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

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

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

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

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

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

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

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

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

Importantly, studies are now beginning to address how self-referential information is processed. Findings from this stream of research suggest negative processing biases in BPD. Auerbach et al. (2016) showed that, compared to healthy youth, patients with BPD endorsed, recalled, and recognized

more negative and fewer positive self-relevant words. Using a controlled real-life social interaction design, Korn et al. (2016) investigated the impact of social feedback on self-evaluations. They found that individuals with BPD, when receiving feedback on their character traits, integrated undesirable feedback for themselves to a greater degree than healthy controls did.

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

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

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

Finally, a relevant research question is whether treatment can affect the content, structure, or processing of the self-concept. A randomized controlled trial comparing BPD patients assigned to dialectical-behaviour therapy or to so-called community treatment by experts revealed that the participants in both conditions started therapy with overall hostile, critical, and punishing introjects. However, over the course of the treatment and 1-year follow-up, the patients assigned to dialectical-behaviour therapy reported significantly greater self-affirmation, self-love, self-protection, as well as less self-attack (Bedics et al., 2012). Roepke et al. (2011) compared a 10-week inpatient dialectical-behaviour therapy to wait-list. They found that, compared to wait-list controls, patients in the treatment group showed significant enhancement in self-concept clarity and in some facets of self-esteem. Moreover, a naturalistic study revealed that BPD patients who had a very negative self-image at study start showed improved self-image on all aspects of the SASB (Structural Analysis of Social Behavior; Benjamin, 1974) after 18 months of mentalization-based therapy (Löf et al., 2018).

However, we know little about how change in identity and self-concept occurs in treatment and how competencies in this area could be brought out in therapy. If we aim to explore treatment-related change in identity and self-concept, the first-person perspective of patients can illuminate important aspects that researchers and therapists may be unaware of. Qualitative research into the phenomenology of identity and self-concept may help further the development of useful treatment strategies that target these central problems.

Study Aims

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

Method

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

Recruitment and Setting

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

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

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

Treatment

Group Intervention

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

Treatment as Usual

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

Participants

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

Researchers

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

Measures

In-Depth Interview

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

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

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

Borderline Personality Disorder Severity Index Interview

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

Data Collection

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

Data Analysis

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

Choice of Method

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

The Analytic Process

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

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

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

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

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

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

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

Reflexivity

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

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

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

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

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

Ethics

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

Findings

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

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

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

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

process regarding identity was initiated during treatment, change was evident already at treatment end.

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

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

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

Processing of Self-Concept and Identity

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

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

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

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

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

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

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

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

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

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

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

Self as Actor: Sense of Agency

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

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

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

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

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

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

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

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

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

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

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

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

parents' mental states with little validation or mentalization of the child's mental states or needs:

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

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

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

Challenges to the Processing of Self-Concept and Identity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Discussion

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

Returning to Literature

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

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

In the present study, participants often associated their increased sense of agency with a waning of their self-

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

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

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

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

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

Limitations and Strengths

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

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

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

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

Clinical Implications

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

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

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

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

Implications for Further Research

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

Reflexivity

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

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

Conclusions

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

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

References

Adler, J. M., Chin, E. D., Kolisetty, A. P., & Oltmanns, T. F. (2012). The distinguishing characteristics of narrative identity in adults with features of borderline personality disorder: An empirical investigation. *Journal of Personality Disorders, 26,* 498–512. https://doi.org/10.1521/pedi.2012.26.4.498

Agnew, G., Shannon, C., Ryan, T., Storey, L., & McDonnell, C. (2016). Self and identity in women with symptoms of borderline personality: A qualitative study. *International Journal of Qualitative Studies on Health and Well-being, 11*(1), 30490. https://doi.org/10.3402/qhw.v11.30490

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

Arntz, A., Dietzel, R., & Dreessen, L. (1999). Assumptions in borderline personality disorder: Specificity, stability and relationship with etiological factors. *Behaviour Research and Therapy, 37*, 545–557. https://doi.org/10.1016/S0005-7967(98)00152-1

