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Exploring Descriptions of Occupational Experiences among People Living with Borderline Personality Disorder:
An Interpretive Enquiry

By

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DECLARATION

I declare that this thesis, which I hereby submit for the degree of Master of Science in Occupational Therapy applied to Psychiatric Disorders at the University of Witwatersrand, is my own work and has not previously been submitted by me for a degree at this or any other tertiary institution.

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NOMENCLATURE

Concepts used throughout the research report are defined as follows:

Occupation: In occupational therapy, occupations can be understood as the everyday activities that people do as individuals or collectively that occupy time and bring meaning and purpose to life. Occupations include things people need to do, want to do, and are expected to do (World Federation of Occupational Therapy, 2022).

Meaningful: The value and importance of an occupation, that makes engagement in the occupation worthwhile, as interpreted by the individual (Ramugondo, 2017).

Purposeful: The goal and reason for engagement in an occupation, as defined by the individual (Ramugondo, 2017).

Self-harm: Any act of self-poisoning or self-injury carried out by an individual irrespective of motivation (According to National Institute for Health and Care Excellence (NICE) guidelines) (Ward & Curran, 2021).

Non-suicidal self-injury: Deliberate and intentional injury to body tissue that occurs in the absence of suicidal intent (American Psychiatric Association, 2022).

Non-sanctioned occupations: Encompassing occupations that, within historically and culturally bound contexts, tend to be viewed as unhealthy, illegal, immoral, abnormal, undesired, unacceptable, and/or inappropriate (Kiepek et al., 2019, p. 2).

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ABSTRACT

Background

Borderline personality disorder (BPD) is a diagnosis characterised by a pervasive pattern of unstable interpersonal relationships, self-image, identity, affective functioning, and marked impulsivity. Engagement in occupations and behavioural patterns considered undesirable and/or harmful is a key characteristic associated with people diagnosed with BPD, often resulting in stigmatisation. However, engagement in these occupations and behaviours is motivated by attempts to mitigate the impact of symptomology and cope with everyday life. This study explored how people diagnosed with BPD experience meaning and purpose in their everyday occupational engagement.

Methods

This study used a descriptive qualitative design consisting of a semi-structured interview with thirteen participants diagnosed with BPD in an inpatient private psychiatric hospital in Gauteng, South Africa. Data was analysed and inductively coded using the ATLAS.ti 24 software.

Findings

Findings from this study indicate that participants' occupational experiences, especially concerning meaning and purpose, are largely influenced by the impact of their symptomology. The purpose of engagement in occupations was motivated by the mitigation of the challenging and harmful impact of BPD symptomology. Participants identified creativity as an important tool for creating and experiencing meaning in their lives.

Implications

Findings from this study raise important questions regarding the understanding and categorisation of occupations. Occupational therapists are encouraged to collaborate with patients and clients diagnosed with BPD through the compassionate understanding of why and how they engage in chosen occupations to find ways in which occupational engagement can positively contribute to creating meaningful lives

for this population. Findings from this study reflect on the role of occupational therapists in fighting the stigma associated with BPD through increased understanding of their occupational experiences.

KEYWORDS: Borderline personality disorder, stigma, occupational therapy, categories of occupation, meaning and purpose, occupational experiences.

CHAPTER 1: INTRODUCTION TO THE STUDY

1.1. INTRODUCTION

The global prevalence of personality disorders is estimated at 1.8% (Winsper et al., 2020), with the prevalence among clinical populations being very high, estimated at between 30% and 70%, compared to between 4% and 10% among non-clinical populations (Gawda, 2018). Of this, borderline personality disorder (BPD) does not show greater prevalence in general compared to other personality disorders. However, BPD is the most prevalent of all the personality disorders in treatment- and psychiatric settings (Gawda, 2018; Kulacaoglu & Kose, 2018) with a predominance estimated up to 20% (Saleem et al., 2019). Borderline personality disorder is, therefore, a significant predictor of acute psychiatric admissions, and especially of re-admissions (Jebsen et al., 2021; Paruk & Janse van Rensburg, 2016).

In the latest version of the DSM 5-TR, 2022, BPD is part of the cluster B personality disorders, described as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts” (American Psychiatric Association, 2022, p. 752). There are nine diagnostic criteria for BPD, of which an individual would need to comply with five or more of the criteria to make a diagnosis. Recurrent suicidal behaviour and self-harm are key characteristics of BPD and are defined as criterion five under the diagnostic criteria of the DSM 5-TR (American Psychiatric Association, 2022). A longitudinal study over 10 years of follow-up found that the most significant factors contributing to increased suicide attempts among individuals diagnosed with BPD were identity disturbance (criterion three), frantic efforts to avoid abandonment (criterion one), and chronic feelings of emptiness (criterion seven) (Yen et al., 2021). Risk management of suicidal behaviour and self-harm is described as the predominant reason for admission to acute psychiatric settings among this population (Enoksson et al., 2022; Stapleton & Wright, 2019).

Given the high rates of admission and re-admission among patients diagnosed with BPD, a study by Stapleton and Wright (2019) explored the experiences of these patients in a psychiatric in-patient setting. Results from this study indicated that patients

diagnosed with BPD had both positive and negative experiences of inpatient admission. Themes describing participants' positive experiences included being able to talk to staff and other patients who were willing to listen. Participants also described admission as a refuge and escape from the realities of their lives. Negative experiences described dependency on hospital admissions, feeling lost and abandoned upon discharge, and negative experiences related to staff attitudes and knowledge. Results from this study were strongly indicative of patients and clients diagnosed with BPD experiencing staff lacking empathy and having negative attitudes toward them and their treatment (Stapleton & Wright, 2019). Behaviours and symptomology associated with BPD often lead to this diagnosis being experienced as difficult to manage and treat, resulting in BPD being described as a highly stigmatised diagnosis among healthcare professionals and general society (Ociskova et al., 2017, 2023; Stiles et al., 2023).

According to Ociskova et al. (2017, p. 18) stigma is an umbrella term that consists of three main components, namely ignorance, prejudice, and discrimination. Negative attitudes from healthcare professionals toward patients diagnosed with BPD are well-documented (Bodner et al., 2015; Sulzer, 2015; Tusiani-Eng & Yeomans, 2018). However, contrary to these findings, a study by Day et al. (2018) compared the attitudes of mental healthcare professionals toward patients diagnosed with BPD. Findings from their study indicated a positive shift in the attitudes and perspectives of healthcare workers working with patients diagnosed with BPD (Day et al., 2018). A systematic review by Ring and Lawn (2019) compared patient and clinician perspectives on stigma and BPD, with results identifying several fundamental processes that contribute to the creation and perpetuation of stigma. These processes were identified as stigma related to diagnoses and disclosure, perceived 'untreatability' and demand for service, stigma as a response to feeling powerless, stigma due to preconceptions of the BPD patient, and low BPD health literacy (Ring & Lawn, 2019, p. 4). Therefore, the presence and perpetuation of stigma concerning BPD is an existing and concerning phenomenon leading to the marginalisation of this population.

Although not abundant, there is evidence from international interdisciplinary literature, predominantly the disciplines of psychology and nursing, with an apparent paucity within occupational therapy, describing the lived experiences of people diagnosed with

BPD (Enoksson et al., 2022; Marco et al., 2017). One study focused on the experience of ‘meaning in life’ for people diagnosed with BPD. Marco et al. (2017) describe meaning as a sense of satisfaction and fulfilment in life and a sense of purpose and goal-directedness. Results from this study indicated that participants diagnosed with BPD had a lower feeling of meaning in life compared to participants with a mental disorder but no diagnoses of BPD (Marco et al., 2017). International research in occupational therapy has focused on the occupational experiences of people diagnosed with a personality disorder, including BPD (Falklöf & Haglund, 2010; Potvin et al., 2019), the use of intervention techniques such as sensory modulation among patients diagnosed with BPD (Matson et al., 2021), and the experience of recovery among people diagnosed with BPD (Birken & Harper, 2017; Larivière et al., 2015).

Falklöf and Haglund (2010) explored occupations and adaptation to daily life by women diagnosed with BPD. Findings from their study identified themes related to performance and self-image. The women described experiences where they felt competent in the performance of daily occupations, as well as experiencing a positive self-image related to occupational performance where they felt competent. However, experiences of incompetence regarding occupational performance and a resulting negative self-image were much more prevalent among this population with BPD and outweighed positive experiences significantly (Falklöf & Haglund, 2010). Findings from the study by Falklöf and Haglund (2010) are echoed in the findings from a more recent study by Potvin et al. (2019), exploring occupational experiences among people with a personality disorder. Participants in this study described daily occupations, such as meal preparation and self-care, as socially important but painful, tedious, and meaningless. Some participants even described these occupations as stressful and a source of feelings of incompetence and being judged by others (Potvin et al., 2019). Another significant finding from the Potvin et al. (2019) study was the nature of occupations described as important and meaningful by participants diagnosed with a personality disorder. Participants described engaging in occupations that would generally be considered harmful, unhealthy, or unsanctioned by society, such as substance abuse and self-harm. However, these occupations were described and considered purposeful and meaningful by participants. They also described participating in occupations in ways that their families and social networks disapproved of, such as behaviours associated with eating disorders or excessive gaming.

However, participants indicated these occupations as purposeful and valuable (Potvin et al., 2019). Twinley (2013, p. 1) introduces the concept of “dark occupations”, which refers to occupations considered unhealthy, illegal, harmful, and socially unsanctioned. The tendency of people diagnosed with BPD to engage in ‘dark occupations’ is well documented (Potvin et al., 2019; Wasmuth et al., 2020) but arguably perhaps not very well-researched.

In a South African context, one study focused on the lived experiences of women diagnosed with BPD. Findings from this study focused on the ‘life stories’ of women diagnosed with BPD in an in-patient psychiatric ward. The identified themes indicated narratives of childhood trauma, feelings of emptiness, unstable interpersonal relationships, and compromised mental health (Ntshingila et al., 2016). However, this study was conducted specifically in the field of nursing, and although there is evidence in occupational therapy literature of the experience of meaning in occupation, no published evidence (in English) could be found of the experience of meaningful occupation among this specific population in a South African context.

Occupations experienced by people living with BPD do not fit within the traditional meaning attributed to occupations in occupational therapy practice. This alludes to a limited understanding of the meaning, value, and purpose of different occupations for this population specifically. Harding (2020a) postulates that occupational therapy is uniquely positioned to make a difference in this regard and, therefore, has a role in understanding the function and purpose of these unsanctioned occupations for people who engage in them. However, the voices of occupational therapists are limited and largely unheard when it comes to occupations involving self-harm or people diagnosed with personality disorders in general (Harding, 2020a).

Wilcock (1999, p. 2) theorised that an inherent relationship exists between occupation and health to the extent that we are biologically, physiologically, and psychologically hard-wired to engage in meaningful and purposeful occupation. Not only does occupation play a central role in our health and quality of life, but it is also instrumental in constructing who we are. Christiansen (1999, p. 547) underscores the paradigmatic assumption of occupational therapy in as much as “occupations are key not just to being a person, but being a particular person, and thus creating and maintaining an

identity." Kielhofner expanded on this concept and coined "occupational identity" (Taylor, 2017, p. 184). The theoretical foundations from these seminal authors indicate and emphasise the important role of occupation in creating meaning, constructing identities, and achieving health and well-being. Understanding the occupational experiences of people diagnosed with BPD, especially when these occupational experiences might fall outside of what might be considered 'traditional' and in as much as assuming that they contribute to health and well-being, is essential if we are to adhere to our goal, as occupational therapists, of enabling participation in meaningful occupation for this population.

1.2. PROBLEM STATEMENT

Patients diagnosed with BPD make up a large portion of the population that makes use of psychiatric services (Saleem et al., 2019). Not only is this diagnosis prevalent among patients making use of psychiatric services, but the diagnosis of BPD is synonymous with engagement in harmful occupations, such as self-harm and substance abuse (Enoksson et al., 2022; Stapleton & Wright, 2019; Yen et al., 2021). This diagnosis is also synonymous with behavioural patterns notoriously viewed as difficult to treat and manage by most healthcare professionals (Bodner et al., 2015; Sulzer, 2015; Tusiani-Eng & Yeomans, 2018). As a result, patients diagnosed with BPD are, though perhaps discreetly, often stigmatised by the healthcare professionals supposed to support and serve them, resulting in these patients often feeling isolated and marginalised (Bodner et al., 2015).

There is limited understanding of how this population experiences meaningful occupation and how their engagement in occupation influences the development and construction of their occupational identity (Potvin et al., 2019). Considering what is known regarding the experience of occupations among people diagnosed with BPD, Potvin et al. (2019) emphasise the importance of further research to build empirical evidence regarding taken-for-granted assumptions about healthy and unhealthy occupations, especially amongst this population.

A better understanding of the occupational experiences of people diagnosed with BPD can provide more opportunities for the voices of these clients, as well as the voices of

occupational therapists, to be heard in the treatment of this population (Harding, 2020a). It may also provide opportunities to address the stigma that surrounds people diagnosed with BPD, especially from the perspective of healthcare practitioners who render services to this population.

1.3. RESEARCH QUESTION

The Background and Problem Statement paves the way for the following question: How do people living with BPD describe their experiences of their daily occupations?

1.4. AIM OF RESEARCH

The aim of the study is, therefore, to explore how people with BPD view and describe their experiences of their daily occupations.

1.5. RESEARCH OBJECTIVES

The action verb in the above research question signals a qualitative type of enquiry, and the following objectives ensued from the research question:

1.5.1. To describe how people with BPD view occupations they experience as meaningful.
1.5.2. To describe how people with BPD view occupations they experience as purposeful.
1.5.3. To describe how people with BPD view their occupations as enabling and/or disabling.

1.6. SIGNIFICANCE OF THE STUDY

An improved understanding of how meaningful and purposeful daily occupations are experienced by people living with BPD can lead to increased empathy among healthcare professionals and can be instrumental in combating the negative effects of stigma concerning this population. Furthermore, findings from this study provide valuable insights into the occupational lives and experiences of people diagnosed with BPD in a South African context and give a voice to occupational therapy in the treatment and intervention of this population. This could inspire opportunities for further

and future research in occupation-based solutions and interventions for this specific population.

1.7. POSITIONALITY OF THE RESEARCHER

As part of enhancing the rigour and trustworthiness of this study, it is important and necessary to clarify my personal and professional background and disposition to reflexively address how this might impact interpretations of the findings throughout this research report. I am a white female South African raised in an Afrikaans family in a small town. As a young occupational therapist working in mental health, I was always fascinated but troubled by the concept of personality disorders. I wondered, how do you understand and help someone who has a diagnosis that suggests the core of who they are is disordered? At the time this study was conducted, I worked as an occupational therapist in a private psychiatric hospital serving adults and teenagers in need of mental health services.

In the ten years I have worked in private psychiatric hospital services, I have always been aware of a significant population of our clients struggling with personality-related disorders. People diagnosed with BPD were often the clients I got to know very well over time, as they were frequently re-admitted. In my personal life, I met someone with BPD who had become important to me and significant to my life. I experienced and bore witness to the struggle that accompanies this diagnosis in a personal way, without the distance that my role as a healthcare professional might have afforded me in clinical contexts where I interacted with people living with this diagnosis. I wanted to understand this person better and help in ways that would make a difference. After reading an article by Potvin et al. (2019) exploring the occupational experiences of people with personality disorders, I was moved into action. Starting this research project was the result of what Carl Jung calls ‘synchronicity’ (Jung, 2013), which resulted in a decision to pursue a better understanding of people living with BPD, professionally and personally.

Before this research, I had a basic but limited understanding of what BPD was and how this diagnosis presented from undergraduate exposure and training, as well as experiences working with clients diagnosed with BPD. Throughout the research

process, I became cognisant of several biases I had to confront. Firstly, I realised that I was guilty of participating in many behaviours that added to the stigmatisation and marginalisation of this population. I recall frequent frustrated conversations with colleagues and multi-disciplinary team members, discussing and complaining about the 'difficult patients' within a collective discourse. Often probing about and ideating the potential discharge date and sometimes referring to these clients simply as 'the borderlines.' Secondly, I realised as a healthcare practitioner that I was quite ignorant of the complex nature of this diagnosis in many ways. Engaging in this research process has allowed me to improve my knowledge of the complexities associated with BPD significantly. Most importantly, listening to participants' experiences and stories allowed me to develop greater compassion, empathy, and understanding of the complex occupational experiences of this population. I am aware that the interpretation of the findings remains subjective and may reflect biases that I am unconscious of. However, several strategies (as expanded in the Methodology chapter) were employed to limit the subjective effect of my perspectives and biases on interpreting the findings.

1.8. ORGANISATION OF THE RESEARCH REPORT

In adhering to the Wits Faculty of Health Sciences, Style Guide for Thesis, Dissertations and Research Reports (2016), the research report is organised into the following chapters:

Chapter 1: Introduction to the study

This chapter provides an overview of the research study. It includes an introduction, problem statement, research questions and objectives, discussion of the significance of the study, and reflection on my positionality as the researcher. Throughout the research report, Mendeley Reference Manager version 2.126.0 was the automated referencing system used to manage all references. In this chapter and throughout the research report, I will use the terms 'patients' and 'clients' when referring to rendering services to people diagnosed with BPD, as it includes both healthcare and other areas of service to this population.

Chapter 2: Literature review

This chapter discusses literature and information related to the topic of the study, as well as literature relevant to the interpretation of findings. This literature review included relevant international and South African literature, as well as relevant interdisciplinary-, occupational therapy-, and occupational science literature. The aim was to triangulate throughout this research report with recent literature, however, in instances where literature is limited, I had to compensate to adhere to the *most* recent literature. Literature for Chapter 2 was sourced from a wide range of databases, search engines, etc., including EBSCOHost from the University of Witwatersrand library, Google Scholar, Pubmed, Public Library of Science, ResearchGate, and PsycINFO. Valuable literature was also identified from the reference list of articles consulted during the reading process. Books relevant to the study were sourced privately or through libraries.

Chapter 3: Methodology

This chapter provides a critical and comprehensive overview of the research methodology implemented in this study. This includes a description of the method of inquiry, data collection procedure, data analysis strategies, considerations for trustworthiness, validity, reliability, and ethical considerations.

Chapter 4: Findings and Discussion

This chapter includes an overview of the demographics of the study participants and an explanation of how data will be discussed and presented. Findings are then presented by describing the themes, categories, and codes that emerged from the data and a thorough discussion of these findings. Given the qualitative nature of this study, under the guidance of my supervisor, I opted for the reporting style, to combine the findings and their discussion to allow for a more in-depth triangulation of each category or subcategory. In this way I could remain true to the qualitative and rich intertwinement of the findings and their concomitant discussion, offering a layered presentation and interpretation of the findings (Creswell & Poth, 2018). Separation of the findings and discussion will be reconsidered depending on the journal selected for submission of the article.

Chapter 5: Conclusion

This chapter discusses conclusions based on the study's findings. Final conclusions are drawn and discussed, including the study's limitations and recommendations for occupational therapy practice and future research. The research report is concluded with final reflections.

CONCLUSION

The first chapter introduced the study and included important key concepts. The research problem and significance of the research study were argued, and the research question, aims, and objectives were presented. The researcher also clarified and reflected on the researcher's positionality in this study. The following chapter will review all the relevant literature on the research topic and the findings of this study.

CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

Chapter 1 provided an overview and introduction to this study, including the problem statement, research question, study aim and objectives, significance of the study, ethical considerations, and a summary of the methodology. This chapter will review the literature concerning the main concepts relevant to the study. Firstly, this literature review will explore the inner- and outer worlds of people diagnosed with borderline personality disorder (BPD) to frame a theoretical and personal in-depth understanding of their experiences. A theoretical exploration of the history, development, and nature of BPD is essential to understanding the narratives and contexts of this population. Kielhofner (2009) asserts the importance of context as a dynamic relationship exists between an individual's internal characteristics and the external environment. It is, therefore, necessary to craft a clear picture of the internal- and external factors that influence the lives of people diagnosed with BPD to situate the role of occupation as a part of the dynamic interaction between these factors. Secondly, the concept of occupation will be explored, especially concerning the categorisation of occupation and how meaning and purpose are defined within this context. The literature review will include the latest and most pertinent research and literature from seminal authors within the realms of BPD and occupational therapy.

2.2. THE HISTORY OF BORDERLINE PERSONALITY DISORDER

"The patient is living in a kind of inner theatre in which the forces of cruelty, rage, submission, and self-numbing each takes their turn on stage" (Kellogg & Young, 2006, p. 447). This is one attempt to capture the experience of people living with BPD. Another account, from the viewpoint of someone diagnosed with BPD, reads:

> *Now, don't think I'm saying I don't struggle with the symptoms; I do. But I am simply so much more. I am the sister, daughter, friend. I am my love of animals and the hours I can read, lost in stories I can only wish were my life. I am my pure enjoyment of walking in the woods and running, I am my need for adrenaline and my impulsivity.* (Morris, 2018, p. 23)

Both depictions of the experiences of people living with BPD, while wildly different, ring true, with a marked tension between the weight of the 'symptoms' of BPD juxtaposed with a lived and deeply human and occupational experience.

As a medical science, psychiatry found its origins near the end of the 18th century, leading to the psychopathology of personality as a topic of discussion before the 1900s (Campbell et al., 2020; Crocq, 2013). However, the description and categorisation of personality types, much akin to the contemporary DSM (Diagnostic and Statistical Manual of Mental Disorders), were documented centuries earlier. The first categorisation of personality types originated in the Greco-Roman world, detailed in a book called *The Characters*, written by the Greek philosopher Theophrastus (c371 to c287 BC) (Crocq, 2013). Theophrastus, a student of Plato's academy and a close follower of Aristotle, introduced 30 descriptions of 'characters,' all organised according to a similar structure. Each 'character' was named, briefly defined, and illustrated using examples, indicating how this person would typically respond in various life situations. An example would be the description of 'The Suspicious Man,' which bears a resemblance to what we might today classify as 'paranoid personality disorder' (Crocq, 2013, p. 148).

Centuries later, personality disorders were added to the DSM-III in 1980 and categorised according to three clusters: cluster A, cluster B, and cluster C, based on similarities in symptomology. The DSM-III introduced the multi-axial system of diagnosis. The multi-axial diagnostic system separated primary mental disorders being treated on Axis I from personality disorders placed on Axis II, alongside developmental disorders such as intellectual disability (Campbell et al., 2020). The classification of personality disorders on Axis II was indicative of its permanent nature and added to the trajectory that would infamously classify personality disorders as pervasive, enduring, and untreatable (Campbell et al., 2020).

2.2.1. Development of the concept and diagnosis of borderline personality disorder

The first descriptions of a collection of symptoms that resemble that of BPD, as it is currently classified, were documented as early as 400 BCE in the writings of

Hippocrates. He described patients who presented with intense anger, melancholia, and noticeable mood instability. These symptoms also resembled bipolar disorder, as both BPD and bipolar disorder are characterised by fluctuations in mood (Ritschel & Kilpela, 2014). Multiple physicians and scientists have described BPD over the last several centuries, using different terms. In 1684, the Swiss physician Theophile Bonet (1620-1689) used the term 'folie manico-melancolique', which translates to 'melancholic manic madness'; and in 1921, German psychiatrist Emil Kraepelin (1856-1926) described the term 'excitable personality' (Ritschel & Kilpela, 2014, p. 1). However, the term 'borderline' was coined by Adolf Stern (1879-1958) in 1938 (Al-Alem & Omar, 2008; Ritschel & Kilpela, 2014). Before the 1970s, the dominant paradigm in psychiatry was the psychoanalytical paradigm; thus, the classification of diagnoses was based on analysability. Neurotic patients were considered analysable and, therefore, treatable, while patients with psychosis were considered not analysable and, therefore, untreatable (Gunderson, 2009). The term 'borderline,' as introduced by Stern, described a cluster of symptoms characterised as straddling the 'border' of psychosis and neurosis, resulting in these patients primarily being categorised under schizophrenia (Al-Alem & Omar, 2008; Gunderson, 2009; Ritschel & Kilpela, 2014).

Years since the term 'borderline' came into existence, and continuing today, it's been used to describe patients that do not fit into existing diagnostic categories and are synonymous with patients that are difficult to treat using conventional approaches and psychotherapies (Al-Alem & Omar, 2008; Leichsenring et al., 2024; Ritschel & Kilpela, 2014). A shift in the understanding of BPD as a 'psychotic spectrum' disorder towards the conceptualisation of personality disorders as it is viewed today was introduced by Otto Kernberg (born 1928) in 1967 (Gunderson, 2009; Ritschel & Kilpela, 2014). Kernberg defined the term 'borderline personality organisation' and suggested that these patients could be successfully treated using psychoanalytic psychotherapy (Gunderson, 2009; Leichsenring et al., 2024). The official diagnosis of 'borderline personality disorder' was introduced in the DSM-III in 1980 and grouped under cluster B, alongside antisocial personality disorder, narcissistic personality disorder, and histrionic personality disorder (Campbell et al., 2020; Ritschel & Kilpela, 2014). Since the addition of BPD to the DSM-III (1980), the diagnosis has remained relatively unchanged in the subsequent DSM-IV (1994), DSM-5 (2013), and DSM 5-TR (2022)

editions (Leichsenring et al., 2024; Ritschel & Kilpela, 2014).

According to the DSM 5-TR, BPD is described as a pervasive pattern of instability of interpersonal relationships, self-image, and affects, marked impulsivity, beginning by early adulthood and present in a variety of contexts. The current diagnostic criteria for BPD, stipulated in the DSM 5-TR, consists of the following nine criteria:

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
- Identity disturbance – markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
- Recurrent suicidal behaviour, gestures, threats, or self-mutilating behaviour
- Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights) and
- Transient, stress-related paranoid ideation or severe dissociative symptoms (American Psychiatric Association, 2022).

