Recovery in Borderline Personality Disorder from service users' perspective and the Complete Mental Health Model: A systematic review

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Abstract

Background: Borderline personality disorder (BPD) is a serious mental illness characterized by psychosocial impairment, an extreme fear of abandonment and emotional dysregulation. Although the course of BPD is considered to be chronic in nature, cases of symptom remission and even full symptomatic recovery are known. However, literature focuses less on recovery in terms of positive mental health but mainly on the reduction of symptoms. This systematic review is the first to assess the implementation of the Complete Mental Health Model as a theoretical framework for recovery from clients' perspectives. This model defines complete mental health as both the relative absence of psychopathology and the presence of well-being.

Method: A systematic review and a qualitative meta-summary approach were used. Twelve studies with service users' that had been in psychotherapy for BPD-related symptoms and meeting various quality and inclusion criteria were included. The result section of the articles were searched for relevant themes. All themes were analysed using a meta-summary technique. Themes were labelled into criteria for recovery and the frequency and intensity effect sizes were calculated.

Results: In addition to symptom remission, dimensions of psychological well-being were found to be important criteria for BPD recovery. The most frequent mentioned criteria were self-acceptance, personal growth, self-dysregulation, positive relationships with others, interpersonal dysregulation, emotional dysregulation and cognitive dysregulation. Emotional and social well-being were found to less important, according to service users.

Conclusions: Service users rate psychological well-being as a central criterion for BPD recovery in addition to remission of BPD symptoms. Although the complete mental health model seems to be over-complete as a new theoretical framework for BPD recovery, more research is needed to understand underlying mechanism between the different dimensions of this model.

Keywords: Borderline personality disorder, BPD, recovery, well-being, complete mental health model, systematic review, qualitative research, positive psychology, service user perspective

Introduction

Borderline personality disorder (BPD) is a severe mental disorder which is characterized by psychosocial impairment, unstable relationships, an extreme fear of abandonment, and emotional dysregulation (APA, 2000; Skodol, Gunderson, McGlashan, Dyck, Stout & Benders, 2002; Zanarini, Frankenburg, Hennen & Silk, 2004). The effect is that not only individuals with BPD suffer from the consequences of this illness, the social system around people with BPD will have to face the reality of the disorder as well. In order to estimate the magnitude of the consequences of BPD on social systems and societies, it is important to note that about 2% of the general population is diagnosed with BPD (Lieb, Zanarini Schmahl, Linehan & Bohus, 2004). BPD characteristics such as unstable relationships, emotional dysregulation and fear of abandonment may have severe effects on patients' lives which can ultimately result in suicide. Exact mortality rates of individuals with BPD are non-existent but are estimated to fall between 8 and 10% (Oldham, 2006; Paris, 2002).

As previously mentioned, BPD is (among others) characterized by emotional dysregulation and a fear of abandonment. For a large part, these symptoms manifest itself in chaotic and unstable relations, therefore, BPD may not only have destructive consequences for an individual with this diagnosis but may also have rather severe consequences on a societal level. For example, people with BPD are likely to use mental health services more extensively than individuals with major depression (Bender et al., 2001). Two studies assessed the economic consequences that this may have on a society. The first study by Wagner et al. (2014) found that BPD-related societal cost-of-illness are on average €28026 per patient in the year prior to participation in a dialectical behavior therapy treatment. In comparison, in the same population the mean annual direct and indirect costs-of-illness for generalized anxiety disorder amounted to €1799, €1677 for panic disorder and €1606 for social phobia (Andlin-Sobocki & Wittchen, 2005). In the year that patients followed the DBT program, this decreased to €18758. During the follow-up year they continued to diminish further to €14750 (Wagner et al., 2014).

Many treatments for BPD focus on symptom remission, however, this approach is deemed insufficient because it fails to address quality of life-related aspects. In order to shift the focus of current available treatment from symptom remission towards a more holistic standpoint, a new theoretical framework regarding recovery in BPD is necessary. By identifying important criteria for recovery in BPD, this study seeks to contribute to the

formulation of a more holistic theoretical framework regarding BPD (Stone, 2019; National Collaborating Centre for Mental Health, 2018).

Recovery in Borderline personality disorder

The course of BPD is often considered to be chronic in nature, however, remission of symptoms and even recovery can be accomplished either through the natural course of the illness or through treatment. For example, Zanarini et al. (2010) found that 93% of individuals diagnosed with BPD achieved a remission of symptoms that lasted at least two years. 50% achieved a two-year recovery meaning, concurrent symptomatic remission and good social and vocational functioning (Zanarini et al., 2010).

A consensus regarding a definition of recovery in the context of BPD seems to be absent, illustrated by the large variation of outcome measures that are applied to estimate the success of treatment. These outcome measures vary from scales that assess self-harming behavior or general symptoms, such as depression or anxiety, to a GAF score which not only assesses remission of symptoms but also includes social and occupational functioning (National Collaborating Centre for Mental Health, 2018). In other words, while some measure recovery in the clinical sense of the word, others assess recovery from a more holistic perspective.

Nehls (2000) proposes that a renewal of the concept of recovery can help to shift both the negative public opinion as well as the often pessimistic and paternalistic attitude of clinicians towards clients with BPD. Andresen et al. (2010) note that a traditional framework of recovery which only includes symptom remission as criterion for recovery is insufficient. A better understanding of the process of recovery in individuals with BPD can potentially contribute to a consensus regarding recovery in BPD and the development of interventions used in treatment for this target group

Whereas clinical recovery has its emphasis on symptom remission and recovery in terms of an outcome measure, personal recovery focusses more on recovery in terms of a process. For example, Anthony (1993) described personal recovery as a “deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles … a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness” (p. 17). In other words, one may still suffer the consequences of an illness, but one finds a way to give new meaning and purpose to one’s life as one moves beyond the destructive consequences of an illness. For example, even though one experiences significant improvement in emotion regulation after psychotherapy, one may still find it very difficult to

regulate emotions. Instead of engaging in self-harming behavior, one may find a way of coming to terms with emotions that one does not understand and to accept that for the time being, this is simply a part of who one is.

