again I think I will be able to manage it better now, the paranoid states I believe I can live with them with pills, but the most uncomfortable for me is the intolerance, maybe if I can do something about it I could feel much better... don't know really.

Int: When did you realise that you have a problem?

Par: When I was 7, and they took me to the therapist, I thought that psychologists are for crazy people, they took me because I was an aggressive child. I went for 3 months and then I thought that I was normal until I did something that I regret.

I did 2 things, one its in the past but the other is going to mortify me until I learn to move on from it ... it is the most awful thing I have done...silence... and because of that I realised I had a problem. In high school I confirmed it, when they hospitalised me and started to medicate me. They hospitalised me because I took a bunch of tablets, it was not my intention to kill myself but it was more an act to ask for help.

They sent me to the psychiatrist, I thought something was wrong but I felt more normal than ill, sometimes I felt weird but I could continue with my social life and life, since I started the treatment and I felt labelled, my parents changed my school then I felt uncomfortable and this feeling got bigger until they gave my problem a name.

Int: uncomfortable?

Par: I always felt sick, as if I had been ill all my life... how am I going to cure this? And if this is incurable how can I live with it? It would be stupid if this is not curable and you can`t manage it, because if one day your parents die, how are you going to return to the same way as before? ...

Maybe you can recover faster but then all this shit that they told me, that it is curable, that maybe in 2 years and after 2 years doctors told me 2 more years, this frustrated me a lot. The idea of always being different from others upsets me and to think that I will not want to do many things because people are going to distance from me because I have a mental problem concerns me

Int: Has that happen to you?

Par : Yes, not exactly but similar things, because people don't tell me things because they think that they cannot trust me , they believe I am something that I'm not. On a social level everything has changed for me, I don't know if people have changed but I feel that people don't care for me in the same way.

Regarding my family for example, my mother - since I was her first son - didn't know if other children were different, but after I starting the treatment my parents started to act differently... they don't treat me as if I were disabled but they don't treat me as normal either.

They treat me different than my sisters, they treat me better than the sister who follows me, they are very strict with her, the other, my little sister, she is quite similar to me but

it is obvious that they give to me more attention and care. When I'm intolerant I scream at them, I fight more with my middle sister, she knows about my difficulty. At school they took gave an exam to my little sister and the psychologist said to my parents that she also thinks I have something weird because of the way I react and my behaviour.

T: It seems like people can notice that something happens to you although they don't have the diagnosis. They can perceive that something is happening to you

Par: In some way, it depends in the way I talk, what I say that day and how I am that day. Int: so it is obvious because of what you said, that your perception about yourself changed and also the social life changed a lot for you, do you agree with this?

Par: yes it has changed a lot

Inter: The feeling of being part of this world of being part of a group, did it change or not after the diagnosis. Par: it was the same but when they gave me the diagnosis I felt worst "I have a disease", it is like someone told you, you have cancer, not necessarily you are going to die because of the cancer but maybe you are not going to be cured.

The idea of only controlling the problem is something I don't like. For example diabetes doesn't kill but the difference is that if something happen to me with diabetes they can treat you instantly, but if something happens with this difficulty it takes longer to be stable again and I don't want to waste time being depressed or staying only in my world but it happens always and in some way. Since they give me the diagnosis and I started to take pills, my psychological part and my mental health have improved but my studies have got worse and that frustrates me. I think that maybe this is going to improve by areas and little by little, because of that I quit my studies to fully concentrate on getting better.

Int: what do you think has marked the difference between the before and after your diagnosis? Par: before I felt bad and didn't know why; I questioned it but you never had an answer. Since the diagnosis I feel bad and I know why; it is because I have a diagnosed problem but no solution. They told me that I will be fine in 2 years and now 3 years, have gone by, so the diagnosis doesn't help me it only make things worse for me

Int: if they had not given you the name and they told you that you have some symptoms and never used the World BPD do you think you would have preferred this?

Par: Yes, because it is better and easier to improve one thing at a time, but when they give you a name that means lots of things and lots of problems; you feel overwhelmed. The name is almost impossible to remove, I have to wait until the doctors tell me that I'm cured... it is not under my control do you know what I mean?