Borderline personality disorder is a complex diagnosis consisting of many different symptoms and characteristics that have a dynamic influence on one another. Due to the complex nature of this diagnosis, it is important to consider significant factors relevant to diagnosing BPD.

2.3. CONSIDERATIONS IN THE DIAGNOSES OF PERSONALITY DISORDERS

There has been longstanding debate regarding the diagnosis and diagnostic criteria of personality disorders that continue in contemporary discourses about psychopathology. One example is the debate regarding the dimensional- versus categorical nature of personality disorders (Campbell et al., 2020; Leichsenring et al.,

2024). It is common for the patterns, symptomology, and characteristics of different personality disorders to overlap, causing one individual to meet the criteria for several personality disorders all at once. It is, therefore, difficult to differentiate between different types of personality disorders (Campbell et al., 2020). Another important point for consideration is perhaps the limited specificity the categorical approach provides in the classification of BPD. For example, to make a diagnosis of BPD, an individual would need to meet five of the nine diagnostic criteria (as described above). One person might meet criteria one to five, while a second person might meet criteria five to nine. Both people are given the same diagnosis yet show significant differences in presentation of symptomology and challenges experienced (Harding & Berrigan, 2024). The tendency toward overlap, difficulty in differentiation, as well as potentially unhelpful broad descriptions, affirms the notion that personality disorders might be better described as dimensional rather than categorical (Campbell et al., 2020; Leichsenring et al., 2024). The latest version of the DSM 5-TR suggested an alternative system based on different dimensions of functioning in the diagnoses of personality disorders. However, it was decided to revert to the original categorical model, despite mounting evidence that this model of diagnoses might lose utility because it does not provide a clear focus or specificity in understanding the condition diagnosed (Harding & Berrigan, 2024).

Another question in the diagnosing of personality disorders is whether personality disorders are a universal or a Western concept. Although personality disorders are known across all cultures, there are concerns about specified types being culturally biased (Gawda, 2018). For example, studies in rural and urban Taiwan indicated a very low prevalence of antisocial personality disorder (Winsper et al., 2020) whereas antisocial personality disorder has a high prevalence in North America, Europe, and South Africa (Gawda, 2018; Naidoo & Mkize, 2012). Similarly, avoidant-, dependent-, and borderline personality disorders are not specified in the Chinese classification of mental disorders (Winsper et al., 2020) whereas especially BPD is highly prevalent in clinical populations in North America, Western Europe, and South Africa (Gawda, 2018; Paruk & Janse van Rensburg, 2016).

However, Wang et al. (2012) commented on the need for BPD to be added to the Chinese classification of mental disorders, as research on BPD has increased in

China, confirming the presence of BPD as a clinical entity. Nonetheless, some researchers argue that the diagnosis of personality disorders reflects North American and Western European concepts of personality (Gawda, 2018, p. 319). Expanding on this argument, Jani et al. (2016) reflected on the cross-cultural bias that might exist in the diagnosis of BPD specifically. The researchers argued that BPD presents with varying symptomatic prevalence, not only due to the culture in which the disorder developed but also due to differences in cultural perspectives (Jani et al., 2016). The impact of culture, ethnicity, and race on the understanding of mental disorders, and specifically personality disorders, is still relatively unknown and warrants more exploration and understanding (Gawda, 2018; Winsper et al., 2020).

2.4. EPIDEMIOLOGY OF BORDERLINE PERSONALITY DISORDER

Given the most recent systematic review demarcating the prevalence of BPD among adults in prison (Dahlenburg et al., 2024), the global prevalence of personality disorders is estimated at 1.8% (Dahlenburg et al., 2024; Winsper et al., 2020). The prevalence of BPD, however, among clinical populations is very high, estimated at between 30% to 70%, compared to 4% to 10% among non-clinical populations (Gawda, 2018). Of this, BPD might not show greater prevalence in general compared to other personality disorders, but it is the most prevalent of all the personality disorders in treatment- and psychiatric settings (Gawda, 2018; Kulacaoglu & Kose, 2018), with a predominance estimated up to 20% (Saleem et al., 2019). Borderline personality disorder is, therefore, a significant predictor of acute psychiatric admissions, especially of re-admissions (Jebsen et al., 2021; Paruk & Janse van Rensburg, 2016). Considering the high prevalence of patients diagnosed with BPD in treatment- and psychiatric settings, as well as the high frequency of re-admissions among this population, it is arguably a mental health crisis worthy of investigation. Another noteworthy observation regarding the prevalence of BPD is the presence of a significant gender gap in the frequency of diagnosis, with evidence of a higher prevalence among women compared to men. Bozzatello et al. (2024) describe possible reasons for the higher prevalence of the diagnosis of BPD among women as related to potential bias within the diagnostic criteria, the influence of population sampling (community versus clinical), and the instruments used in evaluation (clinician evaluation versus self-report measures).;

2.5. EXPERIENCES OF PEOPLE LIVING WITH BORDERLINE PERSONALITY DISORDER

Heard and Linehan (2019) have conducted pertinent and extensive research on BPD, which has resulted in a therapeutic approach designed explicitly for the treatment of people diagnosed with BPD. The sociobiological theory developed by Heard and Linehan (2019) is based on evidence that people diagnosed with BPD have an innate tendency to react with more intensity to lower levels of stress and that they might take longer to recover from an emotional reaction. It can, therefore, be said that the core of BPD presentation and dysfunction is linked to 'emotional dysregulation'. Heard and Linehan (2019) further describe the emotional experiences of people diagnosed with BPD being misunderstood, dismissed, and judged for most of their lives because of what is called an 'invalidating environment'. It is possibly the existence of this dynamic between 'emotional dysregulation' and an 'invalidating environment' that could be the heart of many consequences and struggles faced by people diagnosed with BPD (Heard & Linehan, 2019; Lieb et al., 2004; Salsman & Linehan, 2012).

2.5.1. Frequency of admissions and readmissions

As discussed under the epidemiology of BPD (cf. 2.4.), this diagnosis is associated with frequent admissions and re-admissions that make up 30% to 70% of in-patient clinical populations (Gawda, 2018; Jebsen et al., 2021; Paruk & Janse van Rensburg, 2016). Evidence suggests that most admissions and re-admissions, in the case of people diagnosed with BPD, are aimed at 'crisis management' (Besch et al., 2023; Sveticic et al., 2020). Considering the nature of BPD, as it has been explored thus far in this chapter, a 'crisis' can be caused by any number of stress-related or stress-inducing situations, which in turn can result in social- and relational consequences that might add to the severity of the crisis experienced.

Another contributing factor to frequent admissions and re-admissions among patients diagnosed with BPD is the high prevalence of suicide and self-harm behaviour (Enoksson et al., 2022; Stapleton & Wright, 2019). Borderline personality disorder also has an increased rate of co-morbidity with other conditions, such as major depression, substance abuse, and eating disorders, that might contribute to a higher rate of admission (Leichsenring et al., 2024; Lieb et al., 2004; Mooney et al., 2023; Ritschel

& Kilpela, 2014). However, contrary to research indicating more frequent admissions among patients diagnosed with BPD, results from an older study by Wong & Tye (2005) found evidence of low re-admission rates among their study population of patients diagnosed with BPD. It is, however, important to note that their study population consisted of patients diagnosed with BPD, who received community-based care and support upon discharge from a network of healthcare practitioners, as this is part of their standard management protocol (Wong & Tye, 2005). The role that 'step-down-support' and community-based care play in the prevention of re-admission of patients diagnosed with BPD is corroborated by Chiesa et al. (2004) and recent findings from Grindey et al. (2023), advocating for the role of community-based intervention to decrease re-admission rates among people diagnosed with BPD. The claim for the effectiveness of community-based support in the treatment of people diagnosed with BPD is further supported by research evidencing the effectiveness of 'brief admission' as a treatment approach for patients diagnosed with BPD, as opposed to longer admissions (Enoksson et al., 2022; Sveticic et al., 2020).

Community-based support for people living with BPD is potentially an important approach in healthcare delivery that might contribute to lower rates of admission and re-admission among this population. Evidence of the effectiveness of community-based intervention for people diagnosed with BPD could be an opportunity for occupational therapy to fill the gap where traditional in-patient intervention might fall short (Javaras et al., 2017; Katakis et al., 2023).

2.5.2. Suicide and self-harming behaviour

As discussed under the diagnostic criteria for BPD (cf. 2.2.1.), recurrent suicidal behaviour and self-harm are often key characteristics of the presentation of BPD. Goodman et al. (2017) studied a population of adolescents and adults diagnosed with BPD and found overall rates of self-mutilation at around 90% and suicide attempts at around 75% for both populations. The prevalence of death by suicide among patients diagnosed with BPD is estimated at an alarming 9% to 10% (Paris, 2019; Yen et al., 2021). However, other studies have reported lower rates, between 3% and 6%, in prospectively followed cohorts (Temes et al., 2019; Zanarini et al., 2012). A study by Zimmerman and Becker (2023) shed light on a sub-group of patients diagnosed with

BPD that often goes unnoticed due to not engaging in recurrent suicidal or self-injurious behaviour. Results from their study indicated that self-harm and suicidal behaviour are not synonymous with BPD, as half of their study population did not engage in such behaviours. Healthcare practitioners, therefore, need to be aware that a lack of self-harm and suicidal behaviours does not rule out a diagnosis of BPD (Zimmerman & Becker, 2023).

A longitudinal study over 10 years of follow-up found that the most significant factors contributing to increased suicide attempts among individuals diagnosed with BPD were identity disturbance, frantic efforts to avoid abandonment and chronic feelings of emptiness (Yen et al., 2021). In addition, Kuehn et al. (2020) identified challenges concerning problem-focused coping strategies and difficulties with emotional regulation as predominant risk factors for recurrent suicide attempts among their population of adults diagnosed with BPD. On the one hand, these results are supported by earlier research conducted by Brown et al. (2002), indicating that reasons for non-suicidal self-injurious behaviour among a population of women diagnosed with BPD were intended as self-punishment and an effort to provide distraction and relieve negative emotions. On the other hand, the function of suicidal acts was identified as an attempt 'for others to be better off' and to relieve the perceived burden of oneself to loved ones (Brown et al., 2002, p. 200).

Evidence from research, therefore, clearly illustrates the potential consequences of self-harm and suicidal behaviour among people diagnosed with BPD, for the individuals themselves and for those who love them. The high rate of death due to suicide among people living with BPD should be of great concern to all healthcare practitioners rendering services to this population, including occupational therapists.

2.5.3. Co-morbid conditions and diagnoses

Borderline personality disorder has a high association of co-morbidity with numerous other mental disorders such as depressive disorders, substance use disorders, attention deficit and hyperactivity disorder, bipolar disorder, eating disorders, and posttraumatic stress disorder (Leichsenring et al., 2024; Mooney et al., 2023). Research conducted by Eaton et al. (2011) used a multivariate co-morbidity model

comprising two broad dimensions that grouped common mental disorders. The first dimension, categorised as ‘internalising’, consisted of unipolar mood disorders and anxiety disorders. The externalising dimension included disinhibitory disorders, such as substance use disorder, antisocial personality disorder and conduct disorder. Results from the study indicated that BPD is characterised by complex patterns of co-morbidity that present connections with other mental disorders in both internalising and externalising dimensions (Eaton et al., 2011).

Considering firstly the relationship between BPD and mood disorders, Luca et al. (2012) found that the presence of depression worsened the clinical impact of BPD, especially in the case of early-onset depression and a higher frequency of depressive episodes. Borderline personality disorder is associated with a higher risk of recurrence of major depression and negatively impacts the course of depression as it is a strong predictor of persistent major depressive disorder (Luca et al., 2012). Recent research by Söderholm et al. (2023) supports findings from the study conducted by Luca et al. (2012). Additionally, the researchers identified higher instances and increased risk concerning suicidal ideation and suicide attempts among a population of participants diagnosed with BPD (Söderholm et al., 2023). Research also indicates a high prevalence of co-morbidity of BPD and bipolar disorder and that this co-morbidity is indicative of earlier onset and more severe presentation of bipolar disorder. Therefore, a diagnosis of BPD is highly predictive of a future diagnosis of bipolar disorder (McDermid et al., 2015; Söderholm et al., 2023). It was also found that a co-morbid diagnosis of BPD and bipolar disorder was approximately twice as likely to occur as compared to the co-morbidity of BPD and major depression (McDermid et al., 2015).

Evidence from the literature also suggests a link between BPD and substance abuse or substance abuse disorder (Mooney et al., 2023; Trull et al., 2018). A systematic review by Trull et al. (2018) found evidence from literature suggesting that half of people diagnosed with BPD have at least one substance use disorder, and approximately 25% of people diagnosed with substance use disorder meet the criteria for BPD. A study of youth diagnosed with BPD found the prevalence of substance use among the group diagnosed with BPD ‘disturbingly high’ as compared to the general population and matched controls (Scalzo et al., 2017, p. 9). Wasmuth et al. (2020) found substance abuse as a form of escape, leisure, or entertainment for most of the

participants in their study, consisting of mostly male military veterans diagnosed with BPD. Gillespie et al. (2018) conducted a population-based twin study. Results not only indicated a strong correlation between borderline personality traits and alcohol and/or cannabis abuse but also showed a strong genetic link between BPD and alcohol and/or cannabis abuse. This implicates BPD as a high-risk factor for later substance abuse disorder or addiction (Gillespie et al., 2018). Occupational therapists need to consider all factors that influence and are influenced by the presence of borderline personality symptomology when collaborating on treatment approaches for individuals living with BPD.

2.5.4. Social contexts and relationships

The challenges experienced by people diagnosed with BPD concerning social contexts and relationships can be attributed to a combination of the complex interactions between the co-morbid conditions and symptoms discussed so far. Ikhtabi et al. (2021) conducted a qualitative meta-synthesis of studies exploring the subjective experiences of loneliness from the perspective of people diagnosed with personality disorders. The first theme identified by Ikhtabi et al. (2021) proposed that people diagnosed with personality disorders, in particular BPD, experience intense and constant alienation and disconnection and that these experiences are not necessarily relieved by social interactions or relationships. This finding is supported by Palihawadana et al. (2019), as evidence from their review indicated that sensitivity to rejection in patients diagnosed with BPD can result in even inclusive situations being experienced as rejecting or excluding. Gutz et al. (2015) found neurophysiological evidence of this phenomenon, indicating a negatively biased perception of social inclusion in patients diagnosed with BPD during the initial stage of processing social information. The distorted interpretations of social interactions by people with BPD are theorised to be due to pre-existing frameworks through which social interactions are perceived that are tainted by negative childhood experiences (Gutz et al., 2015). This echoes the second theme identified by Ikhtabi et al. (2021) describing early alienating and rejecting childhood experiences as causing feelings of disconnection and loneliness among people diagnosed with BPD.

The third and fourth themes identified by Ikhtabi et al. (2021) in their qualitative meta-

synthesis speak to the need of those diagnosed with BPD for connection, the difficulty in successfully making these desired connections, and the resulting paradox of wanting closeness yet fearing intimacy. Despite the desire and yearning for social connections and intimate relationships, the simultaneous, paradoxical need for distance results in feelings of emptiness in individuals with BPD, leading to a desperate need to connect, which in turn 'triggers' intense fears of rejection and abandonment as well as not trusting or understanding the intentions of others (Ikhtabi et al., 2021, p. 11), resulting in a continuous and exhausting cycle.

Winter et al. (2017) reflected on the role that negative self-evaluation, common among those diagnosed with BPD, might have to play in this continuous cycle. In their discussion, Winter et al. (2017) suggest that not only does a negative self-concept lead the person diagnosed with BPD to register only information that confirms this negative view of themselves, but it might also result in the avoidance of possibly positive social interactions that would contradict their negative self-concept. Gutz et al. (2016) support this statement with findings from their study indicating that both people diagnosed with social anxiety and BPD tended to blame themselves for their experiences of exclusion but that only participants diagnosed with BPD attributed their experiences of exclusion to the hostile intentions of others. This is echoed by Ikhtabi et al. (2021) describing the experiences of people diagnosed with BPD of the external world as hostile and rejecting due to adverse experiences in both childhood and adulthood. People living with BPD, therefore, might experience fear, threat, and danger even in social interactions that are not dangerous (Gutz et al., 2016; Ikhtabi et al., 2021).

The fifth theme identified by Ikhtabi et al. (2021) described the experiences of people diagnosed with BPD of lacking purpose in life and their existence being meaningless and empty. These experiences result from a lack of collective or shared purposeful activities and individual goals (Ikhtabi et al., 2021). Miller et al. (2020) add to this concept by postulating that a lack of connection with oneself and others causes a sense of emptiness that might lead to self-destructive behaviour as an attempt by people diagnosed with BPD to avoid or alleviate these difficult experiences. This, in turn, results in vocational and social dysfunction, impulsiveness, self-harm, and suicidal behaviours (Miller et al., 2020). Research by Marco et al. (2017) focusing on

the experience of ‘meaning in life’ for people diagnosed with BPD indicated similar findings. Results from their study revealed that participants diagnosed with BPD had a decreased experience of meaning in life compared to participants with other mental disorders but no diagnoses of BPD. The researchers also identified an association between the emotional dysregulation often experienced by people living with BPD and experiencing decreased meaning in life (Marco et al., 2017). It can, therefore, be postulated that how people diagnosed with BPD experience emotions might directly influence how and to what extent they experience meaning in their lives.

Considering these experiences and resulting consequences, Ikhtabi et al. (2021) identified the importance of a sense of ‘belonging’ in the process of recovery for those diagnosed with BPD. People diagnosed with BPD described ‘belonging’ as being understood and heard, as this is essential in reducing the painful feelings associated with alienation and ‘otherness’ (Ikhtabi et al., 2021, p. 15). In rendering services to this population, occupational therapists need to consider the impact of the social environments our patients and clients with BPD are living in if we are to provide interventions that address the needs of this population wholistically. To achieve this, it is also important to consider ‘the bigger picture’ and the role of stigma among people living with BPD.

2.6. STIGMA ASSOCIATED WITH BORDERLINE PERSONALITY DISORDER

Ociskova et al. (2017, p. 18) describe stigma as an umbrella term that consists of three main components, namely ignorance (the absence of knowledge), prejudice (concerned with attitude) and discrimination (concerned with behaviour). Considering the vastness of the term stigma, earlier work by Link and Phelan (2001, pp. 367-370) identified four qualities of stigma, namely, 1) the recognition of differences, 2) these differences are perceived as negative by society, 3) the stigmatised group is defined as the ‘outgroup’, and 4) the result is loss of opportunity, power, and status for the stigmatised group. When considering stigmatised groups, personality disorders are often more stigmatised than any other mental condition, especially in the case of BPD (Sheehan et al., 2016). Borderline personality disorder is possibly the most stigmatised of all personality disorders and, therefore, also the most researched in terms of stigma (Ahmed et al., 2021; Sheehan et al., 2016). Research on stigma in BPD has produced

various subtypes of stigma that can be explored.

2.6.1. Social and structural stigma

Socially, BPD has become synonymous with undesirable traits or behaviours (Masland et al., 2022). The socially created connection with undesirable traits or behaviours is perpetuated by the way BPD is portrayed in media and entertainment. Films such as *Play Misty for Me* (1971), *Fatal Attraction* (1987), *Single White Female* (1992), *Black Swan* (2010), and *Welcome to Me* (2014), are only a few examples of negative and/or inaccurate depictions of BPD, resulting from and advancing a public narrative of people with BPD as nefarious, manipulative, and dangerous. This creates fear and disdain for people suffering from BPD and is harmful to their interactions with others (Johnson, 2021; Masland et al., 2022).

The increased marginalisation and stigmatisation of people diagnosed with BPD have potentially severe and disabling consequences. Social stigma negatively contributes to self-stigma and anticipated stigma, which can impede help-seeking and disclosure among people diagnosed with BPD (Masland et al., 2022). Evidence also suggests that family members of those suffering from BPD might also harbour negative experiences of stigma, resulting in the belief that community attitudes towards the diagnoses of their loved one would be unaccepting, and therefore, are encouraged to avoid disclosure and keep the diagnoses ‘secret’ (Meshkinyazd et al., 2021, p. 22). Juurlink et al. (2019) expand on the challenges associated with non-disclosure, stating that non-disclosure in work environments results in a lack of support for employees suffering from BPD. On the other hand, disclosure can present challenges within itself as the diagnosis often carries beliefs of having little hope for improvement and might ultimately result in impeded ability and opportunity to acquire and maintain employment (Juurlink et al., 2019).

Research also indicates the presence of structural stigma concerning mental health services provided to patients diagnosed with BPD. Klein et al. (2021) postulated that consumers of mental health services diagnosed with BPD are more affected by structural stigma than consumers with other mental conditions. Structural stigma in healthcare systems is “societal-level conditions, cultural norms, and institutional

policies that constrain the opportunities, resources and wellbeing of the stigmatised" (Hatzenbuehler, 2016, p. 742). Tusiani-Eng and Yeomans (2018) support Klein et al.'s (2021) claims by identifying factors that contribute to the barriers to treating BPD. Contributing factors were identified as a) lack of clinical education and diagnostic training in BPD, b) a culture of stigma toward patients with BPD, c) lack of medical research to understand BPD as a legitimate psychiatric disorder with a strong biological basis, and d) the cost of treatments for BPD and the organisation of insurance guidelines (Tusiani-Eng & Yeomans, 2018).

Masland et al. (2022) add to and affirm the factors identified by Tusiani-Eng and Yeomans (2018) by asserting that structural stigma has concrete negative consequences for those diagnosed with BPD, in particular, limited access to appropriate care. Limited access to proper care is a result of many factors, specifically, the limited amount of healthcare professionals able and willing to provide apt treatment opportunities for people diagnosed with BPD due to stigma (Masland et al., 2022). Affirming the costly nature of BPD and the negative impact thereof for those with this diagnosis, Lohman et al. (2017) describe insurance coverage often being more favourable toward the treatment of other mental conditions, such as major depression or bipolar disorder, that are viewed as more debilitating, urgent, and treatable. In addition, there is far less funding for research on BPD compared to other mental conditions from the National Institutes of Health. This also potentially contributes to a lack of services and coverage for BPD treatment (Lohman et al., 2017), perhaps discursively affirming the marginalisation of this diagnosis, arguably against the backdrop of pharmaceutical and medical capitalism. When exploring the stigmatisation of people diagnosed with BPD in accessing healthcare, it would be important to consider the stigmatisation perpetuated by healthcare practitioners as well.

2.6.2. Stigmatisation by healthcare professionals

A systematic review by Ring and Lawn (2019) compared patient and clinician perspectives on stigma and BPD. Results identified several fundamental processes that contribute to creating and perpetuating stigma. These processes were identified as stigma related to diagnoses and disclosure, perceived 'untreatability' and demand for service, stigma as a response to feeling powerless, stigma due to preconceptions

of the BPD patient, and low BPD health literacy (Ring & Lawn, 2019).

Considering the components of stigma identified by Ring and Lawn (2019), a study by Stapleton and Wright (2019) explored the experiences of patients diagnosed with BPD in a psychiatric inpatient setting. Results from their study indicated that patients diagnosed with BPD had both positive and negative experiences of inpatient admission (Stapleton & Wright, 2019). Themes describing the positive experiences of patients included being able to talk to members of staff and other patients who were willing to listen, as well as experiencing admission as a refuge and escape from the realities of their lives. Negative experiences described dependency on hospital admissions and, therefore, feeling lost and abandoned upon discharge, as well as negative experiences related to staff attitudes and knowledge. Participants in this study experienced staff lacking empathy and having negative attitudes towards them and their treatment (Stapleton & Wright, 2019).

Findings from a study conducted by Stapleton and Wright (2019) evidencing negative attitudes from staff toward patients diagnosed with BPD are supported by multiple sources and are well-documented (Bodner et al., 2015; Klein et al., 2022; McKenzie et al., 2022; Sulzer, 2015; Tusiani-Eng & Yeomans, 2018). Characteristics and behaviours that form part of the clinical picture and symptomology of patients with BPD are often the kinds of behaviours viewed and experienced as ‘difficult’ by health care professionals, such as self-harm, rule-breaking behaviour, aggression, destructive behaviour, needing too much care or being uncooperative when it comes to care, and frequent occurrences of manipulation (McKenzie et al., 2022; Sulzer, 2015). Bodner et al. (2015) found that psychiatrists and nursing staff exhibited more negative attitudes, and less empathy compared to other professions (psychologists and social workers) and were more likely to view the decision to hospitalise patients with BPD as less justified compared to other mental diagnoses. Ociskova et al. (2023) and Ociskova and Sedlackova (2017) found similar results, describing the generally negative attitudes and experiences of healthcare professionals towards patients diagnosed with BPD. Mckenzie et al. (2022) also postulate that symptoms associated with BPD may contribute to the negative attitudes of mental health care workers towards patients diagnosed with BPD, as well as a lack of knowledge and previous negative treatment experiences. In addition, Mckenzie et al. (2022) states that the

language used within the label of BPD itself could contribute to negative attitudes of healthcare providers, as it suggests the uncontrollability of the condition and an unlikeliness to change over time.