Arntz, A., Dreessen, L., Schouten, E., & Weertman, A. (2004). Beliefs in personality disorders: A test with the Personality Disorder Belief Questionnaire. *Behaviour Research and Therapy, 42*, 1215–1225. https://doi.org/10.1016/j.brat.2003.08.004

Arntz, A., Hoorn, M., van den, Cornelis, J., Verheul, R., Bosch, W., van den, & de Bie, A. (2003). Reliability and validity of the borderline personality disorder severity index. *Journal of Personality Disorders, 17,* Suppl 1, 45–59. https://doi.org/10.1521/pedi.17.1.45.24053

Arntz, A., Klokman, J., & Sieswerda, S. (2005). An experimental test of the schema mode model of borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, *36*(3), 226–239. https://doi.org/10.1016/j.jbtep.2005.05.005

Auerbach, R. P., Tarlow, N., Bondy, E., Stewart, J. G., Aguirre, B., Kaplan, C., Yang, W., & Pizzagalli, D. A. (2016). Electrocortical reactivity during self-referential processing in female youth with borderline personality disorder. *Biological Psychiatry: Cognitive Neuroscience and Neuroimaging, 1*(4), 335–344. https://doi.org/10.1016/j.bpsc.2016. 04.004

Baumeister, R. F. (1999). Self-concept, self-esteem and identity. In V. Derlega, B. Winstead, & W.

Jones (Eds.), *Personality: Contemporary theory and research* (2nd ed.) (pp. 246–280). Nelson-Hall. https://doi.org/10.1016/B978-012134645-4/50027-5

Bateman, A., & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: Mentalization-based treatment*. Oxford University Press.

Bedics, J. D., Atkins, D. C, Comtois, K. A, & Linehan, M. M. (2012). Treatment differences in the therapeutic relationship and introject during a 2-year randomized controlled trial of dialectical behavior therapy versus nonbehavioral psychotherapy experts for borderline personality disorder. *Journal of Consulting and Clinical Psychology, 80*(1), 66–77. https://doi.org/10.1037/a0026113

Benjamin, L. S. (1974). Structural analysis of social behavior. *Psychological Review, 81*, 393–425.

Binder, P.-E., Holgersen, H., & Moltu, C. (2012). Staying close and reflexive: An exploratory and reflexive approach to qualitative research on psychotherapy. *Nordic Psychology, 64*(2), 103–117. https://doi.org/10.1080/19012276.2012.726815

Davidson, L., Carr, E., Bellamy, C., Tondora, J., Fossey, E., Styron, T., Davidson, M., & Elsamra, S. (2016). Principles for recovery-oriented inpatient care. In N. Singh, J. W. Barber, & S. van Sant (Eds.), *Handbook of recovery in inpatient psychiatry* (pp. 39–58). Springer. https://doi.org/10.1007/978-3-319-40537-7_2

Donald, F., Lawrence, K. A., Broadbear, J. H., & Rao, S. (2019). An exploration of self-compassion and self-criticism in the context of personal recovery from borderline personality disorder. *Australasian Psychiatry, 27*(1), 56–59. https://doi.org/10.1177/1039856218797418

Evans, D., Dalgleish, T., Dudas, R. B., Denman, C., Howard, M., & Dunn, B. D. (2015). Examining the shared and unique features of self-concept content and structure in borderline personality disorder and depression. *Cognitive Therapy and Research, 39*(5)*,* 613–626. https://doi.org/10.1007/s10608-015-9695-3

Fonagy, P., Bateman, A. W., & Luyten, P. (2012). Introduction and overview. In A. W. Bateman, & P. Fonagy (Eds.), *Handbook of mentalizing in mental health practice* (pp. 3–42.) American Psychiatric Publishing.