When they say to you some symptoms you still identify with the others, when they give you a name you are not the same... you are different from that moment, they take you out from this world and put you in another one. All the symptoms I have, everyone have, some people more than others, I didn't suffer with all at the same time but since the name all of those individual problems changed into this big name and attacked me at the same time. For me its like they threw me a bag

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full of stones, they take me out of the world and I feel distanced from others because now I feel different from them. Sometimes I would like this to finish and sometimes not, because at the same time that you feel different you start thinking that you are special in some way, you feel different but special.

Imagine that everyone has white labels, and you have a red one that is good sometimes. Int: when you feel good what exactly did you feel? Par: happiness, some kind of happiness, uniqueness Int: do you feel unique?

Part: unique yes, I'm unique as a person with this diagnosis Int: so...let me try to understand your idea, you are not in the world, you are in a small group but being in that group makes you feel happy in some way because you can stand out from all the others, you feel different, you feel special, so the diagnosis takes you out of the world but also in some moments you prefer to be separate from the world. Par: yes, because sometimes I can see how superficial people can be in the world and the people who I began to go out with, that have difficulties, were people who have more value as a person and I liked that...but not for always. Int: so these people with different names and in a different group; did you feel they are more sincere? Par: yes more sincere more transparent, I realised in some ways that I was better than others after they gave me the diagnosis. I liked to help others and I also started to understand how people are through their behaviour and I could draw some conclusions. So I was in my red bubble for a while but now that I'm better, and I have to go back to the world. It's difficult because I'm out of practise, and that is the part that scares me most. Int: do you still see people as superficial? Yes, I still see people as superficial but less now, they don't like when you say things directly to them and they usually react using their defence mechanisms. I thought that sometimes I didn't fit in the world was because I am quite direct, people feel shocked when I say certain things to them. But another point is that everyone is different so the red label is also different for others. Int: so do you think this is about social abilities? Par: yes I think so; all people with BPD are different from each other Int: so in some way your red label is not the same in all cases?

Par: yes, we have the same label but not the same name. It is not like schizophrenia, I think it is different. Int: Thanks for your help Par: thanks to you for give me this opportunity to clarify this topic

Appendix 2:

Psychology Department

REQUEST FOR ETHICAL APPROVAL

Applicant (specify): Ug PG (Module:DSPsych) PhD Staff Date submitted:
_____

No study may proceed until this form has been signed by an authorised person, indicating that ethical approval has been granted. For collaborative research with another institution, ethical approval must be obtained from all institutions involved.

This form should be accompanied by any other relevant materials, (e.g. questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information sheet for participants[1], consent form[2], or other, including approval by collaborating institutions). A fuller description of the study may be requested.

- Is this the first submission of the proposed study? Yes

- Is this an amended proposal (resubmission)? No

Psychology Office: if YES, please send this back to the original referee

- Is this an urgent application? (To be answered by Staff/Supervisor only) No
- **Name(s) of investigator**(s): Luisa Escudero - Franco
- **Name of supervisor(s)**: Rosemary Lodge

Title of study: How the experience of being diagnosed with Borderline Personality Disorder affects relations with others and one's self-perception (an existential phenomenological study).

1. Please attach a brief description of the nature and purpose of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data. The aim of this study is to analyse and describe the experience of being diagnosed with BPD and how this diagnosis could affect (in cases that it did) relationships with others, the world and self-perception. In this study the methodology to be used will be a qualitative one and the method chosen is Critical Narrative Analysis. Qualitative methods are concerned with the description or interpretation of phenomena and the meanings they have for the person experiencing them. The focus of this methodology is related to the description of a phenomenon or a part of it.

For this study it is my intention to use Critical Narrative Analysis as my main method. The Critical Narrative Analysis method is based on Paul Ricoeur's work and has been extended and developed by Darren Langdridge. In the phenomenological narrative analyses that I will try to use in this research it will be important to let the participant speak. It will be important to try not to impose any meaning or form on his narrative and to focus on the structure and form he uses in his story. CNA research uses a format common to other phenomenological studies. It is usual to first see a literature review with a clear explanation and justification of the research question. Following this we can find the explanation and description of analytical method, and methodology. Then the results or findings are presented, organized by the main narratives in the text, narratives tones and rhetorical function of the narratives. Finally the researcher presents a section of the particular hermeneutic used and the critique of the meaning of the text (Langdridge, 2007).