However, contrary to these findings, a study by Day et al. (2018) compared the attitudes of mental healthcare professionals towards patients diagnosed with BPD working at the same public health service in 2000 and 2015. Results from this study indicated a positive shift in the attitudes and perspectives of healthcare workers working with patients diagnosed with BPD. They showed more optimism about the treatment possibilities and potential of patients diagnosed with BPD. They used more positive language to describe their interactions with these patients. Their data analysis further correlated the shift towards more positive views with improvements in overall treatment practice, suggesting a link between clinician attitudes, effective treatments, and the resulting improvement in recovery outcomes (Day et al., 2018).

From an occupational therapy perspective, an important question to consider posted by Townsend and Wilcock (2004), relates to how occupational therapists can work toward justice in their practices. This includes critically reflecting on how we empower patients and clients diagnosed with BPD to engage in occupational lives that fulfil their needs despite the unique, complex, and sometimes challenging presentation of their diagnosis. This involves collaborating with patients and clients diagnosed with BPD to access engagement in occupations that are necessary and valuable to them, in ways that promote their health and well-being, outside of our own preconceived ideas and judgements, so as not to add to the stigmatisation already plaguing this population. It also requires the need for truly client-centred treatment approaches that meet our clients and patients with BPD where they are, not where we think they should be.

2.6.3. Diagnostic stigma

The weight of the stigma associated with BPD leads to tremendous hesitation among healthcare professionals to diagnose this condition (Ahmed et al., 2021; Lohman et al., 2017). Sisti et al. (2016) studied psychiatry practices concerning diagnosing and documenting BPD. Results indicated that most psychiatrists chose not to disclose diagnostic information to their patients who have BPD. A large proportion of

psychiatrists were hesitant about clearly documenting BPD in the patient's medical record (Sisti et al., 2016). The reason for non-disclosure and not documenting the diagnosis was indicated as uncertainty about the diagnostic category. Though stigma was not endorsed as a reason for non-disclosure, most psychiatrists agreed that it was a motivating factor for not documenting their patients' diagnoses (Sisti et al., 2016). A clear misconception arising from the research by Sisti et al. (2016) was the belief that BPD is an untreatable condition and that, therefore, the disclosure or documentation of the diagnosis would not impact patient care.

A deontological (duty-ethics) perspective on the ethical responsibility of disclosure and the documentation of diagnoses would argue that not disclosing an accurate diagnosis is unethical in any circumstance, as informed consent is an essential element for patient autonomy to be respected (Sisti et al., 2016). This perspective is supported by Sims et al. (2021), who argue the importance of candour concerning diagnosis as an ethical imperative for healthcare practitioners to respect patient autonomy. They further affirm a deontological perspective by arguing that patients can only truly provide consent, engage in appropriate treatment, and receive integrated care if they know their 'true' diagnosis (Sims et al., 2021, p. 3). Campbell et al. (2020) identify the need for accurate diagnoses and disclosure to ensure that patients with BPD gain access to appropriate and efficient treatment. Diagnosis is often essential to acquiring funding for specific treatment modalities. In addition, receiving a diagnosis can contribute to understanding and validating the experiences of patients with BPD for the patients themselves and their social environment. This could be useful in opposing rather than fueling stigma (Campbell et al., 2020).

Contrary to a deontological perspective on bioethics, utilitarianism or pragmatic ethics argues that diagnostic reservation might be justifiable in particular cases. When viewed from a utilitarian or practical standpoint, the ethically appropriate decision would be the action that 'minimises harm' and 'maximises good consequences' (Sisti et al., 2016, p. 7). Therefore, non-disclosure could be justifiable if the healthcare professional is motivated by the principle of beneficence (Sisti et al., 2016). The beneficence of non-disclosure could be argued when considering the concept of 'labelling'. Evidence within mental healthcare settings indicates a movement away from the use of pre-modified noun labels (e.g., 'she is a schizophrenic') or adjective

labels (e.g., ‘she is schizophrenic’) to rather favouring the use of more humanistic person-first labels (e.g., ‘she is a person with schizophrenia’) or possessives (e.g., ‘she has schizophrenia’). However, the common practice currently in clinical and specialised settings is the continuation of using pre-modified label constructions when referring to people diagnosed with BPD. One often hears patients with BPD being referred to as ‘borderlines’ (Masland & Null, 2022, pp. 89-90). Yet, surprising results from a study conducted by Masland and Null (2022) found overwhelming evidence that noun and person-first labels had no differential impact on stigma. Another unexpected result from their research was that the absence of a ‘label’ was a catalyst producing the most significant stigma (Masland & Null, 2022).

An interesting consideration that emerged from the research conducted by Masland and Null (2022) can be found in a limitation of their study. During the comparison of labels, to identify a difference in stigmatising behaviour towards the particular label, the researchers used an example of the person-first label as ‘Anna is a woman with BPD’ and the noun label as ‘Anna is a borderline’. In both examples, the words ‘personality disorder’ were not used, which might have obscured results concerning the finding that there is no difference in the stigmatisation of these two labels (Masland & Null, 2022, p. 95). However, this limitation of their study brings to light questions regarding the possible negative impact of the ‘personality disorder’ label rather than the ‘borderline’ label. The potential detrimental impact of the term ‘personality disorder’ is addressed in a response from Harding (2020b) to the Royal College of Psychiatrists’ position statement on personality disorders. In his response, Harding (2020b) expresses concerns regarding the use of terms such as ‘personality disorder’ in the first place. He further argues the perpetuation of stigma and alienation of people diagnosed with ‘personality disorders’ and that it is not surprising that many healthcare practitioners and patients alike avoid this label for this reason (Harding, 2020b). It is, therefore, possible that the issue might not lie with making a diagnosis of BPD based on a collection of symptoms that are present but rather the words that are used to define, describe, and conceptualise this diagnosis.

Harding and Berrigan (2024) argue that the ‘personality disorder label’ adds little to the treatment and understanding of people given this label and therefore causes more harm than good. Occupational therapists do not focus on the diagnoses given by a

psychiatrist to start treatment. Rather the goal is to collaborate with patients and clients to identify occupational challenges that they would like to address. The implications of this are that occupational therapists should “look outside of diagnostic criteria and lists of symptoms” to assess our patients’ and clients’ wants and needs, the skills they might need to achieve these goals, and the environmental factors that might be inhibiting these occupational pursuits (Harding & Berrigan, 2024, p. 401).

2.6.4. Self-stigmatisation

The phenomenon of self-stigmatisation is a well-established problem among people diagnosed with BPD. People living with BPD experience more ‘existential shame’ related to their diagnoses compared to people diagnosed with other mental conditions (Ahmed et al., 2021; Ociskova et al., 2024; Sheehan et al., 2016). Research by Grambal et al. (2016) supports this notion, as results from their study identified self- stigma among the BPD population to be the highest compared to populations diagnosed with other mental conditions. Ociskova et al. (2024) also described self- stigma as being prominent among patients diagnosed with BPD.

Self-stigma occurs when individuals observe and experience the negative reactions of others toward themselves and become aware of existing stereotypes. They then internalise these stereotypes and view these beliefs as legitimate and that finally results in individuals applying the stereotype to themselves (Ociskova et al., 2017, 2023, 2024). According to Ociskova et al. (2017), the result of self-stigma can be dire for stigmatised individuals, as is the case for patients diagnosed with BPD. Consequences include a reduction in self-esteem and an increase in depression and anxiety, which can negatively affect the overall morale and quality of life of the stigmatised person diagnosed with BPD (Ociskova et al., 2017, Quenneville et al., 2020). Findings from Grambal et al. (2016) also indicated a connection between increased self-stigma and unemployment among participants in their study diagnosed with BPD. It is, therefore, clear that the stigmatisation of the people diagnosed with BPD is as complex as the diagnosis itself. It occurs at all levels of healthcare service rendering, whether structurally or personally, and can significantly impact the efficacy of treatments and inventions for this population.

2.7. TREATMENTS AND INTERVENTIONS FOR BORDERLINE PERSONALITY DISORDER

Efforts to respect the unique nature of BPD have led to the development of various treatment modalities, specifically for BPD, proven to be effective in short-term and long-term intervention despite the stigma and frequently documented opinions declaring the 'untreatability' of BPD (Lieb et al., 2004; Ritschel & Kilpela, 2014; Zanarini et al., 2012, 2014). The most effective approach to the intervention and management of BPD requires collaboration from a team of multiple healthcare professionals (Gintalaite-Bieliauskiene et al., 2020), and treatment is most effective when provided over a longer period (Campbell & Lakeman, 2021).

The concept of 'brief admission' emerged from the field of nursing and has been well-researched and proven to be an effective management tool for patients with BPD .32, especially in crisis management situations (Eckerström et al., 2020; Enoksson et al., 2022; Helleman et al., 2014, 2018). The central aspects of brief admission include increasing autonomy, promoting constructive self-regulation of emotions, and decreasing stress and anxiety. It is, therefore, an effective tool for preventing self-harm without needing traditional psychiatric in-patient care (Enoksson et al., 2022). Brief admission provides the patient with a limited number of days per month that can be used to self-refer to the hospital when necessary to avoid escalating symptoms (Enoksson et al., 2022; Helleman et al., 2018). It is an effective approach to avoid long and often involuntary hospital admissions that have been proven to not only be ineffective but also potentially escalate symptoms associated with self-harm and suicidality and worsen the condition overall (Enoksson et al., 2022). Brief admission is, therefore, a tool that provides opportunities to manage emotional dysregulation, a core challenge and symptom of BPD. The efficacy of 'brief admissions' in managing BPD perhaps points towards the need for a communal approach in interventions with this population. Evidence from the literature supports the implementation of community-based support and treatment of people living with BPD (Javaras et al., 2017; Katakis et al., 2023). Considering the largely bio-medical and in-patient focus of interventions for people diagnosed with BPD, community- based support could be a valuable opportunity and gap for occupational therapy to fill.

Dialectical Behavioural Therapy (DBT) is well-researched, and ample evidence supports the efficacy of this treatment intervention for people with BPD (Gillespie et al., 2022; Linehan et al., 2015; Neacsiu et al., 2010). Dialectical Behavioural Therapy is a treatment approach that focuses on developing skills for emotional regulation. Marsha Linehan developed DBT, focusing on four main sets of skills: core mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance (Al-Alem & Omar, 2008; Gillespie et al., 2022; Heard & Linehan, 2019; Lieb et al., 2004). During a DBT program, patients and therapists typically commit to almost a year of therapy, with the potential to carry on if outcomes are positive. It is, therefore, intended as a long-term intervention plan characterised by continuous support throughout (Al-Alem & Omar, 2008; Lieb et al., 2004). Evidence especially indicates the effectiveness of DBT in relieving symptoms related to suicidal ideation and behaviour, as well as decreasing the severity of non-suicidal self-harm (Linehan et al., 2015; Neacsiu et al., 2010). Change inspired by DBT is also indicated to be effective, lasting for one year and after that (Gillespie et al., 2022).

Psychodynamic approaches to the treatment of BPD have also proven to be effective, with the focus of these interventions being directed at understanding dysregulated attachment and rather viewing emotional dysregulation as a consequence thereof and not necessarily the core challenge (Keefe et al., 2021; Ritschel & Kilpela, 2014). Mentalisation-based therapy is a specific psychodynamic approach that has received the most empirical support (Leichsenring et al., 2024; Ritschel & Kilpela, 2014). ‘Mentalisation’ is defined as the ability of the patient to understand and interpret their own and others’ behaviour as expressions of specific mental states and established schema modes. The goal of mentalisation-based therapy is, therefore, to be able to regain ‘adequate mentalising’ and achieve improved emotional regulation (Beck et al., 2020, p. 595). Research by Barnicot and Crawford (2019) found greater rates of decreased self-harm behaviour and improved emotional regulation among the population receiving DBT compared to the population receiving mentalisation-based therapy after 12 months. However, Keefe et al. (2021) found no significant difference between DBT and other psychodynamic approaches, such as mentalisation-based therapy, concluding that the efficacy of a chosen treatment strategy and intervention is dependent on the individual characteristics and needs of the specific patient diagnosed with BPD.

When considering neuro-biological interventions for persons living with BPD, Chiappini et al. (2022) conducted a systematic review of the efficacy of non-invasive brain stimulation as an alternative for neuro-biological intervention in patients diagnosed with BPD. Their review found evidence of the effectiveness of non-invasive brain stimulation, specifically concerning improving affective dysregulation. With regards to pharmacological treatments for BPD, there is consensus in the literature that the use of medication provides opportunities for the management of the symptoms of BPD however, there is no pharmacological agent that provides complete remission or cure for BPD (Al-Alem & Omar, 2008; Bozzatello et al., 2020; Cattarinussi et al., 2022; Hopping et al., 2020; Tadros et al., 2019; Waseem et al., 2022). Guidelines from the National Institute for Health and Clinical Excellence (NICE) stated that the use of pharmacological intervention was not recommended for the treatment of BPD, other than to treat co-morbid mental conditions or to control specific acute symptoms during short-term crisis management (Bozzatello et al., 2020; Waseem et al., 2022).

General psychiatric management has also been identified as an effective model for the management of patients diagnosed with BPD (Finch et al., 2019). General psychiatric management is a model for the management of the challenging symptomology associated with BPD by providing feasible and effective management guidelines for healthcare providers rather than relying on complex psychotherapeutic theories and techniques (Finch et al., 2019). Fundamentals of the general psychiatric management model include diagnostic disclosure, psychoeducation, building a meaningful life, managing suicidality and self-harm, conservative psychopharmacology, and coordination of care, which includes family psychoeducation and engagement in individual and group treatments (Finch et al., 2019). Therefore, the general psychiatric management model serves as a practical and holistic summary of the general essentials of managing BPD.

A multitude of intervention options exist for those suffering from BPD, with proven results of efficacy, opposing the idea that BPD is an untreatable condition. However, it is interesting to note that research critically exploring the efficacy of treatments aimed at personality disorders and BPD are few and far between. Evidence from literature is, therefore, not clear on what the contributing factors are that result in successful

treatment for or rather the ‘mechanisms of change’ are for people diagnosed with BPD receiving therapy (Rudge et al., 2020). It could be argued that the large bio-medical focus concerning the treatment of BPD leaves room for alternative methods of intervention. Occupational therapy could make a valuable contribution to meeting the needs of this population by taking an integrative approach outside of a traditional medical model. Occupation-based interventions can be instrumental in facilitating meaningful change in the lives of persons with BPD, both internally and concerning their environments (Gaerke et al., 2019). I will now explore the role of occupational therapy in the treatment of people diagnosed with BPD.

2.8. OCCUPATIONAL THERAPY AND RELEVANT CONCEPTS

Harding (2020a) argues the importance of occupational therapists' role in treating people diagnosed with personality disorders, emphasising the expertise provided by occupational therapy in adapting environments to promote occupational engagement. He concludes by indicating that the understanding of occupation and the use thereof among populations living with personality disorders is an important contribution occupational therapy can make in crafting an understanding of why people engage in these chosen occupations, which in turn can assist in decreasing stigma and increasing empathy (Harding, 2020a). Exploring the concept of occupation will provide a framework from which to discuss the relationship between occupational therapy and people living with BPD. This section will give an overview of the concept of occupation, especially related to the classification and definition of occupations and their impact on people diagnosed with BPD when viewed from an occupational perspective.

2.8.1. The concept of human occupation

The World Federation of Occupational Therapy (2022) defines occupations as the everyday activities people do as individuals or collectively that occupy time and bring meaning and purpose to life. Occupations include things people need to do, want to do, and are expected to do. Wilcock (1999) states that occupation is a very complex concept. However, she suggests one way of describing occupation is a synthesis of doing, being, and becoming, with the later addition of belonging as a dimension as well (Hitch et al., 2014). This conceptualisation of occupation suggests that occupation integrates components related to purposeful action, in-the-moment experiences, the

development of roles and identities, and contextualised interpersonal relationships and connections (Hitch et al., 2014; Wilcock, 1999).

Wilcock (1999, p. 10) emphasises the importance of embracing a "unique understanding of occupation that includes all the things that people do, the relationship of what they do with who they are as human beings and that through occupation they are in a constant state of becoming different". Therefore, in occupational therapy, occupation is central to treating and understanding individuals and populations. Wilcock (1999, p. 2) theorised that "a very strong relationship exists between occupation and health, to the extent that occupation is the natural biological mechanism for health." Not only does occupation play a central role in our health and quality of life, but it is also instrumental in constructing who we are. Christiansen (1999, p. 547) underscores the paradigmatic assumption of occupational therapy in as much as "occupations are key not just to being a person, but being a particular person, and thus creating and maintaining an identity." Kielhofner expanded on this concept and coined the term 'occupational identity' (Taylor, 2017; Kielhofner, 2009).

The Model of Human Occupation (MOHO), developed by Kielhofner (2009), describes the experience of occupational competence and a stable occupational identity as important components of eventual occupational adaptation. Occupational adaptation is defined as "having a positive occupational identity and the correspondent occupational competence constructed over time through the dynamics of a constant interaction between personal factors and environmental impact" (Taylor, 2017, p. 118). Thus, achieving occupational adaptation requires a balance between occupational identity defined as "a composite sense of who one is and wishes to become as an occupational being generated from one's history of occupational participation" and occupational competence defined as "the degree to which one sustains a successful pattern of occupational participation that reflects one's occupational identity" (Taylor, 2017, p. 117). Noting the paucity of recent literature on the MOHO and BPD, the MOHO has been found valuable in assessing and understanding people living with BPD from an occupational perspective (Falklöf & Haglund, 2010; Lee & Harris, 2010). The model, in essence, explains that a) a person's characteristics and the external environment are linked together into a dynamic whole; b) occupation reflects the influence of both the person's characteristics and the environment; and c) a person's

inner characteristics (i.e., capacities, motives, and patterns of performance) are maintained and changed through engaging in occupations (Kielhofner, 2009, p. 149). Therefore, when considering the effect of a diagnosis such as BPD on an individual's development of occupational competence and occupational identity requires the consideration of both their internal (e.g. impact of symptomology on emotional states) and external (e.g. social and relational) contexts.

2.8.2. Assumptions around the concept of occupation

As occupation is the primary modality in occupational therapy, continuous research and inquiry into the complexities of human occupation is essential to understand how best to utilise this unique tool. Mapheyeledi and Peters (2017) suggest attempting to create a universal definition of occupation could negate the voices of diverse and marginalised populations, considering the Western origins of occupational therapy as a profession. Many underlying assumptions and beliefs about human engagement in occupations are scrutinised for their applicability among diverse contexts and populations.

Hammell (2009b) reflects on four foundational assumptions in occupational therapy, namely 1) humans can positively influence their health using their hands and willpower; 2) occupations contribute to life's meaning; 3) humans participate in occupations as autonomous agents; and 4) humans are compelled to master the environment. The author argues, however, that these foundational assumptions might not translate effectively to other contexts and populations (Hammell, 2009b). Therefore, these beliefs might not ring true for populations that cannot affect their health positively, despite their willpower, due to the limitations imposed by illness and disability. This is often the case for many people diagnosed with BPD, who might find themselves disabled by the symptomology, arguably maintained within an uncritical, taken-for-granted biomedical discourse associated with this diagnosis (Bonnington & Rose, 2014). Furthermore, certain populations might not find occupations they engage in meaningful but rather necessary, as is the case for many people living with BPD who find the experience of meaning elusive or, at the very least, experience meaning differently in many areas of their lives (Marco et al., 2017). As occupational therapists, we need to understand the experience of meaning from the perspective of our patients

and clients with BPD if we are to facilitate interventions that contribute to their health and well-being.

Hammell (2009a) also argues that the categorisation of occupation into self-care, productivity, and leisure is over-simplified as it does not represent the full spectrum of experiences of human beings across all contexts. This is the case for many people living with BPD whose occupational engagement in occupations such as self-harm and substance abuse might not 'fit' neatly into these categorisations of occupations. As occupational therapists, we must question and evaluate these assumptions and determine whether our use of and understanding of occupation is aligned with the real-life experiences and needs of those we aim to serve. Hammell's arguments propose that occupation is a subjective individual experience influenced by unique factors (Hammell, 2009b, 2009a). This is echoed by Pierce (2003), who emphasises occupation as a subjective and nuanced experience understood from the perspective of the individual engaging in the occupation. This subjective and nuanced experience can further be described as a complex transactional interaction between personal and internal factors (mind, body, and spirit) (Bailliard et al., 2018), and the environment (socially and culturally) (Hocking, 2021). Therefore, occupation and the occupational engagement of patients and clients with BPD must be viewed in its entirety within context.

As occupational therapists, we are tasked with understanding the nuances accompanying our patients' and clients' subjective experiences of their occupations to promote "occupational well-being" defined by Doble and Santha (2008, p. 186) as "the meaning and satisfaction that individuals derive from their occupational lives." Doble and Santha (2008) identified and suggested seven occupational needs: accomplishment, affirmation, agency, coherence, companionship, pleasure, and renewal (p. 186). Therefore, in our collaborative efforts to pursue and create meaningful occupational lives with our patients and clients diagnosed with BPD, it is essential to consider and understand how these needs are met or not met in their everyday occupational lives.

2.9. OCCUPATIONAL EXPERIENCES OF PEOPLE LIVING WITH BORDERLINE PERSONALITY DISORDER

Contextualising and understanding the experiences of people living with BPD requires an exploration of the concepts of ‘meaning’ and ‘purpose’ as these are terms often used in discussions of human engagement in occupations within occupational therapy literature (Ramugondo, 2017). Ikiugu et al. (2015) state that ‘meaning’ in occupational engagement is difficult to define due to multiple definitions of what is considered ‘meaningful’ from many different perspectives. Hammell (2004) suggests that occupational therapy has demonstrated difficulty differentiating between ‘meaning’ and ‘purpose’ and often uses these terms interchangeably. One definition of ‘meaning’ is doing things that are experienced and perceived as valuable, important, and worthwhile (Christiansen, 1999), while other perspectives describe ‘meaning’ more existentially as what gives purpose to one’s life and feels worthwhile to pursue (Hammell, 2004; Ikiugu et al., 2015). From these multiple perspectives, it is apparent that ‘meaning’ cannot be universally defined. However, the common factor in all perspectives is that meaning is determined from the perspective of the individual engaging in the occupation, perhaps regardless of the definition (Ramugondo, 2017).

When attempting to understand the experiences of people diagnosed with BPD of what, how, and why they ‘do,’ there is research within occupational therapy literature that attempts to answer this question, albeit limited. An earlier study by Falklöf and Haglund (2010) explored occupations and adaptation to daily life by women diagnosed with BPD. Findings from this study identified an overarching theme of having few organised daily activities and that poor personal causation prevented changes in adaptation to daily life for these women. Subcategories identified were related to performance and self-image. The women described experiences where they felt competent in the performance of daily occupations, as well as experiencing a positive self-image. However, experiences of incompetence and a negative self-image were much more prevalent among this population (Falklöf & Haglund, 2010).

Potvin et al. (2019) echoed the research findings of Falklöf and Haglund (2010). Their study explored the occupational experiences of people diagnosed with personality disorders. Participants in this study described daily occupations, such as meal

preparation and self-care, as socially important but painful, tedious, and meaningless. Some participants even described these occupations as stressful and a source of feelings of incompetence and being judged by others (Potvin et al., 2019). Another significant finding from the Potvin et al. (2019) study was the nature of occupations described as important and meaningful by participants diagnosed with personality disorders. Participants described engaging in occupations that would generally be considered harmful, unhealthy, or unsanctioned by society, such as substance abuse and self- harm. However, participants in the study considered engagement in these occupations as functional and meaningful. They also described participating in occupations in ways that their families or social networks would disapprove of, but that were important and meaningful to them, such as behaviours associated with eating disorders or excessive gaming (Potvin et al., 2019). Similarly, Wasmuth et al. (2020) identified substance abuse as a coping mechanism and a form of escape or leisure/entertainment for most of the participants in their study and Connell et al. (2019) identified similar functions for the use of self-harm as an effective strategy to manage and regulate difficult emotions. As evidenced by findings from these studies, both occupations valued by society and occupations that are considered unhealthy or socially frowned upon can be viewed as functional, purposeful, and meaningful in the contexts of people diagnosed with BPD (Connell et al., 2019).

The tendency of people diagnosed with BPD to engage in occupations that are and could be considered harmful, unhealthy, or unsanctioned is well-documented but arguably perhaps not very well-researched. Twinley (2013, p. 2) refers to occupations that are considered antisocial or not socially sanctioned as the ‘dark side of occupations’ or simply ‘dark occupations’. Expanding on the concept of ‘dark occupations,’ Twinley (2013) stated that people do things that might not promote good health and are not always productive but may contribute to a sense of well-being. Wasmuth et al. (2014) support this assertion and found that addictions were reported to contribute to identity, motivation, and routines and didn’t necessarily prevent participation in other occupations. Kiepek et al. (2019), preferring the term ‘non-sanctioned occupations,’ also emphasise the value of expanding occupational therapy scholarship to be inclusive of non-sanctioned occupations, as this could achieve a better and more nuanced understanding of human engagement and meaning-making through occupation. Potvin et al. (2019) underlines the importance of further research

to build empirical evidence regarding taken-for-granted assumptions about healthy and unhealthy occupations, especially among people living with BPD. This is echoed by Kiepek et al. (2019) in inviting clinicians and researchers to develop a more responsive, if not holistic and contextual, understanding of occupational engagement for this population.

2.9.1. Occupational therapy interventions

There is limited research and evidence regarding the nature and effectiveness of occupational therapy interventions for patients diagnosed with personality disorders, including BPD, even less so within a South African context. However, research by Connell et al. (2022) identified the importance of promoting occupational engagement for justice-involved people with a personality disorder. The researchers investigated the development of an intervention program to enhance occupational participation with components identified by the researchers as the most important for intervention to enable occupational participation, including emotional regulation, being able to relate to others, a safe home environment, environmental resources, perceptions of social judgment, and self-efficacy in activity. However, not all components identified were considered 'modifiable,' i.e., able to change or be adapted. The highest ranked 'modifiable' components were identified as a safe home environment, self-efficacy in activity, sustaining routines, problem-solving, role fulfilment, and adaptability (Connell et al., 2022, p. 780). Therefore, it can be concluded that occupational therapy interventions can enhance occupational participation in these areas.