Mental health

Personal recovery seems to resemble the declaration of the World Health Organization (WHO) on mental health: "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization, 2004d, p.12). Meaning that besides the absence of decease, in order to consider someone healthy, something positive must be present as well**.**

The complete mental health model (CMHM) continues to build on the definition for mental health as stated by the WHO, while distinguishing a difference between moderate mental health and a state of complete mental health where in addition to a relative absence of psychopathology, there is also a presence of positive mental health (Keyes, 2005, Keyes & Westerhof, 2010). Positive mental health can be divided in emotional well-being, psychological well-being and social well-being (Keyes & Westerhof, 2010). Emotional well-being consists of happiness, life satisfaction and a balance in experienced positive and negative affect. It is associated with feeling happy, experiencing joy. (Diener, 1984). Social well-being is characterized by the presence of five characteristics: 1) social contribution, 2) social actualization, 3) social acceptance, 4) social integration and 5) social coherence (Keyes, 2005). Psychological well-being, as described by Ryff (1989), consists of six criteria; 1) self-acceptance, 2) autonomy, 3), positive relations with others 4) purpose in life, 5) environmental mastery, and 6) personal growth. Keyes and Westerhof (2010) found that although they are related, mental health and illness lie on two different continua. The continuum regarding psychopathology varies from no psychopathology at all, to severe psychopathology. The other continuum varies from languishing to flourishing.

Flourishing is characterized by experiencing predominantly positive emotions and to be functioning well, both psychological as socially. The opposite of flourishing is languishing which is distinguished by feelings of emptiness and stagnation, and a diminished sense of identity (Keyes, 2002). According to the CMHM, the mere absence of languishing is only a moderate form of mental health. In order to be in a complete state of mental health, one should in addition to the relative absence of psychopathology also experience symptoms of flourishing, for instance, positive emotions.

In accordance with several renown researchers on the subject of positive mental health (Bohlmeijer, Bolier, & Walburg, 2013), reducing individual lives to deficits and shortcomings is a very one-sided approach and does little justice to the complexity of mental health. In the context of BPD, this might entail, for example, focusing merely on difficulties regulating one's emotions, while not paying attention to positive traits or factors that might contribute to well-being and facilitate the process of recovery. The CMHM offers a more holistic approach towards mental health by addressing both the presence of well-being or factors that facilitate flourishing as well as the absence of psychopathology. Yet, no known research has applied this approach in order to uncover factors that play an important role in the process of recovery from the perspective of individuals with lived experience of BPD and its symptoms.

The emphasis on recovery from the perspective of service users may proof to be very important, because individuals with a BPD diagnosis are reported to face stigmatization more, compared to any other psychiatric diagnosis, from both society but also from health care professionals (e.g. psychiatric nurses or therapists; Kverme, Natvik, Veseth & Moltu, 2019). A theoretical framework that includes a service user perception of recovery might contribute to improvement regarding stigmatization and therefore facilitate better cooperation between health care professionals and service users and ultimately contribute to a higher recovery rate.

Current study

The current study seeks to identify essential criteria for recovery regarding BPD as perceived by service users' perspective by performing a systematic review.

As previously described, a more positive approach on recovery and mental health is not new (Anthony, 1993; Jahoda, 1958; World Health Organization, 2004; Keyes, 2002). It has also been systematically reviewed, for example Shepherd, Sanders, Doyle and Shaw (2016) reviewed personal recovery in personality disorder. They found that in order for recovery to take place, it was essential that service users felt safe or contained. Moreover, they found recovery to be an ongoing exercise of personal autonomy and that identity construction to be central in the lived experience of personal recovery. Although this article focused on the experience of personal recovery in personality disorder, it did not research the importance of symptom remission. Moreover, it was not specifically targeted on the lived experience of recovery in individuals with BPD like symptoms; instead they took a broader approach by addressing personal recovery in people with PD. A limitation of this research is that it only included three qualitative articles.

Another review on recovery from BPD was conducted by Katsakou and Pistrang (2018). By using a thematic analysis method, they took a more bottom-up oriented approach towards clients' perceptions of recovery from BPD. In addition to perceptions of recovery, they also chose to investigate clients' experiences with treatment for BPD. Central themes regarding recovery that the study aimed to investigate were experience of change, and processes that might facilitate positive change. Regarding recovery the researchers found four areas in lives of service users to undergo change during the recovery process namely 1) developing self-acceptance and self-confidence; 2) controlling difficult thoughts and emotions; 3) practicing new ways of relating to others and 4 implementing practical changes and developing hope. Although the bottom up approach allowed the investigators to research lived experiences of recovery in a more holistic way than an approach that only focused either symptom remission or personal recovery, a theoretical framework was not applied, this makes it difficult to compare findings of other research on the subject.

As opposed to previous research from Katsakou and Pistrang (2018) a theoretical framework will be implemented. The benefit of a theoretical framework over a pure bottom up approach is that the implementation of a theoretical framework may help to identify the limits of the generalizations of previous research. Moreover, this approach may assist further research in the formulation of relevant hypotheses. Therefore, it will be proposed to explore the possibilities for a theoretical framework on recovery for BPD in terms of the complete mental health model as conceptualized by Keys (2005) by investigating service users' perspectives of important criteria for recovery. In order to do so, two research questions are formulated.

1. Which studies regarding recovery from borderline personality disorder are conducted from service users' perspective?
2. Which dimensions from the complete mental health model (2005) are important criteria for recovery regarding BPD?

Method

Search strategy and selection of studies

Guidelines from the PRISMA statement for reporting systematic reviews were used for the search strategy (Liberati et al., 2009). Firstly, a systematic search was conducted in three electronic databases, namely PsycInfo, Scopus and Web of Science (final search date 12th February 2019). The search was conducted within all research fields and not limited to a specific year of publication. The main search terms were (("borderline personality disorder"

OR "borderline" OR "BPD") AND ("recovery" OR "well-being") AND ("client perspective" OR "qualitative" OR "interview")) resulting in 58 hits from PsycInfo, 116 hits from Scopus and 95 hits from Web of Science. Secondly, an additional search was conducted, screening two previous systematic reviews (Shepherd, Sanders, Doyle & Shaw, 2016; Katsakou & Pistrang, 2018). This provided an additional 7 articles. Duplicates between PsycInfo, Scopus and Web of Science were removed. In total, 191 unique studies remained for screening. Studies were included in this systematic review if they met the following conditions:

1. The study had to be published in a peer-reviewed journal or in an academic book,
2. The study had to report on concepts or processes for recovery in the context of BPD,
3. The study ensured the credibility of the data by using a rigorous system,
4. The design of the study was qualitative in nature, and
5. The data provided a service users' perspective of concepts and/or processes for recovery in BPD

Initially only diagnosed borderline personality disorder was included since the target was to assess the perspective of service users regarding processes or criteria for recovery for BPD. Therefore, it would be logical to only include those diagnosed with the disorder. However, many people with other forms of PD suffer from comparable problems as individuals with BPD. Some studies researched PD in a broader sense, but the majority of participants seem to suffer from symptoms that can be defined as BPD related characteristics (e.g. Castillo, Ramon & Morant, 2013). Studies that included people without a formal diagnosis were therefore also considered for inclusion in order to minimalize the waste of valuable information. In this case key criteria for inclusion were that participants followed BPD related psychotherapeutic interventions for example DBT, and that they also reported BPD-like symptoms. In order to avoid inclusion of studies that were not peer-reviewed, unpublished reports and dissertations were excluded.

During the first phase, studies were selected based on title and the content of the abstract. Following, all selected articles were individually screened based on full text. Reference lists of included articles were scanned for additional studies. Finally, twelve studies were included in total in the present systematic review (see Figure 1), including seven that were obtained through an additional screening.

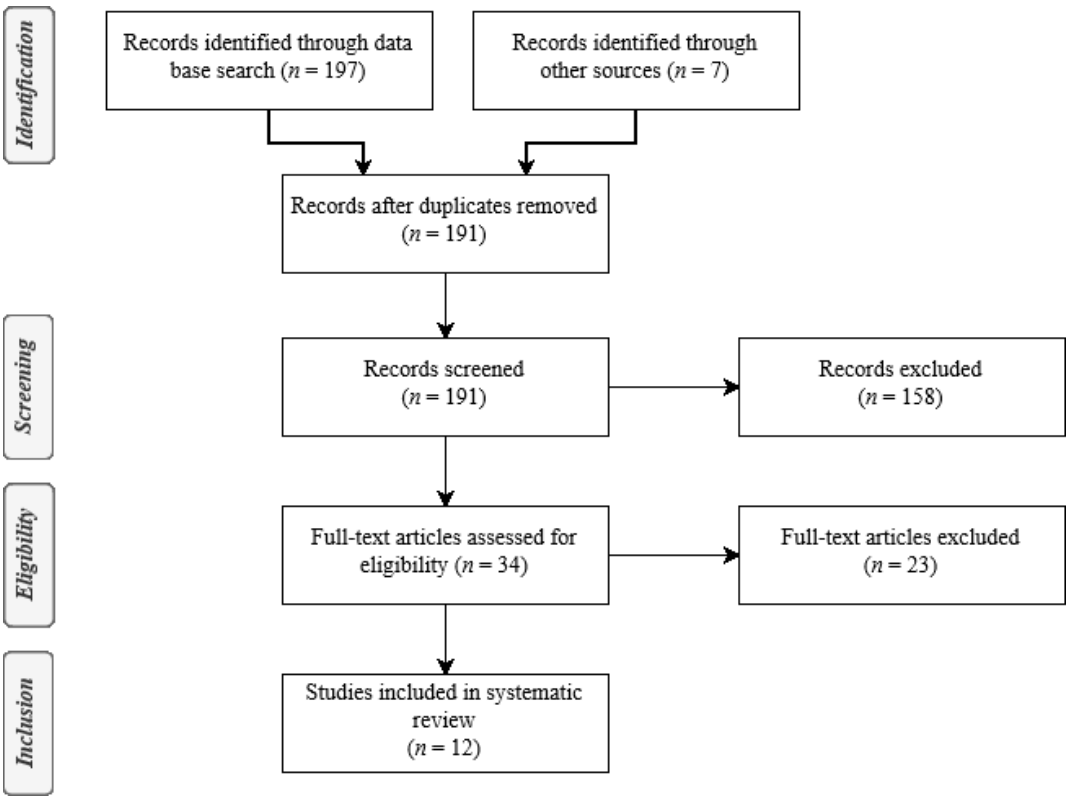

Figure 1. Flowchart illustrating the systematic search process

Assessment of the quality of the studies

In order to assess quality of the studies that were included in this systematic review, the Critical Appraisal Skills Programme (CASP) was used. The CASP method enables researchers to systematically assess the relevance, trustworthiness and results of published papers (CASP, 2018). The CASP method uses 10 questions to establish to what extend papers are deemed to be of sufficient quality to be included.

Extraction of relevant statements

In order to extract relevant statements, the results and findings of included articles were scanned for themes that seemed to resemble criteria for recovery. Later in this process, the CMHM was used as a framework to give meaning to extracted themes. In other words, the analytic process was both inductive and deductive in nature since themes were extracted from data (bottom up) subsequently interpreted in terms of labels of the CMHM (top down). Data was only reviewed by one researcher. In order to limit personal bias, articles were scanned at least three times for relevant themes. This resulted in a dataset with 122 themes. An overview of the labels and descriptions can be found in Table 1. These labels were based on the dimensions of the CMHM (Keyes, 2005). In this case it included the three forms of well-being (i.e. PWB, SWB and EWB) and a way to assess symptom remission (Keyes, 2005; Ryff, 1989). The symptom remission dimension was based on the five types of dysfunction

as conceptualized by Linehan (2006). Furthermore, a miscellaneous label was created in order to categorize themes that did not fit any of the existing labels.

Analysis of recovery in terms of the CMHM

As stated, this study aims to review recovery in BPD as perceived by service users in terms of the CMHM (Keyes, 2005). For this, a meta-summary technique was used which was described by Sandelowski and Barroso (2003). The techniques that were used for creating this meta-summary are (a) distilling relevant themes of included studies, (b) capturing these themes into conceptualized findings; and, (c) calculating of intensity and frequency effect sizes (Sandelowski & Barrosso, 2003).This method not only allows for extracting themes, but also their frequencies (Sandelowski & Barroso, 2003; Timulak, 2009). In addition to creating an overview of how often certain themes were mentioned, it also allowed comparing the importance of findings and how they relate to each other.