Regarding the number of participants, I will work with a minimum of 3 and maximum of 5 male and female participants. All of them will be over 18 as it is not possible to diagnose a personality disorder earlier.

I will conduct this research in Lima, Peru, so I will contact psychiatrists and counsellors who work in the private field. For more details about this please see the research proposal annexed to these forms 2.

Could any of these procedures result in any adverse reactions? NO If "yes", what precautionary steps are to be taken?

3. Will any form of deception be involved that raises ethical issues? NO .

If participants other than Middlesex University students are to be involved, where do you intend to recruit them? This research will be conduct in Lima, Peru. I will personally contact psychiatrists and counsellors working in private practices or hospitals. I will ask the counsellors and psychiatrists to personally ask their clients if they would be prepared to participate in the research. To maintain control and consistency of the process of seeking participants I will give all the psychiatrists and counsellors an identical question that they will need to ask their clients.

The question will be: "The psychologist, Luisa Escudero-Franco, is doing research about the experience of being diagnosed with BPD. She has asked me to invite you to be part of the research. If you would you like to be one of the participants of the research you would need to have one meeting with the researcher for 60-90 minutes before one of our sessions. You will not need to go anywhere or do anything except answer the questions about your experience of being diagnosed with BPD. If you feel you would like to participate I will arrange an initial meeting with the researcher so that she can explain personally the aims of the research".

I would like to explain and clarify some important differences between the way the health system works in Lima, Peru and in the UK. As I have explained in my viva most of our health system is completely private and for this reason all my participants will be private clients who are completely responsible for all their treatment. This gives the client control over decisions regarding their treatment. For this reason, each client has the power to withdraw from treatment at any time and, as a participant, they know they have the same power to withdraw.

2. Does the study involve?

Clinical populations YES

Children (under 16 years) NO

Vulnerable adults such as individuals with mental health problems,

Learning disabilities, prisoners, elderly, young offenders? NO

3. How, and from whom will informed consent be obtained?

From the participants!

7. Will you inform participants of their right to withdraw from the research at any time, without penalty? YES

8. Will you provide a full debriefing at the end of the data collection phase? YES

9. Will you be available to discuss the study with participants, if necessary, to monitor any negative effects or misconceptions? YES

10. Under the Data Protection Act, participant information is confidential unless otherwise agreed in advance. Will confidentiality be guaranteed? YES

11. Are there any ethical issues which concern you about this particular piece of research, not covered elsewhere on this form? NO

(NB: If "yes" has been responded to any of questions 2, 3, 5, 11 or "no" to any of questions 7-10, a full explanation of the reason should be provided -- if necessary, on a separate sheet submitted with this form).

Researcher................. Date : ....

I will keep the files and data in a secure place. The names of the participants will be changed for the study.

Signatures of approval: Supervisor: .... Date

Ethics Panel .... Date .... (signed pending approval of Risk Assessment form)

12. Some or all of this research is to be conducted away from Middlesex Universi If "yes", tick here to confirm that a Risk Assessment form has been submitted

13. I am aware that any modifications to the design or method of this proposal will require me to submit a new application for ethical approval

14. I am aware that I need to keep all materials/documents relating to this study (e.g. participant consent forms, filled questionnaires, etc.) until completion of my degree

15. I have read the British Psychological Society's *Ethical Principles for Conducting Research with Human participants*[4] and believe this proposal to conform with them

Y es	N o
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X	
X	
X	

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Appendix 3:

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT

This proforma is applicable to, and must be completed in advance for, the following

fieldwork situations:

1. All fieldwork undertaken independently by individual students, either in the UK or
   overseas, including in connection with proposition module or dissertations.
   Supervisor to complete with student(s).

2. All fieldwork undertaken by postgraduate students. Supervisors to complete with
   student(s).

3. Fieldwork undertaken by research students. Student to complete with supervisor.

4. Fieldwork/visits by research staff. Researcher to complete with Research Centre

Head

FIELDWORK DETAILS

Name Luisa Escudero-Franco

Supervisor Bernice Sorenson

Student No Research Centre (staff only)

Degree course: Dpsych in Counselling Psychology and Existential therapy

_____

Telephone numbers and name of next of kin who may be contacted in the event of an accident

NEXT OF KIN

Name:

Phone: Physical or psychological limitations to

carrying out the proposed fieldwork

Any health problems (full details)

Which may be relevant to proposed fieldwork activity in case of emergencies.