Gad, M. A., Pucker, H. E., Hein, K. E., Temes, C. M., Frankenburg, F. R., Fitzmaurice, G. M., & Zanarini, M. C. (2019). Facets of identity disturbance reported by patients with borderline personality disorder and personality-disordered comparison subjects over 20 years of prospective follow-up. *Psychiatry Research, 271*, 76–82. https://doi.org/10.1016/j.psychres.2018.11.020

Gbrich, C. (2007). *Qualitative data analysis: An introduction* (1st ed.). Sage Publications.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* Prentice-Hall.

Grambal, A., Prasko, J. Kamaradova, D., Latalova, K., Holubova, M., Marackova, M., Ociskova, M., & Slepecky, M. (2016). Self-stigma in borderline personality disorder: Cross-sectional comparison with schizophrenia spectrum disorder, major depressive disorder, and anxiety disorders. *Neuropsychiatric Disease and Treatment, 12,* 2439–2448. https://doi.org/10.2147/NDT.S114671

Jørgensen, C. R. (2009). Identity style in patients with borderline personality disorder and normal controls. *Journal of Personality Disorders, 23*, 101–112. https://doi.org/10.1521/pedi.2009.23.2.101

Karan, E., Niesten, I. J. M., Frankenburg, F. R., Fitzmaurice, G. M., & Zanarini, M. C. (2014). The 16-year course of shame and its risk factors in patients with borderline personality disorder. *Personality and Mental Health, 8*(3), 169–177. https://doi.org/10.1002/pmh.1258

Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism*. Aronson.

Klein, M. H., Wonderlich, S. A., & Crosby, R. (2001). Self-concept correlates of the personality disorders. *Journal of Personality Disorders, 15*(2)*,* 150–156. https://doi.org/10.1521/pedi.15.2.150.19214

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

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

Korn, C. W., La Rosée, L., Heekeren, H. R., & Roepke, S. (2016). Social feedback processing in borderline personality disorder. *Psychological Medicine, 46*, 575–587. https://doi.org/10.1017/S003329171500207X

Kverme, B., Natvik, E., Veseth, M., & Moltu, C. (2019). Moving toward connectedness: A qualitative study of recovery

processes for people with borderline personality disorder. *Frontiers in Psychology, 430*(10), 1–11. https://doi.org/10.3389/ fpsyg.2019.00430

Kyngäs, H., Mikkonen, K., & Kääriäinen, M. (2020). *The application of content analysis in nursing science research*. Springer.

Lam, D. C., Salkovskis, P. M., & Hogg, L. I. (2016). 'Judging a book by its cover': An experimental study of the negative impact of a diagnosis of borderline personality disorder on clinicians' judgements of uncomplicated panic disorder. *British Journal of Clinical Psychology, 55*, 253–268. https://doi.org/10.1111/bjc.12093

Leppänen, V., Hakko, H., Sintonen, H., & Lindeman, S. (2016). Comparing effectiveness of treatments for borderline personality disorder in communal mental health care: The Oulu BPD study. *Community Mental Health Journal, 52*(2), 216–227. https://doi.org/10.1007/s10597-015-9866-4

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press.

Livesley, W. J. (2003). *Practical management of personality disorder*. Guilford Press.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine, 71*, 12, 2150–2161. https://doi.org/10.1016/j.socscimed.2010.09.030

Löf, J., Clinton, D., Kaldo, V., & Rydén, G. Symptom, alexithymia and self-image outcomes of mentalisation-based treatment for borderline personality disorder: A naturalistic study. *BMC Psychiatry, 18*(185), 1–9. https://doi.org/10.1186/s12888-018-1699-6

Meinefeld, W. (2004). Hypotheses and prior knowledge in qualitative research. In U. Flick, E. von Kardoff, & I. Steinke (Eds.), *A companion to qualitative research* (pp. 153–158). Sage.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250–260. https://doi.org/10.1037/0022-0167.52.2.250

Moses, T. (2011). Stigma apprehension among adolescents discharged from brief psychiatric hospitalization. *Journal of Nervous and Mental Disease, 199*(10), 778–789. https://doi.org/10.1097/nmd.0b013e31822fc7be