Still resonating with current inferences, earlier research by Lee and Harris (2010) focused on enhancing occupational engagement by implementing the Model of Human Occupation (MOHO) as an assessment and intervention tool for patients diagnosed with BPD. They created a program with different treatment pathways, allowing patients to explore and engage in various everyday occupations while focusing on specific problem areas identified during assessment. The researchers found that creating a structured environment that supports the challenges they are experiencing concerning emotional dysregulation and risk behaviours allowed them to better understand the impact of maladaptive behaviours on their occupational engagement. Results also indicated an increase in their understanding of meaningful

occupations and greater collaboration on identifying ways to improve participation in meaningful activities (Lee & Harris, 2010). Though there is limited research in occupational therapy concerning the application of occupation-based interventions for people diagnosed with BPD, these earlier findings indicate the potential powerful opportunities of an occupation-based approach in the treatment of this population.

Larivière et al. (2021) specifically focused on engagement in work as an important and valuable occupation for persons diagnosed with BPD. The researchers developed a combination of individual and group interventions to promote work integration and job tenure among people diagnosed with BPD. Interventions focused on multiple factors, including improving self-knowledge and self-esteem and providing experiences of competence as a worker. Furthermore, the intervention model focuses on developing a deeper understanding of the meaning of work for participants diagnosed with BPD, learning tools and strategies to manage professional activities better, establishing a more diversified routine to improve life balance, and finally, ensuring an improved fit between the specific person and future employment (Larivière et al., 2021).

Against a backdrop of an observed paucity of research in BPD and occupational therapy within a South African context, one study by Paruk and Janse van Rensburg (2016) investigated the inpatient management of patients diagnosed with BPD. Their review indicated that the current protocol for intervention, as evaluated, did not meet the desired outcome for patients with BPD, as these patients frequently had longer hospital admissions, showed high rates of re-admission, and did not follow-up through appropriate channels after discharge. The researchers recommended that the specifically researched facility incorporate short-stay inpatient and outpatient interventions, using principles from well-researched intervention tools such as Dialectical Behavioural Therapy and focusing on early intervention (Paruk & Janse van Rensburg, 2016).

Evidence from these research studies suggests that occupational therapy interventions for people living with BPD are focused on promoting engagement in purposeful and meaningful occupations. These interventions aim to create a satisfying occupational life and promote health and well-being. A better understanding of occupational experiences, especially as they relate to meaning and purpose – if not a

humanist lived experience, is essential for this population to achieve these goals.

2.10. CONCLUSION

This chapter attempted to paint a clear and holistic picture of the lived experiences of people diagnosed with BPD, as well as explore the role of occupational therapy in the treatment of this population. Stigma and struggle, due to the nature of BPD symptomology, is the golden thread linking discussions around BPD throughout this chapter and can, therefore, be described as constant companions to this condition. The nature and symptomology of BPD, as explored throughout this chapter, seem to attract and call for judgment on alienation and marginalisation, resulting in the belief that there is no help or hope for those suffering from this condition, even if evidence indicates otherwise. This creates a challenging conundrum, as the development of these so easily stigmatised symptoms is an essential survival response by this population to cope with and live in a world experienced as frightening, cruel, and invalidating. Understanding creates opportunities for insight, empathy, and compassion. Therefore, truly understanding the narratives and experiences of people diagnosed with BPD is a powerful method to produce opportunities for connection and to turn toward and not away from this population for society, healthcare professionals, and even people living with BPD themselves.

To conclude this chapter, words by Cone (2020) reflecting on the 'tragic gap', referring to the gap between the harsh reality around us and what we know is possible, seem fitting. She writes:

> *We are all standing in this space, but the difference for a person given the label of borderline personality disorder is that lacking some of the defenses available to others, they are aware of it. This is not to dismiss the painful pathology of a diagnosis called borderline, but merely to acknowledge that someone with this personality organisation is far from hopeless, simply deeply human. And if we listened, we might find that canary-like, they are alerting us that something is wrong in our culture and needs to change.*
>
> (Cone, 2020, p. 300)

CHAPTER 3: RESEARCH AND METHODOLOGY

3.1. INTRODUCTION

This chapter aims to provide a detailed description of the methodology used, including methods of inquiry and ethical considerations, to answer the research aim and objectives stated in Chapter 1 (cf. 1.4-1.5, p. 6).

3.2. METHOD OF INQUIRY

This section discusses the method of inquiry into the research question concerning the study design, research context, population and sampling, exploratory study, data collection procedures and instruments, data management, data analysis, and strategies to enhance rigour.

3.2.1. Study design

This exploratory study used a qualitative approach based on an interpretive description defined as “an analytical, inductive approach designed to create ways of understanding human health and aspects related to the experience of a disease that has consequences for the clinical context and practice in health” (Teodoro et al., 2018, p. 2). The chosen methodology supported the purpose of this research study as it provided the opportunity to understand complex experiential questions while producing practical outcomes (Thompson Burdine et al., 2021). Given the focus of this study to understand the occupational experiences of people diagnosed with borderline personality disorder (BPD), this design was deemed most appropriate to represent and give a voice to their perspectives and narratives. Researchers exploring the experiences of people diagnosed with BPD in previous studies (Falklöf & Haglund, 2010; Ikhtabi et al., 2021; Larivière et al., 2015; Marco et al., 2017; Matson et al., 2021; Ntshingila et al., 2016; Potvin et al., 2019; Stapleton & Wright, 2019) have also employed qualitative approaches, which proved valuable in understanding this population's experiences from their perspectives and giving a voice to this often marginalised community.

3.2.2. Research context

The research site is a private psychiatric hospital located in a middle-class to upper middle-class suburb of Tshwane (Pretoria), Gauteng. This site was conveniently selected for the feasibility of the research study as the researcher is employed by a private occupational therapy practice located at the hospital. This also contributed to convenient access to the study population as people diagnosed with BPD have a higher prevalence among acutely admitted clinical populations (Gawda, 2018; Jebsen et al., 2021).

The hospital has 150 beds, including seven (n≈7) wards (five female and two male), with a multi-disciplinary team of nursing staff, care workers, psychiatrists, clinical psychologists, social workers, dieticians, physiotherapists, and occupational therapists. Admission to the hospital is voluntary through referral by a psychiatrist. Admissions occur for a maximum of 21 days according to medical aid guidelines (Medical schemes act no. 131 of 1998). The occupational therapy practice is an independent unit mainly responsible for the full-day, in-patient group therapy program from Monday to Saturday and occasional individual assessments and interventions requested by referrals. Table 3.1. presents an example of the weekly programme. The occupational therapy team consists of five people at any given time during business hours. Below is an example of the weekly occupational therapy programme presented.

Table 3.1. Example of weekly occupational therapy group program

8:30 – 9:30 Monday to Friday	**Registration and information session (compulsory for all patients attending the group program)**				
Time	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
8:30	Painting group	Painting group	Painting group	Painting group	Painting group
8:30	Tension release exercises	Tension release exercises	Tension release exercises	Tension release exercises	Tension release exercises
9:30	**BREAK**				
9:45	Painting group	Painting group	Painting group	Painting group	Painting group

9:45	Connecting with myself	Information group: Bipolar Mood Disorder	The role of emotions	Information group: Major Depressive Disorder	Information group: ADHD
9:45	Facing change (join; group 1)	Facing change (closed; group 2)	Self-image (join; group 1)	Self-image (closed; group 2)	De-stressing: Unwind
11:00	**TEA**				
11:30	Mosaic group	Mosaic group	Mosaic group	Mosaic group	Mosaic group
11:30	Conflict styles	Take a new look on life	Balance in my life	Letting go (join; group 1)	Letting go (closed; group 2)
11:30	Healthy relationships	Boundaries (join; group 1)	Boundaries (closed; group 2)	Thinking Mistakes	Drumming
13:00	**LUNCH**				
14:00	Mosaic group	Mosaic group	Mosaic group	Mosaic group	Mosaic group
14:00	Relaxation therapy (Bring a pillow)	Anxiety management (join; group 1)	Anxiety management (closed; group 2)	Relaxation therapy (Bring a pillow)	Relaxation therapy (Bring a pillow)
Saturday					
8:30	De-stressing: Brain Training				
9:30	**BREAK**				
9:45	Love Languages				
11:00	**TEA**				
11:30	Relaxation Therapy (Bring a pillow)				

Patients admitted to the hospital consist of adults and teenagers (minimum age of 12 years old) with a variety of diagnoses, including but not limited to psychotic disorders, mood disorders, anxiety disorders, eating disorders, and personality disorders. The demographics of patients admitted are culturally and racially diverse, however, with a majority of white and black people, consisting of mostly middle-class to upper middle-class socio-economic status. Due to the hospital's geographic location, most patients admitted are Afrikaans and English-speaking individuals. From clinical observations, a significant portion of patients admitted have a diagnosis of BPD, as compared to other personality disorders, contributing positively to the accessibility of the population for this study.

3.2.3. Unit of analysis

The unit of analysis was drawn from the research context described above, using a mixture of purposive, snowball and volunteer sampling strategies (Merriam & Tisdell, 2015), consisting of male and female patients aged 18 years and older, currently admitted to the hospital and diagnosed with BPD. The research study aimed to include a sample size of between 10 and 15 participants, which the literature indicates is sufficient for data and meaning saturation. Meaning saturation is defined as "the point when we fully understand issues, and when no further dimensions, nuances, or insights of issues can be found" (Hennink et al., 2017, p. 594). Meaning saturation was reached with 13 participants participating in the research study.

3.2.3.1. Recruitment strategy

Participants were initially recruited in one of two ways, with a third manner developing naturally. The recruitment strategy employed was, therefore, a mixture of purposive-, snowball-, and volunteer sampling. Firstly, the researcher wrote a letter informing all practicing psychiatrists and psychologists at the hospital of the aim and purpose of the research study and providing them with the eligibility criteria. They were asked to inform potential participants who met the eligibility criteria of the research study, after which potential participants could volunteer if they wanted to participate.

Secondly, the hospital manager granted permission for the researcher to distribute pamphlets that included the aim and purpose of the research study, as well as the eligibility criteria, to all the wards and therapy rooms, informing potential participants who might be interested in volunteering for the study.

A third recruitment strategy developed naturally via word-of-mouth from participants who participated in the research study encouraging other potential participants who met the eligibility criteria to volunteer to participate. The second and third sampling strategies proved the most effective. After participants volunteered to participate in the research study, they were asked for permission to confirm their diagnosis of BPD with their psychiatrist or psychologist, to avoid instances of self-diagnosis.

3.2.3.2. Eligibility criteria

The eligibility criteria were aimed at being broad enough to maximise the potential sample size while still addressing the research question specifically and effectively. Participants were eligible to participate in the research study if they met the following criteria:

- Participants had to be 18 years or older to have the legal capacity to consent to participation in the study (Health Professions Council of South Africa, 2008, p. 8). As well as being able to provide free consent for their participation in the study.
- Participants had to have a confirmed diagnosis of BPD.
- Participants needed to speak and understand either English or Afrikaans, as the researcher is proficient in these languages. This criterion was ethically considered from a utilitarian point of view, as well as from a critical pragmatic standpoint in research, to minimise the cost of transcribing interviews and contribute to the ease of conversation during the interview process while still being able to contribute to the body of knowledge in this field. As described under the research context (cf. 3.2.2.), most participants are proficient in Afrikaans or English.

3.2.4. Exploratory study

Before the exploratory study (typically referred to as 'pilot study' in quantitative research), or the interviews, several rounds of clarifying the concepts and questions in the interview guide (Appendix E) were done with the supervisor, as well as a simulated session on the interviews, discussing and applying physical positioning, for example, and how research interviews are different from occupational therapy assessment interviews. This process supported trustworthiness by contributing to the validity of the study (Creswell & Creswell, 2018). Subsequently, an exploratory study was conducted with the first participant who volunteered to participate and was administered according to the data collection methods described in the next section of this chapter. The exploratory study confirmed the suitability of the eligibility criteria and data collection methods to address the research question. Furthermore, it allowed the researcher to affirm and reflect on her interviewing technique. As no alterations were made to the research methods and interview guide, the data generated in this

exploratory study was included for data analysis.

3.2.5. Data collection

This section will provide an overview of the instruments used during data collection and the specific steps followed in the data collection procedure. Data were collected using two main instruments: a demographic questionnaire (Appendix C) and a semi-structured interview (Appendix E).

3.2.5.1. Demographic questionnaire

Considering the qualitative descriptive nature of this study, demographic information on the research participants would be important to contextualise the data collected from interviews to support the transferability of results generated from this study. The demographic questionnaire (Appendix C) collected age, education level, employment, and relationship status information. Participants were also asked to indicate the perceived impact their diagnosis of BPD has on their daily functioning using a Likert-type scale ranging from ‘very light’ to ‘very severe’ (Appendix C). Though transferability was not considered the main focus of this study, demographic information obtained may assist other researchers and practitioners in reflecting on the applicability of the findings of this study to their practice settings.

3.2.5.2. Semi-structured interview guide

The semi-structured interview guide (Appendix E) was developed using open-ended questions to support the depth of information shared by participants regarding their participation in occupations they find purposeful and meaningful. Questions and prompts were inspired by the questions used in a similar study by Potvin et al. (2019). The semi-structured interview allowed for structure regarding the themes and topics discussed to most effectively meet the research objectives while leaving room for flexibility concerning the richness and depth of information exchanged. The interview guide was structured with an opening question asking participants to describe occupations they engage in, both alone and with others, on an everyday or semi-regular basis, that they find meaningful and purposeful. Prompting questions related to the value and importance of described occupations, what makes these occupations worthwhile, and what external or internal forces tend to influence participation in these

occupations. Specific prompting questions also focused on what makes the participant feel competent, gives them a sense of control, provides them with a sense of accomplishment, and finally, how it reflects 'who they are.' The flexibility afforded by the semi-structured interview guide (Kallio et al., 2016; Mashuri et al., 2022) also allowed the researcher to ask prompting questions related to descriptions of meaningful and purposeful occupations shared by participants, leading to more in-depth construction of each individual's narrative.

3.2.6. Research procedure

Data collection commenced once ethical clearance (Appendix F) and permission was obtained from all relevant authorities (Appendix G), including hospital management at the research site and the School of Therapeutic Sciences of the University of Witwatersrand. Data collection took place from March 2023 to June 2023. Interviews were conducted at a suitable time, considering the participants' schedules to avoid disruption to intervention and treatment activities or hospital routines. Interviews were conducted in one of two therapy rooms, depending on availability during scheduled interview times, ensuring privacy and confidentiality. All interviews were audio recorded on two devices, a cell phone and a digital dictaphone.

Upon initial contact with participants volunteering to participate in the research study, the researcher provided participants with an information sheet (Appendix A), with an overview of the purpose and process of the research study. The researcher scheduled a time with the participants to conduct the one-on-one interview. Before the commencement of the interview, participants were asked to complete the demographic questionnaire (Appendix C) and the informed consent documentation (Appendix B), including informed consent to be audio recorded (Appendix D). Participants were also asked whether they had read the information sheet (Appendix A) and had any questions, whether they consent to participate in the interview (Appendix B), and whether they consent to being audio recorded (Appendix D).

Before asking the opening questions during the interview, participants were reminded of the purpose of the research study and given a brief overview of what to expect during the interview. Participants were informed that the interview would last for about

90 minutes and that they were allowed to stop the interview at any time if they chose to do so without any consequence. Following the conclusion of the interviews, the researcher thanked the participants for their valuable insights, willingness to share, and time. Participants were asked if they had any questions or concerns regarding the interview or research study.

3.2.6.1. Data management

Following the interview's conclusion, data were managed to ensure that it was safely stored (Appendix H) and prepared for analysis and interpretation. Within twenty-four hours after each interview, all audio recordings were transferred from both recording devices to a password-protected computer, where the original recordings were deleted. An external hard drive, that was safely stored, was used to create backup copies of recordings to minimise the risk of losing data. All recordings were saved using only the participants' numbers, with only the researcher and her supervisor having access to all audio recordings.

The researcher did verbatim transcriptions of all recordings. This allowed the researcher to be familiarised with the data and completely immersed. Upon completion of all transcriptions, the researcher reviewed the content of the transcriptions by reading the written transcription while listening to the audio recording and correcting any errors that might have occurred. While the transcriptions were reviewed, all relevant field notes made at the time of the interview were added.

3.2.7. Data analysis

An inductive approach was used for data analysis. The primary purpose of the inductive approach is to "allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data, without the restraints imposed by structured methodologies (Thomas, 2003, p. 2). An inductive approach allowed the researcher to understand and describe narratives and phenomena from the participants' perspective, which perfectly supported the purpose of this research study. To enable complete immersion in the data analysis process, the researcher coded all interviews (using in vivo coding) with regular meetings with her supervisor to reflect on the coding process throughout. Data analysis were informed by the five-step process

described by Creswell and Creswell (2018), summarised and illustrated in Figure 3-1. As an underscoring principle of the researcher familiarising herself with the data, the period of data analysis took the longest as the researcher repeatedly engaged with the data analysis process outside of working hours for a period of approximately six months.

Figure 3-1: **Data analysis process** (Creswell & Creswell, 2018, p. 268-270).

Step 1: Organize and prepare data for analysis

Following the transcription of all interviews described in the previous section, all transcribed documents were uploaded and organised using Atlas TI version 24.1.1.30813, a qualitative data analysis software program.

Step 2: Read or look at all data

In this phase of the data analysis process, the researcher read through the transcriptions and used the ATLAS.ti 24 quotes function. Significant quotes and data pieces that answered the research question and objectives were highlighted and described. During this phase, the researcher also noted the general ideas and tones of the narratives shared by participants.

Step 3: Start coding all data

In the coding phase, all created quotes were revisited and inductively coded using the ATLAS.ti 24 software to support trustworthiness by providing an accurate and authentic representation of the data from the perspective and narrative of the participants. Quotes were coded line by line, referred to as “splitting” the data to achieve a more nuanced analysis of the data (Saldaña, 2016, p. 24). Data segments were coded in vivo using participants’ exact words to convey the meaning of the data segments. Code descriptions were added as codes were identified and generated to compile a codebook using the ATLAS.ti 24 software. After initially coding all data sets

consisting of all thirteen transcriptions and no new codes were identified, the researcher grouped codes according to their shared meanings and similarities. To filter the initial set of codes, the researcher reflected on overlapping ideas to determine which codes could be combined into a single code and identify codes and data segments irrelevant to the research aims and objectives. The researcher had regular online, and in-person contact sessions throughout the coding process with her research supervisor to reflect on and discuss the data coding process. The editing and reviewing process of codes was done using the ATLAS.ti 24 software, with the final set of codes organised and saved for an audit trail.

Step 4: Generate descriptions and themes

After the final set of codes was determined and compiled, codes were synthesized into categories and themes. Desantis and Ugarriza (2000, p.362) defined the concept of theme as “an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole”. The creation of categories and themes was approached with this definition as proposed by Desantis and Ugarriza (2000) in mind.

Codes were subsequently written on individual pieces of paper and spread out on a surface, allowing for a visual overview of all codes. The researcher reflected on the descriptions of different codes and started organising codes into categories that represented similar meanings or narratives. The exact process was repeated with the research supervisor to gain alternative perspectives and interpretations. The researcher and supervisor discussed and reflected on potential categories and themes and agreed on the final categories and emergent themes. The names for themes were chosen to best summarise and illustrate the overarching narrative of the specific theme. Similarly, the names of categories were inspired by the codes that defined them and best summarised the specific category. The finalised themes, categories, sub-categories, and individual codes were visually organised and illustrated on posters. Themes and categories were arranged in a specific order to best reflect the data and support the flow of the narrative (Nowell et al., 2017).

Step 5: Represent descriptions and themes

Chapter 4 presents and interprets the findings. Demographic data is presented through tables and themes, categories, sub-categories, and codes. Each code is presented with at least one or more verbatim quotes and triangulated with literature and theory. All deductions and conclusions are then discussed.

Although the procedure of data collection and analysis are presented as a linear process, it can be expected as the case for most qualitative studies that the process was more iterative and involved frequently moving back and forth between data analysis and interpretation as needed (Creswell & Creswell, 2018; Nowell et al., 2017). Due to the inevitable and necessary subjectivity resulting from the researcher's full involvement and emergence in the data analysis process, it was important to consider pursuing trustworthiness through the implementation of methodological strategies to enhance the rigour of the research.

3.2.8. Rigour of research/Trustworthiness

Validity and reliability are core concepts to consider when pursuing rigour in research. Validity is based on determining whether the findings are accurate from the researcher, participant, or reader's perspective (Creswell & Miller, 2000). Validity in qualitative research does not have the same connotations as in quantitative research. ‘Trustworthiness; is the term most often used when addressing validity in qualitative research. Important considerations in the pursuit of trustworthiness include consideration of:

a) credibility (indicating the epistemological standard of truth value, contributing to internal validity),
b) dependability (representing the epistemological standard of consistency, contributing to reliability),
c) confirmability (denoting the epistemological standard of ‘neutrality’, contributing to objectivity), and
d) transferability (signifying the epistemological standard of applicability, contributing to external validity) (Botma et al., 2022).

The following strategies were used to enhance trustworthiness throughout the

research process (Creswell & Creswell, 2018; Nowell et al., 2017).

3.2.8.1. Credibility

Credibility can be described as the intention to ensure that the researcher accurately and authentically represents the perspectives of participants (Nowell et al., 2017). The following strategies proposed by Creswell and Creswell (2018) were applied throughout this research study to enhance credibility.

a) Theoretical triangulation

Triangulation in research refers to examining and comparing evidence from a variety of sources (Creswell & Creswell, 2018). Multiple data sources across various disciplines, including occupational therapy literature, were consulted during the interpretation and discussion of the findings.

b) Member checking

Creswell and Creswell (2018) describe the use of member checking to enhance credibility by determining the accuracy of findings by sharing the identified themes with participants to assess whether participants feel these findings are accurate and representative of their experiences. Four participants were re-admitted after the conclusion of data collection, allowing them to discuss themes and findings identified during the data analysis process at the time. Participants agreed and confirmed that the identified themes were representative of their experiences.

c) Clarifying bias

Creswell and Creswell (2018) emphasise the importance of self-reflection and reflexivity throughout the research process. In qualitative research, the separation between the researcher and the research is nearly impossible and considered undesirable as the researcher is an integral part of the final product. Rather the focus is on assuring reflexivity and transparency throughout the research process (Galdas, 2017). Therefore, the researcher took notes and regularly reflected on her experiences. An important part of reflection included regular discussions and reflections with the research supervisor on experiences, realisations and insights throughout the research process. The researcher also made sure not to contribute to any existing stigma

already faced by this population by maintaining an open- minded and compassionate approach during interactions with participants and the data extracted from their narratives and experiences.

d) Presenting negative or discrepant information

Negative case analysis involves presenting information that is considered contrary to the identified themes (Creswell & Creswell, 2018). In the presentation and discussion of the findings, all contradictory information to the typical pattern of the themes will be included.

e) Peer review and debriefing

Creswell and Creswell (2018) describe the importance of peer review and debriefing to enhance the accuracy of accounts. The study was conducted with regular peer review and debriefing under the guidance of an experienced research supervisor with a doctorate in occupational therapy. The study fulfilled the requirements for upholding research integrity during a postgraduate process in occupational therapy, meaning that consistent peer review and critical reflection on the data methods and data interpretation are a mandatory part of the research process.

3.2.8.2. Dependability

To enhance dependability, researchers need to ensure that the research process is logical, traceable, and clearly documented (Nowell et al., 2017). The following strategies were implemented in this research study to enhance dependability.

a) Audit trail

An audit trail is important in providing evidence and a rationale for all decisions and choices made by the researcher during the research process (Nowell et al., 2017). The researcher has taken great care to keep clear records of raw data, field notes, and transcripts to support the creation of a clear audit trail.

b) Rich, thick descriptions

The use of rich and thick descriptions allows readers to identify how they might be able to apply the research to their specific contexts and gives the discussion an element of

shared experiences (Creswell & Creswell, 2018). During the discussion and interpretation, rich and thick descriptions were provided of the research process (methodology), the demographics of the participants, the research context, and the findings.

3.2.8.3. Confirmability

Confirmability is focused on establishing that the interpretations and findings from the research are accurately derived from the data and that the researcher can demonstrate how conclusions and interpretations have been reached (Nowell et al., 2017). The following strategies proposed by Creswell and Creswell (2018) were applied to enhance confirmability throughout the research process.

a) Checking transcripts

Transcripts were repeatedly checked against the recordings of interviews to correct any mistakes made during the transcription process (Creswell & Creswell, 2018).

b) Consistency in the meaning and definition of codes

The researcher used a codebook generated and continuously updated using the Atlas TI software. Data was continuously compared with the codes with regular memos made about codes and their definitions throughout the data analysis process (Creswell & Creswell, 2018).

3.2.8.4. Transferability

Transferability relates to the generalisability of inquiry (Nowell et al., 2017). The researcher does not know the sites that may want to apply the research findings in their specific contexts. However, by providing rich and thick descriptions, anyone who seeks to transfer the findings to their context can judge transferability for their unique settings (Nowell et al., 2017).