In order to give meaning to statements and abstracted findings, effect sizes were calculated according to a method as described by Sandelowski and Barosso (2003). This method distinguishes two types of effect sizes, namely 1) frequency effect sizes and 2) intensity effect sizes. Frequency effect sizes were "calculated by dividing the number of studies containing the same finding by the total number of studies" (p. 6; De Vos et al., 2017). This measure provides an indication of the frequency that certain criteria regarding recovery were mentioned. For instance, a frequency effect size of 50% indicates that themes regarding a certain label were mentioned in half of the included articles. In order for a label to be seen as strong evidence as a criterion for recovery, they had to be reported in at least 75% of the included articles. Labels were found to be substantial evidence as criteria for recovery when they were mentioned in between 50% and 75% of all studies. Moderate evidence as criteria for recovery were labels that were reported by 25% to 50% of all included studies, all labels that were reported by less than 25% of included studies were deemed to be insufficient evidence as criteria for recovery. The cut-off points are based on previous literature by de Vos et al. (2017). Intensity effect sizes were "calculated as the number of findings for a criterion produced in all studies divided by all findings" (p. 7, De Vos et al. 2017). The intensity effect size estimates how important a criterion is when comparing to other criteria for recovery (Sandelowski & Barosso, 2003). Regarding the interpretation of intensity effect sizes, no guidelines or rules were found in literature that describes the process of meta-summary techniques. Therefore, it was decided to interpret the intensity effect sizes in a dynamic way in terms of how they relate to each other.

Table 1.

Labels theoretical frameworks and descriptions (according to authors of previous studies on frameworks for recovery or well-being)

Health criteria	Description
BPD pathology in terms of five types of dysfunction. (Linehan, 2006)	
Emotional dysregulation	Improvement/ absence of emotional dysregulation symptoms (affective lability, problems with anger)
Interpersonal dysregulation	Improvement/ absence of interpersonal dysregulation symptoms (chaotic relationships and fear of abandonment)
Self-dysregulation	Improvement/ absence of self-dysregulation symptoms (identity disturbance, difficulties with a sense of self, and sense of emptiness)
Behavioral dysregulation	Improvement/ absence of behavioral dysregulation symptoms (suicidal behavior and impulsive behavior)
Cognitive dysregulation	Improvement/ absence of behavior dysregulation symptoms (dissociative symptoms and narrow, rigid thinking)
Emotional well-being (Keyes, 1998)	
Avowed happiness	Feeling happy
Positive affect	Feeling cheerful, in good spirits, calm and peaceful, satisfied and full of life.
Avowed life satisfaction	Satisfied with life overall or domains of life
Psychological well-being (Ryff, 1989)	
Self-acceptance	Possesses a positive attitude towards the self; acknowledges and accepts multiple aspects of self, including good and bad qualities; feels positive about past life
Environmental mastery	Has a sense of mastery and competence in managing the environment; controls complex array of external activities; makes effective use of surrounding opportunities; able to choose or create contexts suitable to personal needs and values
Positive relationships with others	Has warm, satisfying, trusting relationships with others; is concerned about the welfare of others; capable of strong empathy, affection, and intimacy; understands give and take of human relationships
Personal growth	Has a feeling of continued development; sees self as growing and expanding; is open to new experiences; has sense of realizing his or her potential; sees improvement in self and behavior over time; is changing in ways that reflect more self-knowledge and effectiveness
Autonomy	Is self-determining and independent; able to resist social pressures to think and act in certain ways; regulates behavior from within; evaluate self by personal standards
Purpose in life	Has goals in life and a sense of directedness; feels there is meaning to present and past life; holds beliefs that give life purpose; has aims and objectives for living
Social well-being (Keyes, 1998)	
Social contribution	Feeling that one's own life is useful to society and that the output of one's activities is valued by or valuable to others
Social integration	Having a sense of belonging to a community and deriving comfort and support from that community
Social actualization	Believing that people, social groups, and society have potential and can evolve or grow positively
Social acceptance	Having a positive attitude towards others while acknowledging and accepting people's differences and their complexity
Social coherence	Being interested in society or social life, and feeling that society and culture are intelligible, somewhat logical, predictable, and meaningful
Miscellaneous labels	
Religion/spirituality	
Unspecified symptomatic	
Physical activity	

Results

Studies assessing recovery from service users' perspective

Examining the extent to which included studies assess recovery from service users' perspective, it was found that, although all studies based their findings on lived experiences of individuals with BPD-like symptoms, not all studies aimed to explicitly examine the experience of recovery. In total seven articles reported on recovery from BPD (or BPD-like symptoms) from the perspective of service users (Castillo, Ramon & Morant, 2013; Chugani, Seiler & Goldstein, 2017; Gillard, Turner & Neffgen, 2015; Johansen, Tavakoli & Bjelland, 2017, Katsakou et al., 2012; Larivière et al., 2015; McCusker, Turner, Pike & Startup, 2018). Two articles reported primarily on beneficial factors of treatment from client perspective, yet they still reported on recovery although not explicitly (Cunningham, Wolbert & Lillie, 2004; Haeyen, van Hooren & Hutschemaekers, 2015). Fallon (2003) reported how service users with BPD experience contact with mental health services. Although his focus was not primarily on recovery, he still found that patients perceive positive relations with others as a sign of recovery. Langley and Klopper (2005) only found that service users perceive experiencing hope towards the future as a sign of recovery. Perseius, Öjehagen, Ekdahl, Åsberg and Samuelsson (2003) reported on recovery in an indirect way: their primary focus was on perceptions of giving and receiving dialectical behavior therapy.

Importantly, included studies differed in how they collected and analyzed their data leading to a broad variation in used methods and characteristics of the participants. This may affect whether and to which extent they captured the lived experience of recovery in BPD.