Natvik, E., & Moltu, C. (2016). Just experiences? Ethical contributions of phenomenologically-oriented research. *Scandinavian Psychologist, 3*(e17), 1 –15. https://doi.org/10.15714/ scandpsychol.3.e17

Quenneville, A. F., Badoud, D., Nicastro, R., Jermann, F., Favre, S., Kung, A.-L., Euler, S., Perroud, N., & Richard-Lepouriel, H. (2020). Internalized stigmatization in borderline personality disorder and attention deficit hyperactivity disorder in comparison to bipolar disorder. *Journal of Affective Disorders, 262*, 317–322. https://doi.org/10.1016/j.jad.2019.10.053

Roepke, S., Schröder-Abé, M., Schütz, A., Jacob, G., Dams, A., Vater, A., Rüter, A., Merkl, A., Heuser, I., & Lammers, C.-H. (2011). Dialectic-behavioral therapy has an impact on self-concept clarity and facets of self-esteem in women with borderline personality disorder. *Clinical Psychology and Psychotherapy, 18*, 148–158. https://doi.org/10.1002/cpp.684

Roller, M. R., & Lavrakas, P. J. (2015). *Applied qualitative research design*: *A total quality framework approach* (1st ed.). Guilford Press.

Rüsch, N., Lieb, K., Gottler, I., Hermann, C., Schramm, E., Richter, H., Jacob, G. A., Corrigan, P., & Bohus, M. (2007). Shame and implicit self-concept in women with borderline personality disorder. *American Journal of Psychiatry, 164*(3), 500–508. https://doi.org/10.1176/ appi.ajp.164.3.500

Rüsch, N., Hölzer, A., Hermann, C., Schramm, E., Jacob, G. A., Bohus, M., Lieb, K., & Corrigan, P. (2006). Self-stigma in women with borderline personality disorder and women with social phobia. *Journal of Nervous and Mental Disease, 194*, 766–773. https://doi.org/10.1097/01.nmd.0000239898.48701.dc

Ryle, A. (1997). *Cognitive analytic therapy and borderline personality disorder: The model and the method.* Wiley.

Sandelowski, M., & Barroso, J. (2003). Classifying the findings in qualitative studies. *Qualitative Health Research*, *13*, 905–923. https://doi.org/10.1177/1049732303253488

Santagelo, P. S., Reinhard, I., Koudela-Hamila, S., Bohus, M., Holtmann, J., Eid, M., & Ebner-Priemer, U. W. (2017). The temporal interplay of self-esteem instability and affective instability in borderline personality disorder patients' everyday lives. *Journal of Abnormal Psychology, 126*(8), 1057–1065. https://doi.org/10.1037/abn0000288

Sheehan, L., Nieweglowski, K., & Corrigan, P. (2016). The stigma of personality disorders. *Current Psychiatry Reports, 18*(11), 1–7. https://doi.org/10.1007/s11920-015-0654-1

Spitzer, C., Jelinek, L., Baumann, E., Benecke C., & Schmidt, A. F. (2021). Negative self-conscious emotions in women with borderline personality disorder as assessed by an implicit association test. *Personality Disorders: Theory, Research, and Treatment, 12*(5), 456–465. https://doi.org/10.1037/per0000467

Tan, Y. M., Lee, C. W., Averbeck, L. E., Brand-de Wilde, O., Farrell, J., Fassbinder, E., Jacob, G. A., Martius, D., Wastiaux, S., Zarbock, G., & Arntz, A. (2018). Schema therapy for borderline personality disorder: A qualitative study of patients' perceptions. *PLoS One, 13*(11), e0206039. https://doi.org/10.1371/journal.pone.0206039

Yeomans, F., & Delaney, J. (2008). Transference-focused psychotherapy for BPD. *Social Work in Mental Health, 6*(1–2), 157–170. https://doi.org/10.1300/J200v06n01_13

Young, J. E, Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner´s guide*. Guilford Press.

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Appendix

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

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

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

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