In conclusion, this research study was approached with rigour to enhance the quality of its contributions. This was achieved through the implementation of a variety of strategies to enhance trustworthiness throughout the research process. The next section will discuss the ethical considerations pursued and maintained in this study.

3.3. ETHICAL CONSIDERATIONS

The basic ethical principles in health research guided ethical decision-making in this study. These principles include non-maleficence, beneficence, confidentiality, supporting the autonomy of the research participants, and respecting research participants as stipulated by the Health Professions Council of South Africa (HPCSA) in the general ethical guidelines for healthcare researchers' booklet (Health Professions Council of South Africa, 2016). The principles of health research set forth by the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, 2023) were also advised. An important ethical consideration throughout the research process was the management of the duality of roles as 'researcher' and 'clinical therapist'. Within a clinical context the researcher functions predominantly as a group therapist and therefore did not fulfil the role of primary individual therapist for any of the participants throughout the research process. Prior relationships established with participants proved valuable in adding trust and safety during interviews, allowing participants to feel more comfortable sharing their narratives as the researcher was already familiar to them. As part of the risk management plan, before commencement of data collection, the researcher identified a colleague (occupational therapist) that was readily available if participants required support or had any adverse experiences related to the data collection process. However, no adverse experiences occurred throughout the data collection process. Table 3.2. provides a summary of the ethical principles applied during decision-making throughout the different stages of the research process, as suggested by Creswell and Creswell (2018).

Table 3.2.: Ethical principles and strategies relevant to the different stages of the research process

Stage of research	Ethical principle	Strategy for adherence
Before conducting the study (planning of research study)	Obtain permission from ethics committee	Following South Africa's National Health Act (61 of 2003, section 69), the study was submitted to and approved by the University of Witwatersrand Human Research Ethics Committee (Medical), and clearance certificate number M220903 was obtained (Appendix F).
	Obtain permission from relevant authorities at site where research is to be conducted	Permission to conduct the study was obtained from the Mediclinic Clinical Research Committee (Appendix G), the hospital manager, and the nursing manager. Throughout the research process, yearly updates have been provided to the Clinical Research Committee and hospital management upon request.
Beginning the study	Impartiality in selection of research participants	The eligibility criteria included a diagnosis of BPD, as this is the specific population being studied. An age limit of 18 years was set, as there is some disagreement in the literature as to whether personality disorders can be diagnosed before the age of 18. Being of legal age also allowed participants to give consent. No participants were excluded based on race, gender, culture, disability, or level of education.
	Informed consent	During the recruitment of participants, they were provided with both written (Appendix A) and verbal information regarding the purpose and process of the research. This included possible consequences, risks, and benefits of the research, that there would be no monetary compensation, and that confidentiality would be assured. Participants signed providing consent (Appendix B) to participate before starting the research. Before starting interviews the purpose of the research study was revisited and explained. Participants were then asked to verbally consent before starting interviews.
	Voluntary participation	The information sheet (Appendix A) provided to participants during recruitment clarified that there would be no material benefit or consequence resulting from participating or not participating in the study. Before starting the interview, participants were also verbally reminded that they could withdraw from the study at any time without consequence.

Collecting data	Continues consent	The researcher continually checked with the participants regarding their willingness to continue participating. Participants were also reminded that they could withdraw from the study at any time without any consequence.
	Respecting research site and participants	For convenience participants were interviewed during their admission to the hospital. Interviews were scheduled after working hours, and respected participants' schedules and routines. Arrangements were also made with the nursing staff and interviews were scheduled not to interrupt hospital routines or participation in the treatment program (individual and/or group therapy sessions).
	Avoid deceiving participants	Throughout the research process, the researcher clearly communicated to participants the purpose of the study and how data would be used. Participants were encouraged to ask questions if they needed clarification regarding any parts of the research process.
	Respect potential power imbalances	The researcher remained compassionate but impartial throughout the research process, avoiding leading questions or sharing personal impressions. Participants were involved as collaborators in the research process.
	Respect confidentiality and privacy of participants	Interviews were scheduled and conducted in a secure and private room, ensuring the confidentiality of the information shared. All recorded data was managed and kept safe and secure to maintain confidentiality (cf. 3.2.7).
Analysing data	Confidentiality and privacy of participants	Confidentiality was maintained using the methods described in the section discussing data management (cf. 3.2.7.).
	Accurately report all findings	All findings were reported honestly and accurately from the participants' perspectives. The strategies used to enhance rigour (cf. 3.2.9) contributed to accuracy in the interpretation of the data.
Reporting, sharing, and storing data	Avoid plagiarism	All sources were acknowledged using the APA 6th edition as automated by the Mendeley Cite-O-Matic feature for Microsoft Word. Page numbers were included in all in-text references.
		Except when referencing the entire document or paper. All further dissemination of this study will be referenced according to an acceptable referencing method.

	Avoid falsifying authorship, evidence, data, findings, and conclusions	All evidence, data, findings, and conclusions have been reported clearly and honestly, with strategies employed to enhance rigour throughout the research process (cf. 3.2.9.).
	Share data with relevant stakeholders	This research report and any further journal articles will be made available to the Mediclinic Hospital Group, hospital management, and participants who requested access to findings and results.
	Keep raw data and other materials safe	All raw data and materials will be stored and protected according to the strategies and methods described in the data management section (cf. 3.2.7).

3.4. CONCLUSION

This chapter detailed the methods used to answer the research question. It provided a rationale for the methodological decisions made while comprehensively describing the various aspects of the research planning, data collection, data analysis, and strategies to enhance rigour, as well as to allow for possible replicability of the method. Important ethical considerations were also argued. The findings from this study will be presented and discussed in the next chapter.

CHAPTER 4: FINDINGS AND DISCUSSION

4.1. INTRODUCTION

The previous chapter detailed the research design and methods employed to answer the research question and objectives. This study aimed to explore the perspectives of people living with borderline personality disorder (BPD) of occupations they engage in that they find meaningful and purposeful, as well as enabling or disabling. This chapter will provide a combined illustration of the findings and discussion (as motivated in Chapter 1, cf. 1.8., p. 10). Firstly, an overview of the participants' demographic information will be presented, followed by a table summarising the themes, categories, sub-categories, and codes. Each theme will be introduced, and a description of associated categories and sub-categories will be provided. The findings will be triangulated with relevant literature, after which the theme will be concluded.

4.2. DEMOGRAPHICS OF THE PARTICIPANTS

The sampling unit consisted of thirteen participants diagnosed with BPD. The first step in data collection required participants to complete a demographic questionnaire before conducting the semi-structured interview. Table 4.1. represents a summary of the information provided by participants. Please note that all names presented are randomly selected pseudonyms to protect the identity of all participants. Pseudonyms were randomly selected using a name generator corresponding to the race and sex of participants. I am aware of current discussions surrounding the importance of considering how pseudonyms are used to protect the confidentiality and privacy of participants and have ensured to do so as effectively as possible (Heaton, 2022).

Table 4.1. Demographic description of participants

Pseudonyms	Age (at time of interview)	Highest level of education	Employment/ Occupation	Relationship status	Perceived impact of condition on daily functioning
Mandy	34	Matric	Soldier (military)	Single	Moderate
James	24	Certificate (not specified)	Unemployed	Single	Severe
Sarah	30	University degree	Auditor	Single	Very severe
Beth	20	NQF Level 5	Unemployed	In a relationship	Severe
Kelly	19	Matric	Student	Single	Severe
Megan	33	University degree	Unemployed	In a relationship	Severe
Elize	43	Certificate (industry specific)	Property practitioner	Married	Severe
Claire	25	Diploma (industry specific)	Student, Manager at magazine publication	Single	Severe
Jenny	26	Matric	Stay-at-home mom	Separated	Severe
Sam	24	Matric	Hockey coach	Single	Moderate
Carly	23	Matric	Junior property manager	In a relationship	Severe
Steph	28	University degree	Post-production videographer/ photographer	Single	Severe
Rebecca	25	University degree	Junior legal professional	Single	Very severe

4.3. PRESENTATION AND INTERPRETATION OF DATA

The analysis process, as outlined in Chapter 3 (c.f. 3.2.8.) by Creswell and Creswell (2018), was used during the interpretation of the data. Table 4.2. provides a summary of the themes, categories, sub-categories, and codes. Three primary themes emerged from the data: 1) Living this life, 2) Filling the void, and 3) Creating meaning. The themes have been arranged in a specific order to most effectively illustrate the participants' narrative and create an optimal flow for the reader.

Each theme will be presented and discussed according to the categories and sub-categories that inform it. When each category or sub-category is given, a brief description will be provided, followed by verbatim quotes relevant to each category. The reader will notice some codes are the same as the category's or sub-category's name. The name was chosen for the category or sub-category as it best represents

the collection of codes under the category or sub-category while still including the specific code as a separate entity among other codes. Interviews were conducted in Afrikaans and English. In the case of interviews conducted in Afrikaans, the original verbatim quotes are presented in Afrikaans to maintain the voice of participants, as well as including English translations. The original Afrikaans quote is presented first, followed by the English translation in block brackets. As far as possible translations were done in such a way to ensure that the chosen words and meanings were kept true to the original style. Verbatim quotes are presented in their original style, including grammatical errors. When verbatim quotes are too long, ellipses have been used to indicate where information has been omitted or deleted. Where relevant, block brackets have also been used to provide context within the verbatim quotes. For each category, one or two verbatim quotes have been chosen that best illustrate and support the category discussed. Themes, sub-categories, and codes will be illustrated using tables, with 'snapshot' tables used before the discussion of each sub-category to support the flow and ease of reading for the reader. Finally, for discussion, each category has been systematically triangulated with relevant interdisciplinary literature and, secondly, relevant occupational therapy and/or occupational science literature before being concluded.

Table 4.2: Summary of themes, categories, sub-categories, and codes

Theme	Category/*Sub-category*	Code
4.3.1. Theme 1: Living this life	4.3.1.1. Emotions control everything in my life	i) Emotions control everything in my life ii) You can't control it iii) My emotions fluctuate very quickly iv) I go from zero to a hundred in a second v) My emotions are much more intense than other people's vi) That empathy is amplified vii) Other people determine my emotions
	4.3.1.2. Everything judges you	i) Everything judges you ii) I've always felt on the outside iii) People don't understand iv) Desperate to be accepted v) That feeling of rejection never goes away
	4.3.1.3. Coping strategies	
	a) It's my comfort zone	i) It's my comfort zone ii) Cutting is super calming iii) Cannabis makes you feel calm

	b) It's an escape	i) Substances are a coping mechanism ii) Substances take away the depression and you feel euphoric iii) The confidence to interact with people iv) It's an escape
	c) It's just you and nature/your pet	i) I find peace in nature ii) It's just you and nature iii) My pet is a coping mechanism for me iv) My pet is my best friend v) My pet is always there vi) I feel like my pet relates to me vii) My pet knows when I'm sad
	d) It physically feels good	i) It physically feels good ii) Physical pain is better than emotional pain iii) It gives me a sense of accomplishment iv) It releases frustration
4.3.2. Theme 2: Filling the void	4.3.2.1. It fills that feeling of emptiness	i) It fills the feeling of emptiness ii) I get easily bored iii) I don't experience accomplishment in most things I do
	4.3.2.2. I don't know when to stop	i) I don't know when to stop ii) I'm all in
	4.3.2.3. I actually feel something	i) I actually feel something ii) I like speed iii) Cutting is thrilling iv) The adrenaline v) I take chances, I love it
	4.3.2.4 It's new and different	i) I love learning new things ii) It's new and different
4.3.3. Theme3: Creating meaning	4.3.3.1. You can create something beautiful	i) You can create something beautiful ii) Creativity coming out iii) Art is my passion iv) More creativity in my art v) Being able to express myself
	4.3.3.2. I don't know who I am	
	a) That's my thing	i) That's my thing ii) It makes me different iii) I like shocking people iv) I like making people happy
	b) Making sense of it all	i) Having someone put into words what you're feeling really helps ii) Writing helps me make sense iii) You put those emotions on paper

4.3.1. Theme 1: Living this life

The first theme illustrates the everyday lived experiences of participants diagnosed with BPD. These experiences include the daily challenges they face due to the impact of their diagnosis. This theme also describes participants' subsequent choices, behaviours, and occupational engagement as attempts to mitigate the challenges they experience.

4.3.1.1. Emotions control everything in my life

The first category under the theme ‘Living this life’ describes the all-encompassing role and impact of emotions on the daily lives of the participants living with BPD concerning their daily occupations and relationships with others. It included codes that specifically emphasised the sense of limited control and overwhelming intensity of emotions experienced by participants. The feelings of ‘overwhelmedness’ and limited control that participants described experiencing can be associated with the term ‘emotional dysregulation’, defined by Beauchaine (2015) as emotional reactions that are prolonged, intense, labile, situationally inappropriate, or result in maladaptive behaviours related to emotional states.

Table 4.3. Summary of category: Emotions control everything in my life

Category	Sub-category	Codes
Emotions control everything in my life	N/A	i) Emotions control everything in my life ii) You can’t control it iii) My emotions fluctuate very quickly iv) I go from zero to a hundred in a second v) My emotions are much more intense than other people’s vi) That empathy is amplified vii) Other people determine my emotions

The following verbatim quotes illustrate examples of participants’ experiences of the impact of emotions on their everyday lives:

i)	**Emotions control everything in my life:** *En dan dit is hoe ek voel, en dan ah, affekteer it alles in my lewe sou ek sê. So dit reguleer hoe ek alles doen. Of ek eet, of ek nie eet nie, of ek so loop op 'n sekere manier, of ek so praat, of ek so aantrek, of ek dit drink, of ek, hoe ek met my ma praat, um, wat ek, alles, ja. Dit beheer alles in my lewe.* *[That is how I feel, and then ah, it affects everything in my life I would say. So, it regulates how I do everything. If I eat, or if I don't eat, if I walk in a certain way, how I speak, how I dress, if I drink, if I, how I speak to my mother, um, what I, everything yes. It controls everything in my life.]* (Kelly)
ii)	**You can't control it:** *Maar ek kan nie voel in daai oomblik nie, want ek sit en kyk basies vir wat ek doen. Ek sit agteroor en kan sien wat ek doen, maar ek het geen beheer oor dit nie.* [*But you can't feel in that moment, because I basically sit and watch what I'm doing. I sit back and I can see what I'm doing, but I have no control over it.]* (Beth)
iii)	**My emotions fluctuate very quickly:** *Soos ek sê, dis super high, en dan kom jy op 'n lelike low. En dis heeltemal so, dis maar soos 'n heartbeat.* *[Like I said, it's super high, and then you go to an ugly low. And it's completely like that, it's like a heartbeat.]* (Megan)
iv)	**I go from zero to a hundred in a second:** *Um, partykeer as ek kwaad raak of iets soos dit, dan sal dit normaalweg so lyk en dan obviously net soos, dan net ewe skielik soos snap en dan... Of dit bou half so bietjie soos irritasie en dan sal ek geirriteerd voel en dan net snap, of ietsie, en dan net te kere gaan.* *[Um, sometimes when I get angry or something like that, it would be normal and then obviously just like, just all of a sudden I snap and then… Or it kind of builds, so a little irritation, and then I would feel irritated and then just snap and go crazy.]* (Kelly)

v)	**My emotions are much more intense than other people's:** *Our emotions, we feel our emotions… Where someone feels sadness, perhaps on a level 10 and that is the most sadness they will ever feel, I feel sadness on a level 1000. So, my emotions are much more intense than other people's emotions. Most people, I should say, most people's emotions.* (Claire)
vi)	**That empathy is amplified:** *…'n ander ding wat ek haat is, ah, ek weet nie of dit die borderline is of wat nie, maar om mense, ander mense se emosies sterker aan te voel as jou eie. Iemand is hartseer, iemand het iemand verloor, laat dit leterlik voel asof jy so vas gevat word terwyl jy met daai persoon praat, en voel hoe seer daai persoon het.* *[…another thing I hate is, ah, I don't know if it's the borderline or what, but to feel people, to feel other people's emotions stronger than your own. Someone is sad, someone lost someone, so it literally feels like you are taken over while you're speaking to that person, and you feel the pain that person is feeling.]* (Mandy)
vii)	**Other people determine my emotions:** *Omdat dit moeilik is om te cope met my gevoelens teenoor mense.* *[Because it's difficult to cope with my feelings toward people.]* (Elize) *Ja, en mense kan my baie trigger, en my triggers kan verskriklik erg raak wat ook spiral into anger outbursts en dis nie mooi nie.* *[Yes, and other people can trigger me a lot, and my triggers can get really bad and spiral into anger outbursts and it's not pretty.]* (Carly)

Emotional instability or 'emotional dysregulation' is described as a core feature of BPD and is the most widely researched dimension of this diagnosis (Daros & Williams, 2019; D'Aurizio et al., 2023). Emotional dysregulation is a defining feature of BPD to the extent that 'affective instability' is one of the diagnostic criteria described in the DSM-V-TR, as well as 'inappropriate anger or difficulty controlling anger' (American Psychiatric Association, 2022). The first five codes identified in this category could all be described as features belonging to the 'affective instability' and 'inappropriate anger

or difficulty controlling anger' criterion of the DSM-V-TR diagnosis of BPD. Experiencing emotions with overwhelming intensity and frequent fluctuation is, therefore, a well-documented feature of BPD.

Pertinent and extensive research on BPD has been conducted, concluding that the core presentation and dysfunction experienced by people diagnosed with BPD are related to emotional dysregulation (Chapman, 2019; Daros & Williams, 2019; D'Aurizio et al., 2023; Lieb et al., 2004; Reisch et al., 2008; Spytska, 2024). The socio-biological theory developed by Salsman and Linehan (2012) is based on evidence that people diagnosed with BPD have an innate tendency to react with more intensity to lower levels of stress and that they might take longer to recover from an emotional reaction as compared to people who do not present with challenges related to emotional dysregulation. Due to the inherent tendency identified among populations of people diagnosed with BPD, Salsman and Linehan (2012) further describe the emotional experiences of people diagnosed with BPD as often being misunderstood, dismissed, and or judged for most of their lives because of what is called an 'invalidating environment. It is possibly the existence of this dynamic between 'emotional dysregulation' and an 'invalidating environment', that could be the heart of many consequences and struggles faced by people diagnosed with BPD.

One of the potential consequences of chronic emotional dysregulation, as experienced by people living with BPD, is the experience of limited control in their everyday lives. Hope et al. (2018) identified a positive association between the features of BPD and the presence of an external locus of control, defined as believing that external factors control and predict outcomes more than internal factors. Hope et al. (2018) further affirmed that individuals diagnosed with BPD who were more external in their locus of control reported experiencing more difficulties with emotional regulation. Therefore, challenges concerning emotional control can be akin to experiencing a lack of power in other areas of daily life. Participants in this study shared similar experiences, as Sarah stated when asked what contributes to her experience of an 'emotionally challenging' week:

Ja, dit is ander mense, dit is nie, ek dink nie my eie faktore nie, dis soos buite faktore. [Yes, it is other people, it's not, I don't think it's my own factors, it's like outside factors.] (Sarah)

Specifically, with regards to the impact of other people on the emotional experiences of people diagnosed with BPD and the experience of 'amplified empathy,' research in this domain has identified what is called 'the borderline empathy paradox.' This term refers to evidence suggesting that people diagnosed with BPD experience enhanced affective empathy, the ability to share others' affective states, but experience impaired cognitive empathy, which refers to one's ability to understand the thoughts, feelings, beliefs, and intentions of others. Therefore, people diagnosed with BPD experience enhanced empathy despite impaired interpersonal functioning (Blunden et al., 2024; Salgado et al., 2020). As Claire, one of the participants in this study, explained:

It's difficult for me to control my emotions because other people's emotions impact me so much. (Claire)

From an occupational therapy perspective, challenges of chronic emotional dysregulation can have a profound negative impact on occupational engagement. A study by Falklöf and Haglund (2010) found that participants had trouble organising their daily occupations and that their emotional state greatly impacted their ability to engage in or perform occupations. Similarly, participants in this study reflected on the negative impact fluctuating and overwhelming emotional states have on their ability to perform and engage in important occupations and roles, as Kelly indicates.

Dit het 'n groot effek op soos of ek iets kan doen of ek nie iets kan doen nie. Dieselfde met my verhoudings met my ouers en almal anders eintlik.
[It has a huge effect on like whether I'm able to do something or not do something. Same with my relationship with my parents and everyone else actually]. (Kelly)

Sarah reflected on how her emotional state impacts her ability to perform at work.

Dan sal ek gewoonlik nie al my take af gerig kry by die werk nie. Dit sal gewoonlik baie soos straining en draining wees vir my om te werk. Ek sal sukkel om my werk vir die dag gedoen te kry.
[Then I will usually not be able to complete all my tasks at work. It will usually be very straining and draining for me to work. I would struggle to get all my work done for the day.] (Sarah)

The prominent impact of emotional dysregulation among people diagnosed with BPD is an important consideration for occupational therapists in their interactions and interventions with this population, due to the potential resulting consequences related to occupational engagement and maintenance of important social relationships and roles.

4.3.1.2. Everything judges you

The second category under 'Living this life' describes participants' experiences of social exclusion and judgment within society and their relationships. This category included codes illustrating participants' experiences, often feeling rejected, isolated, and misunderstood.

Table 4.4. Summary of category: Everything judges you

Category	Sub-category	Codes
Everything judges you	N/A	i) Everything judges you ii) I've always felt on the outside iii) People don't understand iv) Desperate to be accepted v) That feeling of rejection never goes away

The following verbatim quotes illustrate examples of participants describing the social exclusion and judgment that they experience:

i)	**Everything judges you:** *Want maak nie saak hoe baie mense, hoe baie gelowiges vir jou sê, nee niemand judge nie. Daar buite* [name of hospital] *is sulke gevaarlike plekke. So, alles judge jou, alles wat jy doen is verkeerd, maar hier binne* [referring to hospital] *voel dit veilig.* *[Because it doesn't matter how many people, how many believers tell you, no, no one judges. Out there, outside of* [name of hospital] *there are such dangerous places. So, everything judges you, everything you do is wrong, but in here* [referring to hospital] *it feels safe.]* (James)
ii)	**I've always felt on the outside:** *Ek sou 'n conversation interrupt deur een van my ervarings te wil deel, maar dit het geen, dis van geen toepassing op die conversation van die groep nie. En dis hoekom mense dan begin weird voel om my, want hulle, hulle voel dadelik dat hulle kan nie met my relate nie want ek is op 'n planeet van my eie.* *[I would interrupt a conversation by wanting to share one of my experiences, but it would have no, it would not be relevant to the conversation of the group. And that's why people would start feeling weird around me, because they, they immediately feel they can't relate to me because I'm on a planet of my own.]* (Elize)
iii)	**People don't understand:** *So, dan voel ek half isolated en alleen, dan voel dit asof mense nie verstaan nie. So, dan raak ek ook weer teruggetrokke, al hierdie emosies bou op, ek voel alleen.* *[So, then I feel kind of isolated and alone, then it feels like people don't understand. So, then I become withdrawn, all these emotions build up, I feel lonely.]* (Carly) *Die rede waarom* [other parents at school] *my nie wil leer ken nie, is omdat hulle nie weet hoe om my te hanteer nie.* *[The reason why* [other parents at school] *don't want to get to know me is because they don't know how to handle me.]* (Elize)

iv)	**Desperate to be accepted:** *Ek sou, ek sou legit gedoen het wat enigiemand wou gehad het ek moes doen, net vir hulle acceptance. Ek sou gedrink het wat ek nie wou drink nie net om in te pas. Ek sou seks gehad het met mense net om gesien te word, net om wanted te wees. Ek sou begin hubbly rook het, want dis wat almal doen en ek wil deel wees van dit. Ek sal my waardes change, um, laat dit inpas by hulle s'n.* *[I would, I would legit do anything anyone wanted me to do, just for their acceptance. I would drink what I didn't want to drink just to fit in. I would have sex with people just to be seen, just to be wanted. Just to be wanted. I would start smoking hubbly, because that's what everyone was doing and I wanted to be a part of it. I would change my values, um, so that it fits in with theirs.]* (Steph)
v)	**That feeling of rejection never goes away:** *Ek dink daai is die grootste simptoom vir my, want ek lei verskriklik aan abandonment issues. En, ek bedoel, daai is vir my 'n baie, dit is vir my op my diagnose, die een ding wat my lewe soos baie moeilik maak, is as ek abandoned voel deur mense of enige klein dingetjies wat hulle doen.* *[I think that is the biggest symptom for me, because I suffer from abandonment issues. And, I mean, for me that is a very, in terms of my diagnosis it's the one thing that makes my life very difficult, when I feel abandoned by other people [by] small things they do.]* (Sarah) *Maar ek voel die verwerping baie erger as meeste mense. Ek kan nie die verwerping ding skud nie.* *[I feel the rejection a lot worse than most people. I can't shake this rejection thing.]* (Elize)

Borderline personality disorder is marked by a pattern of unstable relationships that, often, present in two ways, the first being a profound fear of abandonment, manifesting itself in desperate efforts to avoid rejection from others. The second includes relationships with a tumultuous quality resulting in frequent arguments and hostility and may involve the use of maladaptive strategies directed at themselves or others

(Lieb et al., 2004). Difficulty managing relationships with loved ones and navigating social interactions in general is, therefore, a well-documented feature of BPD symptomology that is included as part of the diagnostic criteria described in the DSM-V-TR (American Psychiatric Association, 2022).