Participants. The 12 included studies covered a total of 214 participants, the majority of which was female (179 women and 35 men). The general age ranged between 18 to 65 years, yet, several studies did not specify the age of their participants. Two studies did not specify age (Haeyen, van Hooren & Hutschemaekers, 2015; Langley & Klopper, 2005). Katsakou et al. (2012) only reported a mean age which was 36.5 years (SD = 10.38). Several of the included studies did not regard a psychiatric diagnosis for BPD as an inclusion criterion. Yet, all studies chose to select their participants based on the presence of BPD-like symptoms, for example, non-suicidal self-harming behavior, chaotic relationships or impulsive behavior. In terms of whether the participants are considered to be recovered from BPD or BPD-like symptoms, only one article explicitly mentioned that all included participants were presumed recovered because they underwent at least two years of therapy in specialized PD programs (Larivière et al., 2015). Other studies did not explicitly claim that their participants were recovered but emphasized that they underwent specialist treatment for at least half a year (McCusker, Turner, Pike & Startup, 2018; Cunningham, Wolbert & Lillie, 2004). Some articles did not specify how long participants had been in therapy (Castillo,

Ramon & Morant, 2013; Langley & Klopper, 2005; Chugani, Seiler & Goldstein, 2017) Two articles mentioned that their participants underwent treatment, this varied from 12 months up to two years (Johansen, Tavakoli, Bjelland & Lumley, 2017; Perseius, Öjehagen, Ekdahl, Asberg & Samuelsson, 2003; Gillard, Turner & Neffgen, 2015). Haeyen et al. stated that their participants attended at least 15 sessions of art therapy (2015). Katsakou et al. (2012) included both patients that perceived themselves to be recovered as patients who did not. Fallon (2003) did not specify the attendance of therapy or status of recovery of his participants. Table 2 gives an overview of the characteristics of the participants of each included study.

Data collection. Most articles conducted individual interviews or used focus groups to gather data. One study additionally used collages made by the participants to obtain more information (Larivière et al, 2015). The case study by Johansen et al. (2017) used letters that the participant wrote to herself. A detailed overview of all data collection methods can be found in Table 2.

Data analysis. Six studies used thematic analysis (Castillo, Ramon & Morant, 2013; Chugani, Seiler & Goldstein, 2017; Gillard, Turner & Neffgen, 2015; Katsakou et al., 2012; Larivière et al., 2015; McCusker, Turner, Pike & Startup, 2018) , while three studies used grounded theory to give meaning to their data (Katsakou et al., 2012; Haeyen, van Hooren & Hutscgemaekers, 2015; Fallon, 2003). Moreover, one study used an ethnographic approach (Chugani, Seiler & Goldstein, 2017), one used a general inductive method (Johansen, Tavakoli & Bjelland, 2017) and another used practice-based theory (Langley & Klopper, 2005). Perseius et al. (2003) used qualitative content analysis.

Quality assessment of included studies. Eight out of twelve studies scored at least 9 out of 10 on the Critical Appraisal Skills Programme (CASP, 2018) (Fallon, 2003; Gillard, Turner & Neffgen, 2015; Haeyen, van Hooren & Hutschemaekers, 2015; Johansen, Tavakoli & Bjelland, 2017; Katsakou et al., 2012; McCusker, Turner, Pike & Startup, 2018; Perseius, Öjehagen, Ekdahl, Asberg & Samuelsson, 2003).

Table 2.

Overview characteristics of included studies (N = 12)

Article	Aims	*n*	Female %	Setting	Data collection method	Data analysis method	CASP score
Castillo, Ramon & Morant 2013	To explore how individuals with personality disorder diagnosis define recovery	60	78	A variety of settings within a mental health service provider in Colchester UK	Focus groups, individual interviews	Thematic analysis	9
Chugani, Seiler & Goldstein 2017	To investigate the perspectives and experiences of recovery from individuals diagnosed with BPD.	6	83	Unspecified	Interviews	Thematic analysis	8
Cunningham, Wolbert & Lillie 2004	Understanding the reasons for DBT's success as a treatment for BPD from service users' perspective	14	100	A private nonprofit agency that provides ACT services in the US	Interviews	No specific type of analysis	8
Fallon 2003	To investigate how people with BPD experience their contact with mental health services	7	57	Two mental health service centers in the UK	Interviews	Grounded theory	10
Gillard, Turner & Neffgen 2015	To explore understandings of recovery from the perspectives of people with lived experience of personality disorders.	6	50	Specialist personality disorders' service in the UK	Interviews	Thematic analysis	10
Haeyen, van Hooren & Hutschemaekers 2015	To systematically investigate service users' experience of the benefits of art therapy	29	93	A specialist PD mental health center in the Netherlands	Interviews, focus groups	Grounded theory	9
Johansen, Tavakoli, Bjelland & Lumley 2017	To explore one client's recovery from BPD, trauma and problem gambling	1	100	Public mental health service and private practice in the US	Interviews, letters	General inductive method	10
Katsakou et al. 2012	To explore what service users with BPD view as recovery	48	81	Secondary mental health services in the UK	Interviews	Grounded theory, thematic analysis	10

Article	Aims	*n*	Female %	Setting	Data collection method	Data analysis method	CASP score
Langley & Klopper 2005	To develop practice-level model for the facilitation of mental health of patients diagnosed as having BPD by the community psychiatric nurse.	6	83	Psychiatric community services in South Africa	Individual and focus group interviews	Practice based theory	7
Larivière et al. 2015	To qualitatively capture the experience of recovery in women with BPD	12	100	Two specialist programmes in two cities in Quebec, Canada	Interviews, collage	Thematic analysis	7
McCusker, Turner, Pike & Startup 2018	To explore meaningful change within recovery as perceived by service users	15	80	Two specialist Personality Disorder services in the UK	Focus groups, semi-structured Interview	Thematic analysis	9
Perseius, Öjehagen, Ekdahl, Asberg & Samuelsson 2003	To investigate patients and therapist perceptions of giving and receiving DBT	10	100	Outpatient DBT service in Sweden	Semi-structured Interviews, Semi-structured questionnaires	Qualitative content analysis	9

Most important dimensions of the CMHM

Regarding the assessment of the importance of different dimensions of the complete mental health model as criteria for recovery in BPD, it was found that the overarching dimensions psychological well-being (100%), and BPD pathology (91.7%) showed strong evidence as criteria for recovery. Substantial evidence as a criterion for recovery was found for social well-being (58.3%) whereas moderate evidence as a criterion for recovery was found for emotional well-being (33.3%). There was insufficient evidence found for the miscellaneous dimension as a criterion for recovery (25%).