None None

Lima- Peru

None

N/A

Locality (Country and Region) Travel Arrangements

NB: Comprehensive travel and health insurance must always be obtained for independent overseas fieldwork.

Dates of Travel and Fieldwork PLEASE READ THE INFORMATION OVERLEAF VERY CAREFULLY

N/A

Hazard Identification and Risk Assessment PLEASE READ VERY CAREFULLY List the localities to be visited or specify routes to be followed **(Col. 1).** For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern **(Col. 2).**

Examples of Potential Hazards:

- Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)

- Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.

- Demolition/building sites, assault, getting lost, animals, disease.

- Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc.), parasites', flooding, tides and range.

- Lone working: difficult to summon help, alone or in isolation, lone interviews.

- Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.

- Safety Standards (other work organisations, transport, hotels, etc.), working at night, areas of high crime.

- Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task.

- Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury.

- Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage.

- Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task **If no hazard can be identified beyond those of everyday life, enter 'NONE'.**

1. LOCALITY/ROUTE	2. POTENTIAL HAZARDS
Peru	None

The University Fieldwork code of Practice booklet provides practical advice that should be followed in planning and conducting fieldwork.

Risk Minimisation/Control Measures PLEASE READ VERY CAREFULLY For each hazard identified **(Col 2),** list the precautions/control measures in place or that will be taken **(Col 3)** to **"reduce the risk to acceptable levels",** and the safety equipment **(Col 5)** that will be employed. Assuming the safety precautions/control methods that will be adopted **(Col. 3),** categorise the fieldwork risk for each location/route as negligible, low, moderate or high **(Col. 4). Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident. An acceptable level of risk is:** a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.

Examples of control measures/precautions:

Providing adequate training, information & instructions on fieldwork tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individuals fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of fieldwork area.

Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc. If a proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will be preceded by a thorough risk assessment.

3. PRECAUTIONS/CONTROL MEASURES	4. RISK ASSESSMENT

PLEASE READ INFORMATION OVERLEAF AND SIGN AS APPROPRIATE

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the fieldwork period and additional precautions taken or fieldwork discontinued if the risk is seen to be unacceptable.

Signature of Fieldworker (Student/Staff) Signature of Student Supervisor APPROVAL: (ONE ONLY) **Signature of**

Curriculum Leader

(undergraduate students only)

Signature of Research Degree Co-ordinator or Masters Course Leader or Taught Masters Curriculum Leader

Signature of Research Centre Head (for staff fieldworkers**)**

Luisa Escudero- Franco **Date** 1/4/09

FIELDWORK CHECK LIST

1. Ensure that **all members** of the field party possess the following attributes (where relevant) at a level appropriate to the proposed activity and likely field conditions:

    - Safety knowledge and training?

    - Awareness of cultural, social and political differences?

    - Physical and psychological fitness and disease immunity, protection and awareness?

    - Personal clothing and safety equipment?

    - Suitability of fieldworkers to proposed tasks?

2. Have all the necessary arrangements been made and information/instruction gained, and have the relevant authorities been consulted or informed with regard to:

    - Visa, permits?

    - Legal access to sites and/or persons?

    - Political or military sensitivity of the proposed topic, its method or location?

    - Weather conditions, tide times and ranges?

    - Vaccinations and other health precautions?

    - Civil unrest and terrorism?

    - Arrival times after journeys?

    - Safety equipment and protective clothing?

    - Financial and insurance implications?

    - Crime risk?

    - Health insurance arrangements?

    - Emergency procedures?

    - Transport use?

    - Travel and accommodation arrangements?

Important information for retaining evidence of complete risk assessments: Once the risk assessment is completed and approval gained the **supervisor** should retain this form and issue a copy of it to the fieldworker participating on the field course/work. In addition the **approver** must keep a copy of this risk assessment in an appropriate Health and Safety file.