As previously mentioned, the bio-social theory described by Salsman and Linehan (2012) illustrates a complex relationship between the emotional dysregulation often experienced by people diagnosed with BPD and an invalidating social environment, potentially resulting in the patterns of unstable relationships characteristic of persons living with BPD. Research by Carlson et al. (2020) substantiates the link between emotional dysregulation and social role dysfunction by identifying the type of coping styles most often used among individuals diagnosed with BPD, generally not being supportive or promotive of optimal social functioning. They found that participants tended to use emotion-orientated coping, such as negative affect, rumination, and crying, rather than task-orientated coping, such as problem-solving, which in many circumstances would tend to exacerbate relational conflicts or problems rather than mitigating them (Carlson et al., 2020).

A qualitative meta-synthesis by Ikhtabi et al. (2021) focused on the experience of loneliness among people diagnosed with a personality disorder. Most notably, results indicated that people diagnosed with ‘emotionally unstable personality disorder’, another name for BPD, in particular, experienced high instances of alienation and disconnection (code ii), showed evidence of both seeking and fearing connection (code iii) as well as experiencing a decreased sense of meaning in their lives due to a perceived lack of shared goals and leisure activities compared to other people. However, evidence also indicated that participants viewed meaningful connections and belonging as essential to their recovery, which poses a dilemma of needing meaningful connections to support recovery but avoiding opportunities to create these meaningful connections due to fear (Ikhtabi et al., 2021). The aetiology of these experiences among people diagnosed with BPD seems to be a combination of internal and external factors. A study by Hepp et al. (2021) investigated the perceptions of people diagnosed with BPD as well as those of individuals in a healthy control group. They asked individuals in both groups to rate each other according to their trustworthiness, likeability, and cooperativeness. Results indicated a tendency

towards negative ratings on both sides, meaning that individuals in the BPD group viewed participants as untrustworthy and felt less inclined to socialise with these individuals, with the healthy control group indicating similar negative evaluations of the BPD group (Hepp et al., 2018, 2021). It could, therefore, be concluded that the judgment and alienation experienced by people diagnosed with BPD are both rooted in challenges experienced due to the symptomology of BPD as well as social stigma.

From an occupational therapy perspective, Lariviere et al. (2010) found a strong trend among people diagnosed with a Cluster B personality disorder, experiencing difficulties in employment, relational, and recreational domains. Similarly, in this study, Carly (sub-category 'Emotions control everything in my life', code vii) described having to leave her job as a waitress due to finding interactions with customers very stressful and being unable to control her anger during conflicts with patrons, colleagues, and managers. Kelly (code ii) described feeling judged and alienated by her peers throughout her life as they deemed her interests in anime and gaming as 'weird'.

It is, therefore, clear that the social role dysfunction experienced by people living with BPD has a significant impact on their engagement in important and meaningful occupations as well as their experience of overall meaning in their lives (Ikhtabi et al., 2021; Lariviere et al., 2010). As occupational therapists, it is essential to understand and consider the unique elements involved in creating the 'picture' so often seen among this population so we can facilitate meaningful engagement in occupations and relationships that ultimately contribute to successful recovery and a life worth living for people diagnosed with BPD.

4.3.1.3. Coping strategies

The third category under the theme 'Living this life' includes descriptions of the coping strategies participants employed in their attempts to mitigate the negative impact of the challenges discussed in the first two categories. Participants described different coping strategies to alleviate the burden of overwhelming emotions and ease or avoid difficult relational and social interactions.

Table 4.5. Summary of category and subcategories: Coping strategies

Category	Sub-category	Codes
Coping strategies	a) It's my comfort zone	i) It's my comfort zone ii) Cutting is super calming iii) Cannabis makes you feel calm
	b) It's an escape	i) Substances are a coping mechanism ii) Substances take away the depression and you feel euphoric iii) The confidence to interact with people iv) It's an escape
	c) It's just you and nature/your pet	i) I find peace in nature ii) It's just you and nature iii) My pet is a coping mechanism for me iv) My pet is my best friend v) My pet is always there vi) I feel like my pet relates to me vii) My pet knows when I'm sad
	d) It physically feels good	i) It physically feels good ii) Physical pain is better than emotional pain iii) It gives me a sense of accomplishment iv) It releases frustration

a) It's my comfort zone

The first subcategory describes the role of occupations, objects, and people used by participants as tools for comfort and soothing to cope with everyday life. The following verbatim quotes illustrate how participants describe and experience the use of these tools to create a sense of safety:

i)	**It's my comfort zone:** *Ek het selfs teddiebere wat ek tot nou toe mee vandag slaap, want dit is, dis vir my 'n comfort zone gewees… die oomblik as ek my teddies vas gehou het, dan um, voel dit net asof hulle, dit hou my veilig, dit hou my, dit hou my company.* *[I even have teddy bears that I still sleep with to this day, because it's, it's a comfort zone for me… the moment I hold my teddies, then um, it feels like they, it keeps me safe, it keeps me, it keeps me company.]* (James) *Dis wanneer ek game… Dan voel ek nie daai rage nie want dan's ek in my wêreld waar ek, soos my safe bubble is. So, dis my safe space*. *[It's when I game… Then I don't feel that rage because then I'm in my world where I, like where my safe bubble is. So, it's my safe space.]* (Megan) *En gewoonlik as ek begin angstig raak, dan kyk ek net vir hom* [referring to her brother]*, dan kom hy oor, dan sê hy vir my "is jy okay? You got this" en dan help my so bietjie en dan gaan hy bietjie aan met sy eie dingetjies. Dan weet ek, okay, ek's veilig, want hy's hier.* *[And usually when I start to get anxious, then I just look at him* [referring to her brother]*, then he comes over, then he says to me "are you okay? You got this" and he just helps me a little bit and carries on with his own things. Then I know, okay, I'm safe, because he's here.]* (Carly)
ii)	**Cutting is super calming:** *Um, die main ding was ek het later besef dat ek raak angstig maar ek voel dit nie. So, maar om te gesny het was altyd vir my soos super calming. Dis was soos, dit het net soos kalmering gebring.* *[Um, I think the big thing, the main thing was I later realised that I get anxious but I don't feel it. So, but to cut was always like super calming. It was like, it just brought calmness.]* (Sam)

iii) **Cannabis makes you feel calm:**

Yeah, and just like, completely take my mind off it, 'cause you know when you're, well… I mean, it's different for, you know, the effect of marijuana is different for people, but for me, I just, my mind goes completely blank, and I just sit there. I think I'm very mind [struggling to find word]*, like I become in the moment, like I can probably be as mindful as possible when I'm on marijuana… Nothing, I'm just there. I'm experiencing whatever is happening in that moment. I'm not thinking about anything. I'm not feeling anything. It's just there.* (Rebecca)

Evidence from a wide range of literature suggests that people diagnosed with BPD experience difficulties in employing effective coping mechanisms to manage and overcome the challenges of everyday life (Antiþeviü et al., 2019). Many different theories exist to explain the reason for this among populations of people living with BPD, with the consensus being the complexity and interconnectedness of characteristics and symptomology related to this diagnosis (Carlson et al., 2020; Dixon-Gordon et al., 2021; Lieb et al., 2004; Ng et al., 2019).

One suggestion for the complexity of BPD is that of the development of 'the background feeling of safety' and how this might relate to the experiences of people diagnosed with BPD. Within this context, the 'background feeling of safety' refers to the development of the ability to experience a sense of security in interacting with others and the world, therefore the ability to approach people and situations with an inherent expectation of safety and security, unless proven otherwise (Van Duppen et al., 2022). Research by the same authors postulates that a lack of development of a 'background feeling of safety' since childhood and perpetuated throughout adult life might be central to the experiences and resulting characteristics often identified among people diagnosed with BPD (Van Duppen et al., 2022). As Megan, one of the participants in this study, states:

Ja, veiligheid is vir ons 'n groot ding. Ons voel nie ons het altyd safe spaces nie.
[Yes, safety is a big thing for us. We don't always feel like we have safe spaces.] (Megan)

The first code, ‘It’s my comfort zone’, under this sub-category includes verbatim quotes where all participants used the terms ‘safe’, ‘safety’, or ‘safe space’ in their descriptions of what they were trying to achieve through the different coping mechanisms they used, supporting the theory postulated by Van Duppen et al. (2022).

Four of the thirteen participants referenced the use of ‘transitional objects’, such as stuffed animals and security blankets, as tools for soothing and comfort when feeling distressed. This phenomenon is supported by evidence from research by Hooley and Wilson-Murphy (2012) indicating a significant link between the use of ‘transitional objects’ for coping and the presence of BPD pathology. Kiefer et al. (2017) identified neural correlates in a population of sixteen female participants diagnosed with BPD related to the processing of the functional significance in the use of ‘transitional objects’ as a coping mechanism for anxiety and depression. It is, therefore, clear that ‘transitional objects’ are a significant soothing tool among people diagnosed with BPD.

Considering the use of self-harm as a calming tool, the presence and function of self-harm or non-suicidal self-injury within the context of people diagnosed with BPD have been well-researched over the years, as it is another central feature of the BPD diagnosis. Seven of the thirteen participants in the study described the use of self-harm as a coping strategy. The consensus among researchers on the purpose and function of non-suicidal self-injury relates to the alleviation of overwhelming negative affectivity, with evidence suggesting that engaging in self-harm tends to provide a distraction from negative emotions and, in some cases, soothing of negative emotions (Brown et al., 2002; Kleindienst et al., 2008; Scheunemann et al., 2023; Zanarini et al., 2013). One study by Niedtfeld et al. (2010) found evidence that people with BPD process pain stimuli differently compared to people not diagnosed with BPD in control groups. This provides preliminary neurological evidence supporting the idea that a general mechanism of attentional shift underlies the soothing effect of pain for people diagnosed with BPD (Niedtfeld et al., 2010). Therefore, non-suicidal self-injury seems to be an effective tool for temporary alleviation of overwhelming negative emotional experiences, though still viewed as harmful and problematic behaviour.

In the case of cannabis use, four of the thirteen participants in this study described

cannabis use as a coping strategy. Gillespie et al. (2018) conducted a twin study exploring the association between personality disorders and cannabis use or cannabis use disorder. Evidence indicated a link between cannabis use and cannabis use disorder and genetic risks correlated with Antisocial and Borderline traits (Gillespie et al., 2018). However, an interesting study by Sultan et al. (2022) employed the use of cannabis-based medicinal products for a group of participants diagnosed with emotionally unstable personality disorder, another name for BPD. Results from their study indicated that 6 out of 7 participants experienced noticeable improvements in their symptoms at one-month follow-up (Sultan et al., 2022). This study included a small sample size, and much more extensive research would be necessary in the field of medicinal cannabis and BPD. However, it seems the controlled use of cannabis-based medicinal interventions might have the potential to improve or alleviate some of the detrimental symptoms experienced by people diagnosed with BPD.

From an occupational therapy perspective, the use of coping mechanisms that are generally societally disapproved of, such as self-harm, cannabis use, and even the use of soothing objects that could be viewed as inappropriate or child-like, brings to light the concept of ‘the dark side of occupation’. Twinley (2013) describes the term ‘dark side’ as not to imply that occupation has two sides, but rather as a definition to foster an understanding that traditional views of occupation have evolved and that it is important to consider occupation as something complex and multidimensional. The term ‘dark side of occupation’ refers to occupations that people engage in that might not necessarily promote good health or be productive yet provide a sense of well-being to those who engage in these occupations (Twinley, 2013, p. 2). Kiepek et al. (2019, p. 2) suggested the term ‘non-sanctioned occupations’ defined as occupations that are seen, within historically and culturally bound contexts, as unhealthy, illegal, immoral, abnormal, undesired, unacceptable, and inappropriate. The occupations described by participants in this study as providing comfort and safety would fit into this conceptualisation of ‘non-sanctioned occupations’. Kiepek et al. (2019) argue that acknowledging non-sanctioned activities as occupations does not mean that all occupations need to be considered socially acceptable, but rather that expanding our perspective on what occupation is, to include non-sanctioned occupations allows for a more nuanced understanding of how humans engage in daily life. It is, therefore, less about assigning a value determination of good or bad to occupational engagement but

understanding the meaning and purpose of occupational engagement. For example, consider James's experience of using cannabis as a coping strategy:

> *En dit, dit voel nogals funny, maar dit is, dis 'n lekker ding, dit laat mens kalmeer voel. Maar die ding is, jy moet dit ook die, die regte manier gebruik, want as jy dit nie reg gaan doen nie, dan kry jy die ergste bad trip onder die son.*
> *[And it, it feels kind of funny, but it's, it's a nice thing, it makes you feel calm. But the thing is, you have to use it the right way, because if you're not going to do it right, you will have the worst trip under the sun.]* (James)

Perhaps rather than focusing on excluding, eliminating, or replacing occupations deemed as non-sanctioned that people diagnosed with BPD might experience as meaningful and to some extent contributing to their well-being, occupational therapists could be encouraged to explore ways of engagement in these occupations that fall within certain parameters and allows people living with BPD to successfully and responsibly engage in societal roles (Kiepek & Magalhães, 2011).

b) <u>It's an escape</u>

The second sub-category under the category of 'Coping strategies,' illustrating what it means to be 'Living this life' (Theme 1), describes the use of substances as a tool to manage and cope with the challenges of everyday living as someone diagnosed with a BPD. This includes using substances to manage challenging and overwhelming emotional experiences and navigating social interactions that might otherwise be distressing or completely avoided.

The following verbatim quotes illustrate the experiences of participants using substances as a coping mechanism. Substances in this case mainly refer to alcohol and Methcathinone (commonly referred to as CAT) with three participants describing regular recreational CAT use, and eight out of thirteen participants indicating frequent to regular alcohol use.

i)	**Substances are a coping mechanism:** *So, daar was 'n enorme groot stress op my. En dan het ek nog twee kleintjies ook, en dan moet ek die huis skoon maak, en dan moet ek nog werk. So, ek het CAT gebruik om te kan cope.* *[So, there was a huge amount of stress on me. And then I have two little ones as well, and then I have to clean the house, and then I still have to work. So, I used CAT to be able to cope.]* (Elize)
ii)	**Substances take away the depression and you feel euphoric:** *Dit gee my energie, so dan's ek soos, ja! Soos kom ons doen dit! En dan, dit voel of ek letterlik soos die wêreld soos… Ek kan enigiets doen! Niks kan my seer maak, niks kan my skade doen nie, ek is net, ek thrive, ek lewe my beste lewe op hierdie oomblik, niks anders maak saak nie.* *[It gives me energy, then I'm like, yes! Like come let's do it! And then, it feels like I could literally, like the world like… I can do anything! Nothing can hurt me, nothing can harm me, I'm just, I'm thriving, I'm living my best life at this moment, nothing else matters.]* (Kelly)
iii)	**The confidence to interact with people:** *And just like the experience of like having alcohol and then just like the confidence and being able to interact with people, you know, without like being afraid of them judging. It feels really nice.* (Rebecca)
iv)	**It's an escape:** *Snuif. Dis hoekom ek gesnuif het. CAT. Lekker in die neus op, sy's stil vir drie dae lank. Een lyn, twee lyne is gelyk aan vier dae se stilte vir my*. *[Snorting. That's why I snorted. CAT. Nicely up the nose and she's* [referring to herself in the third person] *quiet for three days. One line, two lines are equal to four days of silence for me.]* (Beth)

Evidence from the literature suggests a significant co-occurrence of BPD and substance use disorders among clinical and non-clinical samples (Trull et al., 2018). The most recent systematic review of the literature on persons diagnosed with BPD and co-morbid substance use disorders by Trull et al. (2018) suggests that the co-morbidity of BPD and substance use disorders can be understood from a variety of theoretical perspectives. One theory suggests that emotional dysregulation and

impulsivity are prominent features of both disorders leading to the development of both conditions (Trull et al., 2018).

A study by Wasmuth et al. (2020) explored occupational participation among a population of veterans diagnosed with BPD. One of the emerging themes related to substance use as an occupation participants chose to engage in to escape negative feelings or circumstances and others used substances as a form of recreation or leisure occupation (Wasmuth et al., 2020). Descriptions from participants illustrated in the verbatim quotes show similar motivations as participants indicated engaging in substance use to regulate negative affective states, such as anxiety or depression, as well as engaging in substance use because it makes life more 'colourful' and enjoyable. Findings from the study by Wasmuth et al. (2020) also indicated the negative consequences of alcohol abuse, specifically concerning increasing symptoms of suicidality. However, routine use of marijuana to escape negative affective states showed less evidence of negative consequences (Wasmuth et al., 2020).

An earlier study by (Wasmuth et al., 2014) explored the concept of addiction as an occupation. Findings from their study pointed out the dichotomy of addiction or frequent substance use in many areas. One such theme was one of 'connection' that described substance use as a tool for participants to feel more included and comfortable in social contexts, however, evidence also indicated isolation because of addiction. Megan describes the feeling of connection when out drinking with her friends:

> *Is jy net, lag jy en jy voel bietjie accepted, jy weet. Jy voel bietjie normaal teenoor die ander mense, saam met hulle.*
> *[You're just, you're laughing and you feel a little accepted, you know. You feel a little more normal towards other people, together with them.]* (Megan)

Findings from Wasmuth et al. (2014) suggest that connections achieved through using substances might be less satisfactory in the long run, even though it might decrease negative emotions related to connecting with others at the moment (Wasmuth et al.,

2014). Contradictory to the findings from Wasmuth et al. (2014) study, participants in this research study did not comment on the long-term consequences of substance use. This is perhaps due to many participants referring to their use of substances as 'recreational', and therefore, they might not perceive their substance use as consistent enough to yield long-term consequences now. Participants in the study by Wasmuth et al. (2014) also indicated the use of substances to decrease negative emotional states related to socialising with others. This supports the experience of participants in this study using substances to be less fearful and anxious about social interactions, as Kelly describes it:

> *Dit vat al my worries weg, so ek gee nie om wat enigiemand dink nie.*
> *[It takes away all my worries, so I don't care what anyone thinks.]* (Kelly)

Another interesting result from Wasmuth et al. (2014) study is experiences of participants both relinquishing and maintaining 'control' through substance use. This is similar to Kelly's experience of 'letting go and living her best life' (code ii) and the freedom that she affords while simultaneously feeling more in 'control' and a sense of invincibility.

Understanding substance use as an occupation that provides purpose and meaning for people diagnosed with BPD can support occupational therapists in developing rapport with people to ultimately collaborate on creating more satisfactory and perhaps more effective coping mechanisms in the occupational lives of this population.

c) <u>It's just you and nature/your pet</u>

The third sub-category described the importance of non-human elements, such as pets and being in nature, as valuable coping mechanisms to manage everyday life's challenges and feel a sense of connection and being understood or accepted. The following verbatim quotes illustrate the repeatedly relayed experiences of participants concerning nature and/or their pets. Seven out of thirteen participants described nature and/or their pet as valuable and significant coping mechanisms in their lives.

i)	**I find peace in nature:** *So, dan ook om die diere te sien, dan voel ek so at peace. Ek is 'n baie spiritual en natuur persoon, so ek vind my, my rus daarin. En veral as ek baie, baie, baie uit beheer voel en kwaad en sad en verlore maar leeg en al daai weird emosies potion hier binne in… Dit is vir my calming om net 'n stappie te vat in natuur.* *[So, then also to see the animals, then I feel so at peace. I'm a very spiritual and nature-person, so I find my, my rest in it. And especially when I feel very, very, very out of control and angry and sad and lost but empty and all those weird emotions potion inside me… I find it calming to just take a walk in nature.]* (Carly)
ii)	**It's just you and nature:** *Ek sal eerder gaan vis vang. Dis vir my baie lekker, want dis uit in die natuur en ek hoef nie vir mense te verduidelik en heeltyd met hulle te praat as ek moet praat nie. Ek kan afsluit.* *[I would rather go fishing. I enjoy it, because it's out in nature and I don't have to explain to people and talk to them the whole time when I have to talk. I can switch off.]* (Megan) *En ek voel baie selfbewus ook, wat mense judge oor wat dra ek, hoe lyk ek, is my make-up okay, is ek te weird of nie te weird nie, of... Natuur gee nie om nie.* *[And I feel very self-conscious as well, if people judge me for what I wear, how I look, is my make-up okay, am I too weird or not too weird, or… Nature doesn't care.]* (Carly)
iii)	**My pet is a coping mechanism for me:** *Dan* [when there is conflict in the household] *sit hulle* [the dogs] *rustig by my, en dan laat dit my kalmeer. En maak nie saak wat nie, ek meen, dit het my rerig gekalmeer. Honde laat my meer kalmeer as wat enigietsie anders doen. Dit het my, dis 'n coping mechanism, en hulle, dis baie, dit help baie vir therapeutic, dis baie therapeutic*. *[Then* [when there is conflict in the household] *they* [the dogs] *sit with me peacefully, and then it makes me calm down. And no matter what, I mean,*

	it really calmed me down. Dogs make me calm down more than anything else does... It got me, it's a coping mechanism, and they, it's very, it helps a lot for therapeutic, it's very therapeutic.] (James)
iv)	**My pet is my best friend:** *My Golden Retriever is my lewe… En ek sê altyd soos, as iemand soos, moet sê soos hierdie random persoon of hierdie persoon of bo my hond, sal ek sê skiet hulle, laat ek net my hond hou.* *[My Golden Retriever is my life... And I always say like, if someone like says, like this random person or that person or, above my dog? I would say shoot them, just let me keep my dog.]* (Kelly)
v)	**My pet is always there:** *Hy's altyd daar… As ek huil, dan die hond weet al as ek gaan huil, of ek is depressed, of ek is besig om deur een van my fases te gaan, of as ek op my period is en ek soek net 'n cuddle buddy, dan is my hond daar.* *[He's always there… If I cry, then the dog knows already that I'm going to cry, or if I'm depressed, or I'm busy going through one of my phases or if I'm on my period and I just want a cuddle buddy, then my dog is there.]* (Beth) *So, dis half daai, ek weet sy's* [Golden Retriever] *altyd daar. Dis half daai soos, net daai, ek weet ek kan op haar vertrou.* *[So, it's kind of that, I know she's* [Golden Retriever] *always there. It's kind of like, just that, I know I can trust her.]* (Kelly)
vi)	**I feel like my pet relates to me:** *Ag, sy was so sweet, sy't* [cat] *die cuteste persoonlikheid gehad. Sy't nie rerig daarvan gehou as jy soos teveel aan haar vat nie, so ek het gevoel sy relate kind of met my.* *[O, she [cat] was so sweet, she had the cutest personality. She didn't really like if you touched her too much, so I felt she could kind of relate with me.]* (Carly) *Ja, daar's iets, daar's, en dan sit ek en hy* [dog] *by mekaar en sê wel, hierdie dag was nou super shitty… En ek sweer hy verstaan.*

	[Yes, there's something, there's, and then he [dog] *and I sit together and say, well, this day was supper shitty… And I swear he understands.]* (Megan)
vii)	**My pet knows when I'm sad:** *Ek weet nie, diere voel jou emosies aan… Hy [dog] sal by my, ek sal nie iets doen of iets, hy sal daar by my kom lê en hy sal my nie uitlos nie. Hy sal my badkamer toe volg. Hy is baie protective oor my.* *[I don't know, animals can feel your emotions... He [dog] will be with me, I wouldn't do anything, he will come lie next to me and he won't leave me alone. He will follow me to the bathroom. He's very protective over me.]* (Megan)

The first two codes under this sub-category relate specifically to how participants experience the value and meaning of being in and around nature. The benefits of nature and nature-based therapy have been well-researched in countries such as Japan, with evidence indicating positive impacts on both psychological and physiological domains (Hansen et al., 2017; Kotera et al., 2022). Kotera et al. (2022) studied the effects of Shinrin-Yoku (forest bathing), which involves immersing in nature using the senses. The results indicated a positive impact on both physiological and psychological factors, specifically depression, stress, anger, and especially anxiety (Kotera et al., 2022). This supports participants' experiences of nature as a place of peace and calm.

Occupational therapy research has also explored the use of nature-based therapy as an intervention tool (Bonham-Corcoran et al., 2022; Koch, 2019). A study by Bonham-Corcoran et al. (2022) in particular, found that benefits from nature-based therapy are not universal, with benefits dependent on personal needs and individual characteristics. As illustrated by the verbatim quotes, a combination of peace and a lack of human interaction when engaging in occupations such as hiking or walking seems to be some of the needs met for participants in this study.

Hayden-Evans et al. (2018) conducted a study exploring the purpose and meaning provided by pets for people diagnosed with BPD. Findings from their research indicated five themes, namely 'Pets provide meaning and purpose', 'Pets influence

positive emotional attachment', 'Pets influence positive social connections', 'Pets promote participation and engagement in meaningful activities', and 'Pets have the therapeutic value' (Hayden-Evans et al., 2018). Except for a positive influence on social connections, descriptions by participants concerning the meaning and purpose found in their relationships with their pets are supported by all other findings from Hayden-Evans et al. (2018) study. Six of the thirteen participants in this research study specifically indicated their relationship with their pet as one of their most valuable and important relationships, citing positive emotional attachment and therapeutic value as some of the prominent reasons. Many participants also identified their pets as valuable in promoting engagement in meaningful activities. In addition to the verbata above, Sarah also described taking her dogs for regular walks as motivation to exercise more and surround herself with nature, and Kelly described taking her dog to a nearby park as something she finds enjoyable and restorative.