Regarding the remission of BPD pathology, it was found that the labels emotional dysregulation (58.3%), self-dysregulation (58.3%) and cognitive dysregulation showed substantial evidence as criteria for recovery. Moderate evidence as criteria for recovery was found for interpersonal dysregulation (41.6%) and behavioral dysregulation (41.6%). Regarding emotional well-being only the label positive affect was mentioned. This label showed moderate evidence as a criterion for recovery (33.3%). For psychological well-being substantial evidence as criteria for recovery were found for the labels self-acceptance and personal growth (both 58.3%), positive relations with others, environmental mastery and purpose in life (all 50%). A moderate evidence as a criterion for recovery was found for autonomy (33.3%). Regarding social well-being the labels social integration and social acceptance were found to show moderate evidence as criteria regarding recovery (both 25%). The labels social coherence and (18.2%), social contribution (8.3%) and social actualization (0%) were all found to show insufficient evidence as criteria for recovery. No labels of the miscellaneous label showed any substantial evidence as criteria for recovery. For the label unspecified symptomatic a frequency effect size of 16.7% was found. For the label religion/spirituality a frequency effect size of 8.3% was found and for the label physical activity a frequency effect size of 8.3% was found.

Regarding intensity effect sizes, the overarching dimensions psychological well-being accounted for 45.1% of the criteria for recovery, BPD pathology for 37%, social well-being for 10.7% and emotional well-being for 4.1%. The later constructed miscellaneous dimension accounted for 3.3% of all criteria for recovery. Regarding the intensity effect size for sub-labels, self-acceptance accounted for 11.5% of all themes. An example of a theme that was labeled self-acceptance was "*Accepting that what one can't change*". Personal growth accounted for 9.8%. "*Feeling safe and wanting to explore*" is an example of a theme that was fitted into this label. Self-dysregulation, for example "*A return to a past 'well self' which one has never experienced*" explained 8.2% of all criteria for recovery. Emotional dysregulation, cognitive dysregulation, interpersonal dysregulation, behavioral dysregulation, environmental mastery and positive

relationships with others each accounted for 7.4% of all themes. For instance, the theme "*Being able to mentalize emotions*" was labeled as an improvement in emotional dysregulation where as "*Controlling the tendency to lash out in public*" was labeled as an improvement in behavioral dysregulation. Examples of the labels environmental mastery and positive relationships with others are; "*Believing in one's own abilities to manage or function*" and; "*Support from family and friends*". Autonomy and purpose in life each accounted for 4.9% of all themes. "*Desire to life more independently with a sense the future holds something better*" and "*Giving meaning to and processing traumatic experiences*" are two examples of themes that were deemed to be characterized best as autonomy and purpose of life. Positive affect, for example "*Experiencing pride*" and social integration, for instance "*Having the feeling that one exists, that one has their own place*" each accounted for 4.1% of all themes, where as social contribution, for example "*Being involved in meaningful roles and activities*" and social acceptance, for instance "*Not condemning others*" each accounted for 2.5%. Social coherence, for instance "*Having Goals and aspirations regarding the improvement of social interaction*", and unspecified symptomatic improvements "*Experiencing reduction in symptoms associated with BPD*" represented 1.6% of all themes. Furthermore religion / spirituality *(Having a good connection with god or having a sense of spirituality*) and improvement of physical activity (*Being physically active*) each accounted for 0.8% of all themes. Table 3 gives an overview over the intensity and frequency effect sizes of the prevalence of the labels of the dimensions of the CMHM.

Table 3.

Frequency and intensity effect sizes

Label	Count	Frequency effect size	Intensity effect size
BPD pathology	*45*	*.917*	*.37*
1. Emotional dysregulation	9	.583	.074
2. Interpersonal dysregulation	9	.416	.074
3. Self-dysregulation	10	.583	.082
4. Behavioral dysregulation	8	.416	.066
5. Cognitive dysregulation	9	.500	.074
Emotional well-being	*5*	*.333*	*.041*
1. Avowed happiness	0	-	-
2. Positive affect	5	.333	.041
3. Avowed life satisfaction	0	-	-
Psychological well-being	*55*	*1.0*	*.451*
1. Self-acceptance	14	.583	.115
2. Environmental mastery	8	.500	.066
3. Positive relationships with others	9	.500	.074
4. Personal growth	12	.583	.098
5. Autonomy	6	.333	.049
6. Purpose in life	6	.500	.049
Social well-being	*13*	*.583*	*.107*
1. Social Contribution	3	.083	.025
2. Social integration	5	.250	.041
3. Social actualization	0	-	-
4. Social acceptance	3	.250	.025
5. Social coherence	2	.182	.016
Miscellaneous	*4*	*.25*	*.033*
1. Religion / spirituality	1	.083	.008
2. Unspecified symptomatic	2	.167	.016
3. Physical activity	1	.083	.008

Discussion

This systematic review aimed to examine important criteria for recovery from borderline personality disorder, emphasizing both the remission or absence of clinical symptoms and the presence of criteria regarding mental health and well-being. In order to do so two research question were formulated.

Studies assessing recovery from service users' perspective

The first research question concerned the identification of studies dealing with recovery of BPD from the service users' perspective. Analyzing the different studies and their approaches to collect and analyze data, it became apparent that various methods were used, varying from individual interviews (e.g. Castillo, Ramon & Morant, 2013), addressing focus groups (e.g. McCusker et al., 2018) to using personal, written letters (Johansen et al., 2017). Yet, all studies were conducted using personal experience from individuals dealing with BPD or BPD-like symptoms.

However, the results have shown that not all articles reported explicitly on recovery, since many studies addressed recovery in a more implicit way (e.g. experience of BPD, effectiveness and perception of DBT). The fact that not all articles used a rigorous system to make sure that participants were actually recovered from BPD or its symptoms may be a problem for the validity of the qualitative results of the current study that aimed to capture the lived experience of recovery. When the participants have not actually experienced recovery, reporting on this experience may be perceived as impossible or invalid. Moreover, it may be problematic that there were no means to differentiate between those participants who feel recovered and those who do not, making it impossible to compare both groups and their experience of the recovery process.