Appendix 4: PERSONAL INFORMATION SHEET

JOINT RESEARCH ETHICS COMMITTEE OF THE NEW SCHOOL OF PSYCHOTHERAPY AND COUNSELLING AND THE SCHOOL OF PSYCHOLOGY OF MIDDLESEX UNIVERSITY Participant Information Sheet (PIS)

1. Study title

"How the experience of being diagnosed with Borderline Personality Disorder affects relationships with others and one's self-perception" (an existential phenomenological study).

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

3. What is the purpose of this research?

You have been invited to participate in this research as you have been diagnosed with Borderline Personality Disorder; it is the intention of this research to describe the experience of receiving that diagnosis and how this could affect your relationships with others and the way you perceive yourself.

4. What will happen to me if I take part?

Your participation will consist in accepting to be interviewed by the Researcher for 60-90 minutes in the office of your counsellor or in a medical institution. During that time the researcher will ask you some questions in relation to your experience both before and after being diagnosed with Borderline Personality Disorder. Your answers and the whole interview will be recorded so that you can be assured that your words and ideas are not being misunderstood. After the interview the researcher will use a phenomenological method to classify and clarify your position on the diagnosis you have received. You can withdraw from the research any time without explanation.

5. What are the possible disadvantages and risks of taking part?

There are no risks or disadvantages to taking part in this research. However, the researcher will take into consideration any type of emotional reaction you may experience during the interview. One possible adverse side-effect of the research is that you could feel overwhelmed during the interview when describing your experience of being diagnosed with BPD. Should that be the case and you feel anxious you can ask the researcher for a few minutes to compose yourself or, if you prefer, you can withdraw from the research. In such an eventuality the researcher will discuss with you the importance of discussing your experience and feelings on this topic with your therapist. If you decide to withdraw from the research your treatment will not be affected.

6. Confidentiality

All the interviews will be recorded for later transcription for the purposes of the study. The tapes will be stored for a year, during which time, participants can, whenever they like, ask for the tapes. Transcription of the tapes will be done by the researcher, Luisa Escudero-Franco; each transcript will be identified by a code to preserve anonymity. To maintain safety, codes will be stored separately from the tapes. All transcripts, tapes and any other data will be kept in a locked cabinet can only be accessed by the researcher; electronic information will be kept in a password-protected file in the researcher's personal computer to which only she has access. Regarding the data, no one apart from the researcher and her supervisor Werner Kierski will be able to view the data. In the event that the research or part of it will be published, any information that could identify participants will be changed to maintain anonymity.

7. Consent

You will be given a copy of the Information Sheet and asked to sign a Consent Form prior to taking part in the research. The Information Sheet includes a form explaining that your participation in this research is entirely voluntary; you do not have to take part if you do not want to. If you do decide to take part you may withdraw at any time without giving a reason.

8. Who is organising and funding the research?

The research is solely funded by the researcher.

9. Who has reviewed the study?

The research has been designed entirely by the researcher and the study has been reviewed by an Ethics Committee. Middlesex Psychology Department's Ethics Committee and the New School of Psychotherapy and Counselling's Ethics Committee have reviewed this proposal.

10. Contact for further information

You will be given a copy of the Information Sheet and a signed Consent Form to keep. Should you wish to contact myself, or my supervisor, please find the contact details below. The NSPC office will let us know should you wish to contact us. Thank you for taking part.

Researcher: Luisa Escudero-Franco

Telephone in London: 07722043117

Telephone in Perú: 00511999625336

Luisa Escudero-Franco ́s email luisaescuderof@hotmail.com

Address: London – Perú Lima

Supervisor: Rosemary Lodge

New School of Psychotherapy and Counselling (NSPC) Belsize Road NSPC

telephone number: 0207 928 4344 NSPC

email address: admin@nspc.org.uk

<center>**Appendix 5:**</center>

CONSENT FORM

New School of Psychotherapy and Psychology Department, Middlesex University School of Health and Social Sciences

Project title: How the experience of being diagnosed with Borderline Personality Disorder affects relationships with others and one's self-perception (an existential phenomenological study)

I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to act as a participant. I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication in an anonymous form, and provide my consent that this might occur. I understand that a recording is being made of this interview and will be securely stored until a verbatim transcript has been made

Print name of participant

Print name of researcher

Participant's signature

Researcher's signature