Understanding the value and meaning people diagnosed with BPD experience from engaging in occupations that involve nature and pet ownership can provide valuable insights into occupational therapists on how to incorporate these elements into therapeutic intervention to potentially improve the outcomes of these interventions. It also provides opportunities to use engagement in these occupations as tools for the development of healthy coping mechanisms that might be uniquely suited to the struggles and needs of people living with BPD. As social interactions and emotional regulation are areas where people with BPD experience the most difficulties, nature could be identified as a tool that provides relief in both these areas.

d) <u>It physically feels good</u>

The fourth sub-category under the 'Coping mechanisms' category includes participants' descriptions of engagement in occupations and activities that provide pleasurable physical experiences and assist in regulating negative and overwhelming emotional states. They also describe the value of concrete and tangible occupations that provide positive feedback and a release for overpowering emotions.

The following verbatim quotes illustrate the purpose and meaning of engagement in these occupations from the perspective of the participants. (Note the allusions to the extreme and the corroboration with intense emotions):

i)	**It physically feels good:** *Ja, en as ek, elke keer wat ek oefen kom die dopamiene uit, en skei mos uit in jou brein, en dit was, dit is een van die lekkerste gevoelens wat 'n mens kan kry onder die son. Dit laat my gemaklik voel, dit laat my beter voel.* *[Yes, and if I, every time I exercise the dopamines come out, it gets released in your brain, and it was, it is one of the best feelings a person can have under the sun. It makes me feel comfortable, it makes me feel better.]* (James)
ii)	**Physical pain is better than emotional pain:** *Um, maar vir my, wil ek die pyn voel. Om fisiese pyn te voel is vir my beter as emosionele pyn.* *[Um, but for me, I want to feel the pain. It's better to feel physical pain than emotional pain for me.]* (Megan) *En dan na die tyd, obviously as mens bad of stort, die brand gevoel dit hou ek van. En die, soos as 'n mens in die bed lê en mens draai en whatever en dit brand of dit steek of dit, ek hou daarvan.* *[And then afterwards, obviously when you bath or shower, the burning feeling I like. And the, like when you lie in bed and you turn and whatever and it burns or it stings or it, I like that.]* (Jenny)
iii)	**It gives me a sense of accomplishment:** *Gaming gee my 'n groot sense of achievement, soos very, want dan's ek van yes! Ek het dit, ek het dit! Kyk watse ranking is ek, soos… Dit sou ek sê is eintlik my grootste source.* *[Gaming gives me a big sense of achievement, like very, because then I'm like yes! I got it, I got it! Look at my ranking, like… I would say it's actually my biggest source.]* (Kelly)
iv)	**It releases frustration:** *Maar, in dieselfde asem help dit my klein bietjie om nie my shit te verloor deur die dag op die mense nie. Want hoe kwater ek is, hoe vinniger hardloop ek, hoe rustiger ek is, hoe rustiger is my pace.* *[But in the same breath, it helps a little to not lose my shit on people*

> *throughout the day. Because the angrier I am, the faster I run, the more calm I am, the more calm my pace is.]* (Beth)

Evidence from research exploring the experience of physical pain stimulation among people with BPD has found that participants reported lower perceived pain intensity and higher levels of pain threshold (Fales et al., 2021; Niedtfeld et al., 2010). The literature suggests that there is a neurological foundation for this phenomenon indicating that pain is processed differently in the brain of people with BPD (Niedtfeld et al., 2010). Arguments are also made for the characteristics and symptomology associated with BPD, being a strong influencing factor in these neurological changes, for example, symptoms of dissociation that are often characteristic of BPD (Fales et al., 2021). However, although speculative but not without merit, Fales et al. (2021) suggest that if individuals with BPD do not experience negative consequences related to self-injury, such as pain, it could be argued that the behaviour might be more easily reinforced if it does yield positive results, such as emotional regulation, relieving tension, or social attention.

From an occupational therapy perspective Matson et al. (2021) explored the experiences of women diagnosed with BPD using sensory modulation approaches as an intervention to alleviate symptoms. Sensory modulation involves using the body and senses to achieve emotional regulation, distraction, or soothing. Participants indicated that, in some cases, it was an effective replacement for self-harm, whereas other participants indicated that self-harm provided more certain and immediate relief (Matson et al., 2021). A focus on practical and concrete techniques could help manage the challenges of people with BPD concerning difficulties in emotional regulation. However, it seems important that occupational therapists need to consider the unique neurological physiology of persons diagnosed with BPD to collaborate on techniques that are effective and useful to this population.

The third (d-iii) and fourth codes (d-iv) under this sub-category, which relate to releasing frustration and achieving a sense of accomplishment, speak to engagement in occupations with tangible features and concrete measurable results. Research by Potvin et al. (2019) focused on the experience of occupations among a sample of

people living with cluster B personality disorders. Although the focus was not specifically only on people living with BPD, findings were similar to what participants in the current study reported. Participants in the study by Potvin et al. (2019) described the meaning of their occupations according to the intended function of engagement in these occupations, for example, providing positive effects on their mood. The function of occupations was therefore derived from the specific effects it had on their own experiences. This is consistent with descriptions from the participants in this study as well; for example, Carly explained how the physical application of her brush strokes when painting helped regulate her emotional state, such as aggressive brush strokes when she feels angry or softer brush strokes when she feels calm. Sam explained that she is attracted to mixed martial arts because she can channel aggression through physical fighting in a way that is socially accepted. Megan described gaming as a tool to manage her frustration in a socially approved manner:

> *Maar as ek 'n stresvolle dag gehad het, dan moet ek iemand skiet.*
> *[But if I've had a stressful day, I have to shoot someone.]* (Megan)

Participants in a study by Potvin et al. (2019) also indicated experiencing a sense of accomplishment through occupational engagement that yielded tangible and measurable results, adding to the meaning of engagement in these occupations. For example, engaging in vigorous exercise without concern for physical injury or consequence to experience intense bodily sensations or feeling validated by being able to see their high ranking among fellow gamers (Potvin et al., 2019). Similarly, in the current study, participants indicated feelings of accomplishment through engaging in occupations such as cooking a pleasant meal, experiencing success when completing gaming missions or improving gaming statistics, seeing plants grow from caring for them or completing an art project.

Occupation is a tool that can be used to facilitate many different positive outcomes for populations of people living with BPD. It can provide concrete, in-the-moment, often physical feedback that can be effective in emotional regulation or 'bigger picture' outcomes such as experiencing a sense of meaning and purpose. This means occupational therapy is in a unique position to provide effective interventions for

people diagnosed with BPD that speak directly to their unique needs and experiences.

4.3.1.4. Summary Theme 1: Living this life

The theme ‘Living this life’ sketched a picture of the experiences of participants living with BPD, illustrating the context from which we can attempt to understand the ‘why’ attached to many of the behaviours and occupational choices among this population. This is an important place to start when exploring how people with BPD experience meaning and purpose in their lives.

The first two categories, ‘Emotions control everything in my life’ and ‘Everything judges you’ illustrated the challenges and burdens that accompany living life as someone with BPD. It would be important to acknowledge that finding oneself in perpetual chaos both internally and externally is a challenge that not many would be willing to face, yet this is the reality for many people living with BPD, including participants in this study. In an online blog post by someone diagnosed with BPD, reflecting on ‘things people don’t get about borderline personality’ the author dryly expressed, “People who have BPD are at a sky-high risk of substance abuse according to the Institute of Duh at No Fucking Wonder University” (Mannen, 2015). Indeed, if we truly recognised the challenges of walking through life in the shoes of people living with BPD, many of the coping strategies employed by this population might not only be understandable, but almost logical attempts at survival. As Cone (2020) poignantly states, “Through this frame, apparently self-destructive behaviour is quite rational: cutting oneself is a ‘benign’ defence if the alternative is suicide” (p. 295). This is not to paint people living with BPD as hopeless victims, but rather an attempt to inspire empathy and compassion from healthcare practitioners and general society alike, for a population that is often stigmatised due to the consequences associated with the symptomology and characteristics of their diagnosis (Ociskova et al., 2017, 2023; Stiles et al., 2023).

The third category described the coping strategies employed by participants as attempts to mitigate the challenging symptoms associated with BPD. This is where occupational therapists can collaborate with their patients and clients diagnosed with BPD to find effective strategies, using occupation, that can alleviate the burden of symptoms experienced by this population and aim at creating meaningful occupational

lives worth living. Occupations identified by participants as meaningful and purposeful, such as self-harm and substance abuse, raise important questions concerning the dialogue around the categorisation of occupations. Hammell (2009b) argues that the narrowly defined categories of self-care, productivity, and leisure cannot be universally applied to all occupational engagement. Indeed, self-harm and substance abuse do not 'fit' as leisure, would not be considered self-care, and would not be generally described as productive. This challenges occupational therapists to expand our perspectives and critically evaluate how we understand and define occupation.

Furthermore, when considering the concepts of purpose and meaning, we are also challenged as occupational therapists to critically evaluate how we understand and apply these concepts when working with patients and clients diagnosed with BPD. Purpose and meaning are generally concepts that are considered positive, productive, and goal-orientated, directed at achieving well-being (Hammell, 2004). However, not all occupations necessarily adhere to this description, yet they are still considered meaningful and purposeful to those who engage in them. Meaning and purpose can be derived from occupations that are considered unhealthy, unacceptable, inappropriate, and societally unsanctioned (Kiepek et al., 2019; Twinley, 2013). Perhaps it isn't necessarily helpful to label occupations as 'good' or 'bad' and 'acceptable' or 'unacceptable'. If we are to live up to our goal as occupational therapists, enabling participation in meaningful occupations, we should look beyond these labels and listen to what our patients and clients living with BPD tell us they need.

4.3.2. Theme 2: Filling the void

The second theme describes participants' experiences regarding the intensity of their occupational engagement to satisfy the feeling of 'emptiness' they all indicated experiencing. The first theme largely focused on the 'why' of participants' engagement in occupations, whereas the second theme provides more clarity on the 'how' of participants' engagement in occupations. The four categories under this theme are: 'It fills that feeling of emptiness', 'I don't know when to stop', 'I actually feel something', and 'It's new and different'.

4.3.2.1. It fills that feeling of emptiness

The first category describes participants' experiences of the impact of the 'emptiness' they experience, which results in feelings of boredom and meaninglessness. The emptiness described by participants in this category is a common experience among persons diagnosed with BPD, to the extent that it is included as criterion number seven, 'chronic feelings of emptiness', in the diagnostic criteria for BPD described in the DSM-V-TR (American Psychiatric Association, 2022).

Table 4.6. Summary of category: It fills that feeling of emptiness

Category	Sub-category	Codes
It fills that feeling of emptiness	N/A	i) It fills that feeling of emptiness ii) I get easily bored iii) I don't experience accomplishment in most things I do

The following verbatim quotes illustrate examples of how participants experience the impact of chronic feelings of emptiness on their everyday lives:

i) It fills that feeling of emptiness:

I feel like it kind of fills that feeling of emptiness that we often feel with borderline personality disorder. You feel empty, so what are you going to do? You're going to try and fill it with something. [Claire – referring to when she engages in binge eating]

Ek wil nie… [pause to think] *Dis amper hoekom ek hierdie goed doen* [referring to substance use] *in 'n manier, dis om te ontsnap van daai bietjie waar jy, net niks voel op 'n manier. Nie soos 'n depressie niks voel nie, dis 'n ander tipe van niks voel nie.*

[I don't want to… [pause to think] *It's almost why I do this stuff* [referring to substance use] *in a way, it's to escape that feeling where you, just feel nothing in a way. Not like a depression kind of feeling nothing, it's a different type of feeling nothing [pause] You just feel empty.]* (Kelly)

ii)	**I get easily bored:** *Sometimes there's literally nothing that can help me get rid of the boredom. I will feel so frustrated because I am just bored out of my soul. And that also kind of goes hand in hand with my depression. I will lose all interest in anything available.* (Claire)
iii)	**I don't experience accomplishment in most things I do:** *Byvoorbeeld, my span kan wen* [referring to team she coaches], *okay great, want hulle het goed gespeel daai dag. Daar's nie vir my 'n accomplishment in meeste van die goed wat ek doen nie.* *[For example, my team could win* [referring to the team she coaches]*, okay great, because they played well that day. There's no accomplishment for me in most of the things that I do.]* (Sam) *Ja, ek vind nie…* [pause to think] *Ja, ek voel nie rerig daai accomplishment gevoel baie nie.* *[Yes, I don't find…* [pause to think] *Yes, I don't really often feel that accomplishment feeling.]* (Kelly)

The feeling of emptiness is common among many clinical populations and conditions other than BPD (D'Agostino et al., 2020). However, a clear definition of 'chronic emptiness' remains elusive with several researchers citing the challenges in defining a subjective experience that is unique to each individual and often difficult to articulate (D'Agostino et al., 2020; Miller et al., 2020), not to mention the challenge of "defining and measuring what is assumed to be an absence of experience" (Miller et al., 2021, p. 1). A systematic analysis of the literature on the feeling of emptiness conducted by D'Agostino et al. (2020, p. 287) proposed that "a feeling of emptiness is a complex, negative emotional state that is experienced in different ways by different individuals". Although the concept of chronic emptiness is complex and a single unifying definition is uncertain, researchers agree on the existence of an inextricable link between chronic feelings of emptiness and BPD (D'Agostino et al., 2020; Elsner et al., 2018; Miller et al., 2020, 2021).

Literature exploring the concept of chronic emptiness indicates a relationship between

feelings of emptiness and other affective states. From their systematic analysis of the literature, D'Agostino et al. (2020) found the feeling of emptiness relates to affective states, such as dysphoria, boredom, loneliness, and numbness. Research by Miller et al. (2021) explored the concept of chronic feelings of emptiness specifically among a population of participants diagnosed with BPD. Findings from their study indicated feelings of emptiness were associated with a "sense of nothingness, numbness, and disconnection from self and others" as well as "feelings of unfulfillment and purposelessness" (Miller et al., 2021, p. 5).

When considering the relationship between the feeling of emptiness and other emotional states, as described by D'Agostino et al. (2020) and Miller et al. (2021), it seems reasonable to argue that feelings of emptiness could be very distressing for any individual to experience.

Findings from a study by Miller et al. (2018) on the experiences of recovery for people living with BPD, indicated that more severe feelings of emptiness correlated with worse outcomes for participants, as well as increased impulsivity and frequency of self-harm behaviours (Miller et al., 2018). Therefore, people diagnosed with BPD seem to potentially engage in maladaptive behaviours as attempts to mitigate the distressing experience of chronic feelings of emptiness (Miller et al., 2018, 2021). This supports the experiences of participants in the current study as well, as Kelly described her engagement in regular substance abuse as an attempt to decrease the distressing and even intolerable feelings of emptiness (code i), which she describes as her 'biggest fear'.

> *Net soos waar jy voel soos 'n normale, quote unquote, normale mens wat net soos deur die lewe soos wandel, net soos, dit is nie…* [thinking] *Ek en my sielkundige praat baie daarvan, dit is my grootste vrees.*
> *[Just like where you feel like a normal, quote unquote, normal person that just like drifts through life, just like, it's not…* [thinking] *My psychologist and I talk about it a lot, it's my biggest fear.]* (Kelly)

Participants in the current study described depression and boredom as frequently co-

existing with their feelings of emptiness (code ii). Boredom was previously included as part of the diagnostic criteria for BPD, paired with feelings of emptiness, before being removed as a criterion from the DSM-IV in 1994 as it was deemed not useful in making a diagnosis because it seemed more characteristic of other diagnoses than BPD specifically (Masland et al., 2020). In an article exploring and reconsidering the lost criterion of boredom, Masland et al. (2020) argue that the observation that patients with BPD often presented with boredom as part of their clinical picture seemed to be persistent in the DSM-IV, and the DSM 5 and continues to be included in the DSM-5-TR. However, it has been relegated to only form part of the general description of BPD. The authors argue that boredom remains a clinically relevant aspect of BPD, despite its removal as a formal criterion (Masland et al., 2020). In the current study, four of the thirteen participants described boredom as a significant and challenging experience in their everyday lives.

Fahlman et al. (2013, p. 69) suggest that “the central defining feature of boredom is the aversive experience of wanting but being unable to engage in stimulating and satisfying activity”. Similarly, Westgate and Wilson (2018, p. 15) described boredom as “an affective indicator of unsuccessful attentional engagement in valued goal-congruent activity”. Both definitions indicate a two-sided experience of boredom, namely boredom due to an inability to maintain focus or attention and boredom due to a lack of meaning derived from engagement in activities. The Meaning and Attention Components Model of Boredom, proposed by Westgate and Wilson (2018) describes the experience of boredom because of these two components, namely attentional (the ability to focus) and meaning (the willingness to focus). Failure in the attentional component is described as a mismatch between the cognitive demands of an activity and the available mental resources, resulting in either overstimulation or under-stimulation (Westgate & Wilson, 2018). Participants in the current study described experiences of boredom that support the concept of an attentional component to boredom. It might also be interesting to note that six out of the thirteen participants presented with a co-morbid diagnosis of attention deficit hyperactive disorder (ADHD) or attention deficit disorder (ADD). Sam describes experiencing boredom at work due to not feeling mentally challenged, and that this experience of boredom negatively affected other areas of her life as well.

So, ek het baie verveeld geraak by die werk, en so aan, en dit het bygedra [to being unhappy at work]*. Nou kry ek nie geoefen nie, op daai stadium het ek nie geswot nie so ek's mentally nie gechallenge nie, so my brein raak verveeld. En die games wat ek het om my brein te challenge raak boring, en allerhande sulke tipe goed.*
[So, I became very bored at work and so on, and that contributed [to being unhappy at work]*. Now I also can't exercise, at that time I wasn't studying, so I wasn't being mentally challenged, so my brain gets bored. And the games I have to challenge my brain also become boring, and stuff like that.]* (Sam)

When considering the meaning component of boredom according to their model, Westgate and Wilson (2018) describe failure in this component as resulting from engagement in an activity that does not effectively serve to achieve valued goals, meaning, "the greater the congruency, the greater the sense of meaning, and thus the lower the likelihood of boredom" (p. 20).

Applying this concept to the engagement of persons diagnosed with a personality disorder in occupations, findings from Potvin et al. (2019), exploring the experiences of occupation among people diagnosed with a cluster B personality disorder, indicated that participants described engaging in occupations in the hope of potential outcomes or influences on their mood and that, at times, participants were not fully aware of why they chose to engage in said occupations. Therefore, the purpose or function of engagement in occupations was derived from the effects of their own experiences and was, thus, more so focused on the purpose of engagement in occupation rather than the meaning. Additionally, the purpose was only achieved if engagement in a specific occupation yielded the desired experiences (Potvin et al., 2019). Similarly, in the current study, participants described their engagement in occupations, specifically regarding attempts to fill feelings of emptiness as less focused on meaning and more focused on purpose. For example, Claire described engaging in binge eating (code i) to relieve the distress she is experiencing.

Exploring the concept of meaning as it relates to boredom and accomplishment, Marco et al. (2017) explored meaning in life as experienced by people living with BPD. Findings from their study indicated that participants had lower feelings of meaning in life compared to participants diagnosed with other mental disorders but without BPD.

They found that meaning in life was highly negatively correlated with symptoms of BPDi (Marco et al., 2017).

From an occupational therapy perspective, studies by Larivière et al. (2016) and Potvin et al. (2019) found that persons diagnosed with cluster B personality disorder experience less accomplishment and meaning from their occupational engagement. Therefore, it seems that decreased experiences of meaning and accomplishment, and increased experiences of emptiness and boredom characterise many of the experiences described by people living with BPD, including participants in the current study (codes ii and iii). It stands to reason that boredom and perceived lack of accomplishment would be an expected outcome among a population for whom meaning in life seems difficult to achieve, especially as meaning appears to be a very significant tool to combat the negative effects of feelings of emptiness, boredom, and a perceived lack of accomplishment.

The link between human occupation and meaning is well-established in occupational science and occupational therapy literature (Argentzell et al., 2012; Ikiugu et al., 2015; Ivtzan et al., 2013; Mcintyre & Howie, 2002; Persson et al., 2001; Ramugondo, 2017). Ikiugu et al. (2015) postulate that in recent times there has been increasing consensus among occupational therapists and occupational scientists that “meaningful occupations, among other things, provide people with a sense of control, identity, connection with other people, self-transcendence, competence, self-expression, and connection to a larger reality than oneself” (p. 48). Most suggested intervention strategies for BPD involve a focus on harm reduction and symptom management (Enoksson et al., 2022; Gillespie et al., 2022; Lieb et al., 2004; Ritschel & Kilpela, 2014), which is undoubtedly an important point of focus for intervention. Hammell (2004) suggests that the consequences of impairment due to illness can be altered through engagement in valued occupations, resulting in changes to both the experience of meaning and impairment. Perhaps this is the opportunity for occupational therapists to make a unique contribution to the treatment of people living with BPD. As the keepers of knowledge on how occupation can be a valuable resource in creating meaning, occupational therapists can collaborate with patients and clients to construct meaning through occupational engagement and possibly transcend the challenges accompanying living life as someone with BPD.

4.3.2.2. I don't know when to stop

The second category under Theme 2 describes participants' experiences managing the boundaries of their engagement in relationships and occupations. Participants described difficulty identifying when to stop or limit their engagement in occupations for 'coping' and enjoyment, resulting in a tendency to over-engage. Over-engagement in occupations was evaluated as such from the perspectives of the participants themselves rather than necessarily only based on feedback from their loved ones.

Table 4.7. Summary of category: I don't know when to stop

Category	Sub-category	Codes
I don't know when to stop	N/A	i) I don't know when to stop ii) I'm all in

The following verbatim quotes illustrate examples of participants' experiences of over-engagement in relationships and occupations:

i)	**I don't know when to stop:** *Ek het net 'n obsessie met hulle* [plants]*, so my hele kamer is vol. Dis tot op die punt waar my plante nou by my ma hulle moet wees* [in their room] *want ek het net teveel van hulle.* So, ek gaan ook op spending sprees waar ek net plante koop. *[I have an obsession with them [plants], so my whole room is full. It's to the point where my plants have to be at my mom's [in their room] because I have too many of them. So, I also go on spending sprees where I just buy plants.]* (Kelly) *But my problem became that I didn't know when to stop [consuming alcohol], so I would usually get to like the blackout point, where like someone would have to make sure that I got home safely.* (Rebecca)
ii)	**I'm all in:** *Dis, ek was, ek het soos, alles…* [thinking] *As jy vir my sê ons gaan nou 'n vriendskap bou, from the word go was ek all in. All in. Niks*

weggesteek, of enigiets. Ek's all in.
[It's, I was, I like, everything… [thinking] *If you tell me now we're going to build a friendship, from the word go I would be all in. All in. Not hiding anything. I'm all in.]* (Jenny)

The second criterion in the DSM-V-TR (American Psychiatric Association, 2022) for the diagnosis of BPD describes "a pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation" (p. 663). Persons diagnosed with BPD tend to idealise loved ones and potential friends or romantic partners, which includes a prominent need to spend a lot of time together as well as sharing very intimate details early in relationships (American Psychiatric Association, 2022, p. 753). Being 'all in' when it comes to relationships (code ii), therefore, seems to be a part of the symptomology associated with BPD. The initial over-investment and over-engagement in relationships associated with BPD might also be related to the first diagnostic criterion, namely "frantic efforts to avoid real or imagined abandonment" (American Psychiatric Association, 2013, p. 753).

When considering over-engagement in occupations Larivière et al. (2016) compared the objective and subjective life balance between women with and without a personality disorder. Findings from their study indicated a significant difference regarding subjective life balance between these two groups, with women diagnosed with a personality disorder describing that they felt more imbalanced when considering time spent on activities to satisfy their physical health needs, support gratifying relationships, feel competent, and provide meaning (Larivière et al., 2016). However, where participants in the current study reported instances of over-engagement in occupations, conclusions from the study by Larivière et al. (2016) found that women diagnosed with a cluster B personality disorder spent a significant portion of their time engaged in daily tasks and leisure activities but that they found their participation in these occupations dissatisfying, resulting in a perceived experience of lack of balance. Therefore, participants did not necessarily report over-engagement in occupations but rather that their engagement did not add to their perceived quality of life, resulting in feelings of 'not enough' (Larivière et al., 2016).

Potvin et al. (2019) found evidence of ‘over-investment’ in occupations among participants diagnosed with a cluster B personality disorder in their study. Participants described their over-investment in occupations as a coping strategy to relieve distressing emotions and experiences. However, they did not initially view their engagement as problematic but rather characterised it as over-investment because their loved ones disapproved of the extent of their engagement in occupations (Potvin et al., 2019). Participants in the current study did not explicitly describe their over-engagement in certain occupations as coping strategies. However, it is interesting to note that the occupations they described over-engaging in were the same occupations cited as coping strategies under theme 1, such as exercise, substance use, and gaming. Therefore, it is reasonable to suggest that over-engagement in these occupations might be related to achieving intended purposes, such as the experience of positive or pleasurable emotional states or avoiding negative or intolerable emotional states. Contrary to findings from Potvin et al. (2019) participants in the current study did not describe their participation in occupation as ‘too much’ due to the negative feedback or perceptions of loved ones but rather described it from their perspectives.

Wagman et al. (2015, p. 161) describes occupational balance as a “subjective concept that implies experiencing the right amount and variation of occupations”. As occupational therapists, we must collaborate with patients and clients diagnosed with BPD to find the ‘sweet spot’ for occupational engagement that meets their individual needs while supporting responsible maintenance of other important roles and responsibilities. In the case of persons living with BPD, meaningful occupational engagement might be experienced differently for this population, as the experience of meaning through engagement in occupations seems to be more challenging to attain due to the symptoms and characteristics of this diagnosis (Larivière et al., 2016; Potvin et al., 2019).

Facilitating balanced occupational engagement among people living with BPD might require occupational therapists to consider the nuances of how people with BPD experience their occupational engagement. Instead of simply labelling engagement as excessive, we might rather be encouraged to investigate and understand the purpose of over-engagement in occupations and collaborate with clients and patients to find

their specific ‘sweet spots’ in the ultimate pursuit of an occupational life worth living.