Investigating how other systematic reviews on recovery deal with this potential problem, Katsakou and Pistrang (2018) approached recovery as an "ongoing process involving a series of achievements and setbacks" (p. 954), rather than a definite outcome measure. They did not differentiate between being recovered and still being in the process of recovery from BPD. Looking at recovery as an ongoing journey rather than a final destination and including participants who are in different phases of this process may provide valuable information about criteria for recovery. The comparison between individuals who are considered fully recovered and those who are not may not be as relevant as initially thought, since recovery seems to be a deeply, personal journey and experiences from every stage of the process may provide valuable information to support those suffering from BPD and its symptoms during their recovery.

Another possible influence on the results of the current study were the various methods that were implemented by the researchers of the included studies. Most themes used in the current study were based on themes synthesized by those researchers, rather than on actual transcripts or quotes

of gathered qualitative information (e.g. interviews). This means that potential bias from included studies may has found its way into the themes of the current study. Katsakou and Pistrang (2018) report that themes presented in three articles (that were also used included in the current study) were based on questionable syntheses, resulting in "a list of poorly connected themes" (p. 947) (Fallon, 2003; Langley & Klopper, 2005; Larivière et al., 2015). They decided, however, to include these studies regardless of their questionable data syntheses, since they wanted the findings to accurately represent the prevailing scientific knowledge. By using the CASP, they aimed to present a detailed description of methodological limitations in included studies (Katsakou & Pistrang, 2018). The CASP was also used in the current study, however, no mentionable deviations in quality were found.

Summarizing the findings regarding the first research question, it can be concluded that, although it is unknown to which extent participants were recovered and how the different methods used in the studies affected the results in those studies, these findings may still provide valuable information that can potentially affect the direction of future research regarding recovery in BPD.

Most important dimensions of the CMHM

The second research question aimed to assess which themes from the CMHM are important criteria for recovery regarding BPD. While remission of BPD symptoms can be considered an important part of the recovery process, many criteria for recovery concern psychological well-being. Compared to symptom remission, psychological well-being is mentioned more frequently. However, social and emotional well-being seem to be less important criteria for recovery. Similarly, the miscellaneous label was also less important.

Symptom remission is reportedly an important criterion for recovery, with self-dysregulation being the most important sublabel of this dimension. An improvement in self-dysregulation entails developing of a sense of identity and feeling emotionally less empty, a key characterization of BPD pathology (American Psychiatric Association, 2000). Previous research on personal recovery from personality disorder underscores these findings (Shepherd et al., 2016). Accordingly, the ability to experience normal emotions (i.e. a reduction in feelings of emptiness) is seen as a criterion for recovery.

Similarly, Katsakou and Pistrang (2018) add that finding new ways of relating to others (interpersonal dysregulation) and taking control of emotions and thoughts (emotional and cognitive dysregulation) are associated with recovery. Yet, this present study also found that improvements in behavioral and self-dysregulation are important criteria for recovery for BPD, according to service users. This is remarkable, since the current review and the systematic review by Katsakou and Pistrang (2018) share the majority (nine out of 15) of the used articles.

A possible explanation for this difference may lie in the fact that Katsakou and Pistrang (2018) used a bottom-up approach (i.e. no theoretical framework), whereas the present study collected themes using both bottom-up and top-down techniques. The theoretical framework applied in the current study may have made the reviewer aware of the connection between themes and labels such as self- and behavioral dysregulation. When only using a bottom-up approach, one may not become aware of such connections/fits.

With symptom remission, normalization seems to be an important aspect of the process of recovering from BPD, however, psychological well-being plays a more dominant role in this process. Within the dimension psychological well-being, two labels are found to be particularly important criteria for recovery for BPD, namely personal growth and self-acceptance. While previous research by Katsakou and Pistrang (2018) supports that self-acceptance is indeed an important aspect of recovery in BPD, they also mention developing hope as being important. Although hope (Katsakou & Pistrang, 2018) and personal growth (the current research) are distinct constructions, they also seem to be related. Shorey, Little, Snyder Kluck and Robitscheck, (2007) found that hope is related to the behaviors that initiate personal growth, indicating that hoping, for example, for improvements in a sense of identity is related to behavior that facilitates this development (e.g. seeking psychotherapy).

One explanation why individuals suffering from BPD and its symptoms consider self-acceptance to be such an important part of recovery may deal with the effect this self-accepting attitude can have on the development of a sense of identity (Katsakou & Pistrang, 2018). Both, self-acceptance and an improvement of self-dysregulation, were found to be important criteria for recovery. Possibly, having a forgiving and compassionate attitude towards oneself and one's own shortcomings may be a facilitator for developing a sense of identity (i.e. improvement in self-dysregulation). This was found to be the case among individuals with bipolar disorder (Inder, Crowe, Moor, Luty, Carter & Joyce, 2008).

Compared to other labels of the psychological well-being dimensions, two particular labels were found to be less important criteria for recovery, namely autonomy and purpose in life. The nature of the recovery process in BPD may provide some explanation why autonomy was relatively less important. Zanarini et al. (2012) state that although symptom remission is not uncommon in BPD, full psychosocial recovery is rare. This means that the fact that this review only found moderate evidence for autonomy does not mean that this is true. This idea is supported by Johansen et al. (2017), they described how recovery moved in three phases 1) from dependence on a therapist, to 2) re-engagement and emotional learning side by side with a therapist, to 3) trying out the gains in the real world in a more autonomous manor. In other words, it is possible that although

participants of included studies all completed psychotherapy, they were potentially not fully recovered in terms of reaching this third, last phase of recovery.

Interestingly, Shepherd et al. (2016) found that autonomy does play an important role in recovery in BPD. However, they only provide one quote on personal autonomy, extracted from an article that was not used in the current review. Their method (meta-synthesis) also did not include the calculation of frequency effect sizes, consequently making it impossible to compare their findings on autonomy to the results of other systematic reviews, such as the current study. Katsakou and Pistrang (2018) did include the article from which Shepherd et al. (2016) extracted the quote on autonomy, yet, they do not mention autonomy to be of importance for recovery.

One explanation why purpose in life was also found to be of lesser importance as a criterion for recovery compared to other psychological well-being labels may concern the relation between being autonomous and formulating goals in life. Maslow (1943, 1954) describes being self-actualized, thus achieving one's full potential, as being autonomous and independent. Therefore, striving for full autonomy and independence may be characterized as a "higher" form of recovery that may not have been experienced or recognized by most of the participants of included studies.

As previously mentioned, emotional well-being was found to be a rather unimportant criterion for recovery regarding BPD. One explanation might deal with the importance of the concept of self-acceptance during a recovery process. Self-acceptance includes acknowledging and accepting one's own shortcomings and limitations and coming to terms with them (Ryff & Singer, 2008), according to the common saying "change what you cannot accept but accept what you cannot change". Truly accepting that experiencing negative emotions is an inevitable part of human existing may involve that experiencing more positive emotions, however comforting and pleasant they are, lose value as a criterion for recovery. In other words, being at peace with one's own feelings of insecurity, anger or depression and accepting their presence might make it less important to individuals suffering from BPD to improve their emotional well-being regarding recovery. Due to the intense and persistent nature of BPD symptoms regarding emotional regulation, this suggests that self-acceptance may have more impact in the recovering process than improvements in emotional well-being.

In addition to emotional well-being, social well-being was also found to be of less importance as a criterion for recovery. One explanation for this finding may be that individuals with a BPD diagnosis face the most stigmatization of all psychiatric illnesses (Kverme et al., 2019). This may result in social withdrawal (Richman & Leary, 2009). This might manifest itself in an attitude characterized by indifference and attaching less value to be part of society.

The CMHM as a framework for recovery in the context of BPD was found to be over-complete, since there was too little evidence for emotional well-being and social well-being as

criteria for recovery. Psychological well-being was still found to be the most important criterion for recovery in addition to symptom remission. This echoes findings from previous research adding to the notion that mere symptom remission does not do justice to the complex processes that are involved in recovery (Andresen, Caputi & Oades, 2010). Self-acceptance potentially serves as an important cornerstone, since several other criteria for recovery (e.g. improvements in self-dysregulation, emotional well-being) seem to evolve around this concept.

Strengths and limitations of current systematic review

One strength of the current review is that it was the first known study that used the CMHM as a theoretical framework to assess recovery in BPD from service users' perspective. The implementation of this framework meant that a holistic approach on recovery was used, thus focusing not only on symptom remission but also on dimensions of well-being. Generally using a theoretical framework allows researchers to explore the limits of generalizability of previous findings regarding the subject of interest (Corvellec, 2013).Using the CMHM as theoretical framework, investigating recovery in BPD lead to a more integrated assessment of recovery, compared to merely focusing on personal recovery, as did Shepherd et al. (2016).

Another strong characteristic of this research lies in the fact that a meta-summary technique was applied. In contrast to this study, Katsakou and Pistrang (2018) and Shepherd et al. (2016) used a meta-synthesis method, leading them with information about important aspects necessary for recovery. However, using frequency and intensity effect sizes allows to make conclusions not only about the importance of these aspects but also about how the different aspects of recovery relate to each other in terms of recovery in BPD. The study of both Katsakou and Pistrang (2018) and Shepherd et al. (2016) did not provide this insight.

A limitation of the current research is the quality of the search query used to find suitable studies for this systematic review. The query provided a total of 184 unique records. An additional search that included records from another systematic review provided seven additional full text articles. The search query only provided a total of five full text articles to include in this systematic review. This means that most full text articles that were included in the current study were obtained through the additional search. This makes it difficult to estimate the quality of the search query. It is likely that a different search query would have provided more relevant full text articles. For future research it can be advised to observe search queries from other reviews on the subject such as for instance, Katsakou and Pistrang (2018) included search terms such as "service user", "change" and "perception". Moreover, they also included "personality disorder" in addition to "borderline personality disorder" in their query. This broadened the search results which resulted in more potential full text articles. Although the search query from the current review on its own may be

considered a limitation, the additional search seemed to have corrected this limitation because it provided enough literature to support this systematic review.

Another limitation is the manner in which articles were screened for quality assessment, relevance and relevant themes. Although all these processes were repeated several times, they were still executed by one singular researcher. It is possible that bias influenced the in- or exclusion of articles in the review. This is also the case for the data extraction. This may be prevented in future research by adding at least one extra researcher to the research team, so that quality criteria, relevant themes and potential articles are rated by two different researchers. In order to adequately estimate the inter-rater reliability a Cohen's Kappa (κ) can be calculated.

Recommendations and future research

The findings of the current research contribute to the knowledge regarding the CMHM in relation to recovery in BPD. Still additional research is needed in order to better understand the underlying mechanism that influence this ongoing process. Future qualitative research could shine light on still remaining questions regarding this topic, for example, on whether or to what extent self-acceptance is a facilitator for identity development or how different stages of recovery influence the experience of autonomy and purpose of life. One option might be to conduct a qualitative (semi-)structured interview study among individuals with BPD or related symptoms who consider themselves to be recovered, using an interview and coding scheme that attempts to assess the importance of the different aspects of the CMHM.

Findings regarding the importance of self-acceptance may also be implemented in treatment of BPD. This can be in the form of exercises that specifically target self-acceptance-related constructs (e.g. self-compassion), or it may also be part of an already existing therapy method (e.g. DBT). One example of exercise targeted at improving self-compassion is the grandmother-exercise (p.116) described in *Dit is jouw leven* (Bohlmeijer & Hulsbergen, 2013). Self-acceptance may also be targeted in existing psychotherapy for instance nonresponding patients showed to have improved levels of well-being after undergoing inpatient schema therapy (ST) (Schaap, Chakhssi & Westerhof, 2016). Schema therapy is a psychotherapeutic approach that integrates behavioral, experiential and cognitive interventions (Young, Klosko & Weishaar, 2003). It has also been described to improve self-acceptance (Claassen & Pol, 2015).

Conclusion

Combined with results from previous research, it can be concluded that recovery in terms of symptom remission is insufficient as a framework for recovery for BPD (Andresen, Caputi, & Oades, 2010; Katsakou & Pistrang, 2018; Shepherd et al., 2016; De Vos et al., 2017) The results from the current study demonstrate that both symptom remission and psychological well-being are

core aspects of recovery. Nevertheless, recovery in the terms of CMHM (Keyes, 2005) seems to be over-complete, since two other dimensions seem (emotional and social well-being) to be of less importance. This study, among others, provides a further direction that may enable professionals to better understand the relation between psychological well-being and a recovery in a clinical sense.

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