4.3.2.3. I actually feel something

The third category under the theme ‘Filling the void’ focuses on participants’ engagement in occupations that result in pleasurable affective states such as excitement and ‘feeling alive’. This starkly contrasts with the emptiness or ‘numbness’ participants described frequently experiencing in the previous category.

Table 4.8. Summary of category: I actually feel something

Category	Sub-category	Codes
I actually feel something	N/A	I actually feel something I like speed Cutting is thrilling The adrenaline I take chances, I love it

The following verbatim quotes illustrate examples of participants’ descriptions of the dichotomy of ‘feeling nothing’ and ‘feeling alive’ as well as their experiences of engaging in high-risk occupations and behaviours:

i)	**I actually feel something:** *En ek rook Cannabis, dit het my verskriklik baie gehelp, maar ek het dit vir die verkeerde redes gebruik daai tyd, want ek wou net iets gevoel het.* *[And I smoke Cannabis, it helped me a lot, but I used it for the wrong reasons at the time because I just wanted to feel something.]* (James) *Maar ek dissociate so laat ek nie weet wat aan gaan nie, binne-in my. En dis* [self-harm] *die enigste manier, o okay, ek voel actually iets.* *[But I dissociate to the extent that I don’t know what’s going on inside of me. And it* [self-harm] *was the only way, oh okay, I actually feel something.]* (Sam)
ii)	**I like speed:** *Ja, ek... I wanna feel alive. As jy op daai oomblik is, is net soos, as daar ‘n wiel bars, what the fuck, dan hopelik tref ek die ding dan’s ek op een slag dood. So, daai ja, die excitement completely outweighs the fear.*

	[Yes, I… I wanna feel alive. When you're in that moment, it's just like, if a wheel bursts, what the fuck, then hopefully I die instantly. So, that yeah, the excitement completely outweighs the fear.] (Megan – referring to when she is speeding on the highway)
iii)	**Cutting is thrilling:** *Probeer ek nou 'n mes… Nee, hierdie werk nie. Gaan kry ek my skerpmaker, klomp klein vinnige* [indicates cutting motion over arm] *toe's ek van, ja! Joh, hierdie is thrilling, hierdie is soos joh, soos ja, ek, ek hou daarvan om dit, dit te sien, soos... En toe van daar af het dit net erger en erger geword. Tot die punt waar ek nie langer as 4 maande al sober was van daai dag af nie, so, ja.* *[I tried a knife… No, this is not working. I got my pencil sharpener, a bunch of small quick* [indicates cutting motion over her arm] *and then I was like, yes! Joh, this is thrilling! This is like joh, like yes, I, I like to, to see it, like… And from that point it just got worse and worse. To the extent where I haven't been sober for more than four months since that day, so yeah.]* (Kelly – describing the first time she self-harmed)
iv)	**The adrenaline:** *Ja, dis soos 'n adrenalien shot want dis… Gaan ek geld maak? Wat gaan gebeur? Ek kort adrenalien nou en dan in my lewe.* *[Yes, it's like an adrenaline shot because it's… Am I going to make money? What's going to happen? I need adrenaline in my life every now and then.]* (Megan – referring to when she engages in high-risk and volatile investments) *Om daai oproep te kry, of die call deur te kry wat sê daar en daar, dit het gebeur, daai jaag daarna toe... Ek is nie een vir spoed nie, maar in daai konteks? Let's go! En dan om pasiente te red en hospitaal toe te vat en, al daai goed, het my groot adrenlien rush gegee. Dit was vir my lekker.* *[To receive that phone call, or when the call comes through that says there and there, this is what happened, the race to get there… I'm not one for speed, but in that context? Let's go! And then to save patients and take them to hospital, all that stuff, it gave me a big adrenaline rush. I enjoyed*

	it.] (Jenny – referring to when she was working as a paramedic)
v)	**I take chances, I love it:** *Die feit dat ek amper kan dood gaan van dit* [speeding on her motorcycle]. *Ek love dit om op die edge te wees van death itself* [laughs]. *Ek weet nie hoekom nie. Maar ook, daarso in* [street name] *waar ek oor en so deur die slopes gaan, vat ek maar ook lekker kanse. Ek gaan uit om basies my dood te veroorsaak. Ek gaan, ek vat kanse, en ek love dit*! *[The fact that I can almost die from it* [speeding on her motorcycle]*. I love being on the edge of death itself* [laughs]*. I don't know why. But also, there in* [street name] *where I go over and through the slopes, I take lots of chances. I basically go out to cause my own death. I go, I take chances, and I love it!]* (Beth)

According to the diagnostic criteria for BPD, as illustrated in the DSM-V-TR, criterion four describes "impulsivity in at least two areas that are potentially self- damaging" with examples of spending, sexual promiscuity, substance abuse, binge eating, and reckless driving (American Psychiatric Association, 2022, p. 752). Increased impulsivity is therefore considered a common characteristic of people diagnosed with BPD. The symptoms and characteristics associated with BPD, especially a tendency toward behavioural impulsivity may result in potentially high-risk behaviours (Hüpen et al., 2020).

The question of why people with BPD tend toward impulsivity and high-risk behaviours is relatively under-researched (Brüne, 2016; Hüpen et al., 2020) explored the altered psychophysiological correlates associated with risk-taking among a population of persons diagnosed with BPD. Risk-taking within the context of the research conducted by the authors can be defined as "a decision to engage in a behaviour for which there is uncertainty about its outcome and potential benefits or costs" (Hüpen et al., 2020, pp. 1-2). The authors investigated skin conductance responses of people diagnosed with BPD as compared to a healthy control group. Skin conductance responses are indicators of sympathetic nervous system activity, meaning that increased skin conductance responses are related to affective arousal. Results from their study indicated that the healthy control group showed elevated skin conductance responses

toward high-risk, whereas, in participants with BPD, there was no evidence of differential physiological sensitivity toward different levels of risk. The researchers concluded that a lack of differential responses to varying levels of risk among participants with BPD resulted in impaired behavioural adaptation and unfavourable task performance (Hüpen et al., 2020).

Brüne (2016) applied a behavioural ecological approach to BPD and risk-taking behaviours, arguing that the characteristics associated with BPD, including a tendency toward risk-taking behaviours, may be meaningful and understandable, even logical when considering a population that experiences the world as generally dangerous and unpredictable. Therefore, it seems that from a psychophysiological and behavioural ecological perspective, high-risk behaviours seem to be an inherent component of living with BPD. Another possible reason for an increased tendency toward high-risk behaviours and activities among people diagnosed with BPD relates to the relationship between boredom and emptiness as discussed under the first category, ‘It fills that feeling of emptiness’.

Bench and Lench (2019) found evidence in their study that experiences of boredom among their participants prompted a need to seek out novel experiences, even when these experiences were hedonically negative. Among a population with a higher incidence of experiencing boredom and experiencing the state of boredom more intensely, this might result in an increased incidence of engagement in higher-risk behaviours and activities (Arenas & Manzanedo, 2016; Bench & Lench, 2019). This is similar to James' description of engaging in cannabis use ‘for the wrong reasons’ and Sam’s description of engaging in self-harm as an attempt to ‘feel something’ (code i).

From an occupational therapy and occupational science perspective, Kiepek and Magalhães (2011) explored whether participation in activities related to addiction and impulse-control disorders could be classified as occupations. Findings from their analysis of the literature indicated that occupations related to addiction and impulse-control disorders can be meaningful even though they could potentially negatively contribute to health and well-being (Kiepek & Magalhães, 2011). Similarly, in the current study, Beth indicates a clear awareness of the potential negative consequences of speeding on her motorcycle, including possible death. However, she

experiences the rush of 'defying death' as meaningful (code iv). Therefore, as Megan states (code ii), the reward outweighs the risk. Kiepek & Magalhães (2011) argue that occupations are neither inherently healthy nor unhealthy as engagement in certain occupations in specific ways might be associated with positive and negative consequences.

The suggestion is not that high-risk occupations should be ignored or encouraged but rather that broadening the scope of what is considered occupation might provide opportunities to explore and understand the meaning and dynamics associated with engagement in high-risk occupations that have previously remained under-researched (Kiepek & Magalhães, 2011). Especially in the case of a population of people whose diagnosis seems to include a collection of symptoms that leave them psychologically and physiologically wired for increased engagement in high-risk occupations. Understanding the nature of engagement in high-risk occupations by people with BPD provides opportunities for occupational therapists to collaboratively assess with their patients and clients when or where engagement in occupations is helpful and unhelpful to find the nuances that ultimately result in an occupationally meaningful life.

4.3.2.4. It's new and different

The fourth and final category under the second theme, 'Filling the void,' describes participants' experiences of needing novelty in their everyday lives. Descriptions illustrated how experiences classified as 'new' and 'different' lead to positive and pleasurable emotional experiences worth pursuing.

Table 4.9. Summary of category: It's new and different

Category	Sub-category	Codes
It's new and different	N/A	i) I love learning new things ii) It's new and different

The following verbatim quotes illustrate participants' experiences incorporating novelty and the search for 'new' and 'different' experiences in their lives:

i)	**I love learning new things:** *Um, ja kyk, dis nie net die violent goed wat ek jol nie* [gaming]. *Ek hou van iets wat 'n storie het en wat geskiedenis het ook aan die, soos ah, ek's baie into Norse mythology dis vir my baie interessant.* *[Um, yeah look, it's not just violent stuff I play* [gaming]. *I like things that have a story and that also has history to it, like ah, I'm very into Norse mythology, I find it very interesting.]* (Megan) *And I mean that's a way to fill my cup with knowledge [researching things she finds interesting]. So, to make myself feel better, I also like, I love learning new things. I love it.* (Claire)
ii)	**It's new and different:** *En meer kreatiwiteit. I mean, dis nie altyd dieselfde goed oor en oor nie. Jy kry ander kliente, jy kry mense met ander perspektiewe en goedjies. Daai's vir my baie lekkerder, om free-spririted te wees.* *[And more creativity, I mean, it's not the same stuff over and over again. You get different clients, you get people with different perspectives and stuff. I really enjoy that, to feel free-spirited.]* (Carly – describing creating and selling art to clients) *Dit was heeltemal hierdie vreemde konsepte wat net neergesit word in 'n goeie manier*. *Goed wat jy nie kan depict in, voel ek soos um, met regte mense nie*. *[It's these strange concepts that are put down in a good way. It's like, um, stuff you can't depict in, I feel like um, with real people.]* (Kelly – describing her interest in anime)

The need for an active pursuit of novelty can be described as normal human behaviour present from birth (Bench & Lench, 2019). It is, therefore, not a characteristic unique to people with BPD but rather a universal human phenomenon. However, there is evidence that the desire for novelty can be heightened and increased during experiences of states of boredom (Bench & Lench, 2019). Therefore, it is an arguably logical conclusion that a population with a higher incidence and propensity toward

experiences of boredom, as is the case for persons diagnosed with BPD (American Psychiatric Association, 2022), would result in higher incidences of seeking out novel experiences, especially experiences that yield changes in emotional states.

An important consideration in the exploration of novelty seeking is the impact of novel or 'different' experiences on changes in affective states (Arenas & Manzanedo, 2016; Bench & Lench, 2019). Bench and Lench (2019) have identified boredom as a strong motivator for engagement in novel experiences and activities due to the attractiveness of changing one's current affective state by seeking out different and more intense emotional experiences. Whether motivated by escaping boredom or other potentially uncomfortable affective states, people with BPD are well documented engaging in behaviours and occupations in the pursuit of emotional experiences (as discussed under theme 1: 'Living this life'). In the current study, Elize describes frequently changing her environment and her 'look' as attempts to gain a new 'lease on life'.

> *En dan die re-modeling van my huis, en miskien my look, het my net half 'n nuwe lease gegee in my lewe. So, ek het konstant 'n nuwe lease gesoek.*
> *[The re-modelling of my house, and maybe my look, just sort of gave me a new lease on life. So, I was constantly looking for a new lease.]* (Elize)

Similarly, Kelly has also identified changing her appearance as a means of introducing novelty and excitement into her life since she was a child.

> *Ek het van klein af al verander ek ook my appearance, soos ek sou my hare net randomly begin sny, en my poppe se hare ook, Ek love dit!*
> *[Since childhood I've changed my appearance, like I would just randomly start cutting my own hair, and my dolls' hair as well. I love it!]* (Kelly)

Boredom and a need for novelty or sensation-seeking behaviours can undoubtedly lead to engagement in occupations that might be considered negative or high-risk (Arenas & Manzanedo, 2016; Bench & Lench, 2019). However, it is also true that the tendency to seek out stimulation, resulting in experiences of excitement or increased creativity (code ii), can have very positive effects and results for people who choose to

engage in such occupations. As occupational therapists, there might be opportunities, when working with people diagnosed with BPD, to use this natural and perhaps increased curiosity and need for novelty in positive ways through adapting routines and encouraging engagement in stimulating and meaningful occupations.

4.3.2.5. Summary Theme 2: Filling the void

The theme ‘Filling the void’ illustrated participants’ experiences of attempting to manage the boundaries of their occupational engagement in the face of persistent chronic feelings of emptiness that can be debilitating, resulting in feelings of meaninglessness and purposelessness.

The first category, ‘It fills that feeling of emptiness’, illustrated participants’ chronic feelings of emptiness that are strongly related to intense experiences of boredom. This category seems contradictory to the second category, ‘I don’t know when to stop’, and the third category, ‘I actually feel something’, that describes experiences of over-investment in occupations and the thrill of intense emotional experiences. Borderline personality disorder is a diagnosis that presents multiple contradictory experiences (Cone, 2020), which can be distressing and challenging to resolve, as is the nature of dichotomies. One of these dichotomies seems to be the experience of feeling ‘too much’ on the one hand and feeling ‘nothing’ on the other. Akin to a swinging pendulum, when one experiences chronic emptiness and ‘numbness’ on one end of the extreme, the swing to the other end involves creating intense and extreme emotional experiences, for example, the adrenaline rush that accompanies defying death itself. When both realities exist in one person simultaneously, finding balance could be considered a nearly impossible task.

In occupational therapy, the notion of balance has often been defined as an equal distribution of time and energy between different occupation categories, namely work, self-care, and leisure. This suggests that consistent choices must be made between different areas of occupation to achieve balance (Pierce, 2003) and avoid over-investment or under-investment in any given occupation. For someone living with BPD and a tendency to live within extremes due to the impact of their symptomology, this seems like a limiting view for achieving balance in their occupational engagement.

Pierce (2003) describes the attainment of balance through designing appealing occupations consisting of a mixture of pleasure, productivity and restoration. Contrary to the categorisation of occupation as work, self-care, and leisure, the mix of pleasure, productivity and restoration is characterised by ‘and’ rather than ‘or’. Therefore, these concepts co-exist during engagement in occupation rather than being separate (Hammell, 2009b; Karlsson et al., 2023; Pierce, 2003).

A focus on subjective experiences of productivity, pleasure, and restoration during occupational engagement rather than the balancing of specific occupations provides opportunities for more nuance and, ultimately, balance in occupational engagement for people diagnosed with BPD. This means collaborating with our clients and patients diagnosed with BPD to create occupational experiences that provide pleasurable, stimulating, and meaningful experiences within their occupational engagement.

4.3.3. Theme 3: Creating meaning

The third and final theme illustrates participants’ experiences engaging in occupations to create meaning. They described the creation of meaning occurring through different avenues, mainly through constructing their identities, feeling like they have an impact or influence on others and the world around them, and making sense of their lives and experiences. The two categories under the theme ‘Creating meaning’ are ‘You can create something beautiful’ and ‘I don’t know who I am’, with the second category consisting of two sub-categories, namely, ‘That’s my thing’ and ‘Making sense of it all’.

4.3.3.1. You can create something beautiful

The first category describes participants’ experiences of meaning through creating art and expressing themselves through means they identified as aesthetically pleasing. Participants’ descriptions mainly centre around creating ‘products’ that are aesthetically beautiful and unique. They also described the value of witnessing the concrete and tangible impact of what they made on others around them.

Table 4.10. Summary of category: You can create something beautiful

Category	Sub-category	Codes
You can create something beautiful	N/A	i) You can create something beautiful ii) Creativity coming out iii) Art is my passion iv) More creativity in my art v) Being able to express myself

The following verbatim quotes illustrate participants' descriptions of experiencing meaning through engaging in occupations that allow creativity and impacting others through their creations. Six out of thirteen participants described regular engagement in artistic and creative occupations as part of their daily lives.

i)	**You can create something beautiful:** *Dit is nogals vir my interessant hoe so fyn sand iets kan mooi maak, heeltemal iets anders kan maak. So, dis part of, ek dink, dit is soos...* [thinking] *Ek sou sê dit is soos seisoene, elke seisoen het sy mooi deel.* *[It's interesting to me how such fine sand can make something beautiful and completely different. So, it's part of, I think, it's like…* [thinking] *I would say it's like seasons, every season has something beautiful.]* (Megan – referring to sandblasting)
ii)	**Creativity coming out:** *Film making is so interessant, hoe jy iets kan maak en soveel meaning kan kry uit iets uit wat mense nie raak sien nie. Soveel emosies wat jy kan oordra, soveel stigmas wat jy tot 'n einde kan bring, soveel like goed wat jy kan doen met jou film making. Toe eindig ek nou op film making doen, want ek het die editing gedeelte ge-love daarvan, want dit was net soos kuns, just moving art.* *[Film making is so interesting, how you can make something and get so much meaning from it that people don't notice. So many emotions you can communicate, so many stigmas you can bring to an end, so many like things you can do with film making. So, I ended up doing film making, because I loved the editing part of it, because it's just like art, just moving art.]* (Steph)

iii)	**Art is my passion:** *Ek sal baie graag meer van 'n, 'n graphic designer of some sort wees, baie meer kunstig* [as opposed to her current job in admin]*. Ek is baie kunstig aangelê, en ek, dis my passie. En ek, ek het al geweet van kleins af dis wat ek wil doen. As ek groot word gaan ek 'n kunstenaar wees.* *[I would love to be more of a, a graphic designer of some sort, a lot more artistic* [as opposed to her current job in admin]*. I'm very artistically inclined, and I, it's my passion. And I, I knew since childhood that's what I wanted to do. When I grow up I'm going to be an artist.]* (Carly)
iv)	**More creativity in my art:** *Dit* [referring to cannabis] *het my eintlik meer motivering gegee om goed te doen, soos baie meer kreatiwiteit in my kuns en goed.* *[It* [referring to cannabis] *actually gave me more motivation to do things, like a lot more creativity in my art and stuff.]* (Carly) *Maar die enigste keer wat ek kon verf is wanneer ek op CAT was want dit sit my in 'n ander wêreld van konsentrasie.* *But the only times I could paint was when I was on CAT because it put me in another world of concentration.* (Elize)
v)	**Being able to express myself:** *Yes, I love being able to express myself through makeup and fashion and hairstyling and jewellery, piercings, tattoos, all of that I love. It's a form of expression and it's kind of a form of therapy for me.* (Claire)

The link between psychiatric vulnerability and creativity has been a topic of interest for a long time, colloquially and scientifically. Aristotle has been famously quoted saying that *no great genius has ever existed without a strain of madness* (Azcona-Granada et al., 2024). Interdisciplinary literature exploring the potential link between creativity or a propensity toward creative pursuits and BPD has yielded mixed results (Azcona-Granada et al., 2024; Leutgeb et al., 2016). A study by Azcona-Granada et al. (2024) investigated potential overlapping genetic influences between creativity and borderline personality symptoms. Results from their study showed evidence of a common genetic mechanism between borderline personality symptoms and creativity. Contrary to these

findings Leutgeb et al. (2016) investigated the link between brain activity and grey matter concentration in different areas of the brain associated with BPD symptomology and creativity, with results indicating no significant link.

Exploring beyond the confines of the BPD diagnosis, there is evidence in research of a link between creativity and bipolar disorder. Johnson et al. (2012) identified the predominant factors contributing to increased creativity and engagement in creative tasks among participants diagnosed with bipolar were impulsivity and openness to experience. These are characteristics associated with BPD as well (American Psychiatric Association, 2022), not to mention the high co-morbidity between BPD and bipolar disorder (Fornaro et al., 2016; Frías et al., 2016; McDermid et al., 2015), indicating a clear link between these diagnoses. Notably, in the current study, seven out of thirteen participants had a co-morbid diagnosis of bipolar mood disorder as well.

The relationship between substance uses and enhanced creativity has also been explored in research. Iszaj et al. (2018) investigated the use of alcohol and cannabis among artists as necessary tools for the artistic creative process. Results indicated that participants relied on these substances to facilitate the emotional states to engage effectively with their artistic and creative processes. This is similar to Carly's description of getting the necessary motivation to engage in her creative pursuits and Elize's description of using CAT to provide her with the necessary focus to engage in creative activities (code iv).

From an occupational therapy perspective, Blanche (2007) argued that creativity plays an important role in many occupations and that creative occupations are "in some respects one of the purest ways for a person to express intrinsic motivation, authenticity, and a sense of autonomy" (p. 21). This suggests a sense of control that can be experienced through engagement in creative occupations, where feeling in control is often an elusive experience among people living with BPD (as discussed under theme 1: Living this life). Steph describes the sense of control she experiences through the creativity of her job as a wedding photographer and videographer.

En dis eintlik, op 'n manier hang dit van my af watse kleur ek wil, watse gevoel… Daar's 'n general gevoel van hoe ons films lyk vir kliente, maar ek het op 'n, ek het beheer oor watse emosie ek wil oor dra op die manier hoe ek dit gaan colour grade. [And it's actually, in a way it's dependent on me what colour I want, what feeling… There's a general feel of how our films look for clients, but I have in a way, I have control over what emotions I'd like to communicate by the way I choose to colour grade.] (Steph – describing the process of editing wedding video footage)

Blanche (2007) continues to describe two types of creativity through occupational engagement, namely creativity that has an instrumental value and is goal-directed towards creating a specific product and creativity that is spontaneous, has an ambiguous goal, and is valued for providing enjoyment rather than attempting to achieve a certain outcome (p. 22). Similarly, Pierce (2003) describes creative occupations, such as arts and crafts, as possessing both productive and pleasurable qualities, consisting of a blend between producing a satisfying end-product and enjoying the in-the-moment process of 'doing' (p. 86). Participants' descriptions of their engagement in creative occupations in the current study support the conceptualisations suggested by Blanche (2007) and Pierce (2003) as they indicated both a product-centred satisfaction that accompanies their creative pursuits (codes i and ii) and a process-centred enjoyment of the creative process (codes ii and v).

Another important characteristic of creative occupations is that they allow one to express thoughts, feelings, and experiences that might be difficult to articulate otherwise. Borovica et al. (2024) employed arts-based methods in their study consisting of participants diagnosed with BPD to understand the complexities of life for this population. Through different art forms, including visual art like painting or sculpting and writing poetry, participants could illustrate the complexities of their lived experiences as someone diagnosed with BPD in ways that garnered more understanding and empathy from others (Borovica et al., 2024). Steph described a similar experience of being able to understand and express herself better through art.

As ek wat ek voel, wat ek sien [express]*. Want mense sien nie die wêreld soos wat ek dit sien nie... So, ek kan dit makliker uitbeeld, en ek kan myself makliker verstaan en uitbeeld as ek kan wat ek sien en dink op papier neersit.*

[If I can [express] *what I feel, what I see. Because people don't see the world like I see it… So, I find it easier to illustrate, and I can understand and express myself better when I can put what I see and think on paper.]* (Steph)

Creative occupations are undeniably a valuable tool for occupational therapists to use and encourage among their patients and clients living with BPD. It provides opportunities for the experience of meaning, accomplishment, satisfaction, and other pleasurable affective states that can sometimes feel few and far between for people living with BPD. Furthermore, people diagnosed with BPD often describe their emotional and relational experiences as chaotic and contradictory (Cone, 2020), making it very difficult for them to understand their feelings and thoughts themselves, not to mention trying to communicate these thoughts and feelings to others in understandable ways. Creative occupations can allow people with BPD to express their thoughts, feelings, and experiences in ways that can inspire more clarity, compassion, and connection from themselves and others around them.

4.3.3.2. I don't know who I am

The second category illustrates participants' experiences of occupation to establish an identity for themselves and how they try to understand themselves and their experiences. The third diagnostic criterion for BPD as described in the DSM-V-TR refers to "identity disturbance with markedly and persistently unstable self-image or sense of self" (American Psychiatric Association, 2022, p. 752) Six out of thirteen participants in the current study indicated that they 'don't know who they are' and experience their identities as inconsistent and unclear.

Table 4.11. Summary of category: I don't know who I am

Category	Sub-category	Codes
I don't know who I am	a) That's my thing	i) That's my thing ii) It makes me different iii) I like shocking people iv) I like making people happy
	b) Making sense of it all	i) Having someone put into words what you're feeling really helps ii) Writing helps me make sense iii) You put those emotions on paper

a) <u>That's my thing</u>

The first sub-category under this category, and the final theme, describes occupations and behaviours participants engage in to differentiate themselves from others and attempt to establish their own identities. The following verbatim quotes illustrate participants' experiences practicing and implementing this self-differentiation. Note how the first three codes under this category indicate a clear focus on wanting to separate themselves from the 'norm' and not fall into general societal conformity.

i) That's my thing:

Ek dink ja, in 'n manier het ek gedink soos, soos aan die begin was ek baie meer teruggetrokke gewees daarmee [anime]*, en toe eventueel toe besluit ek net soos whatever, soos um, toe't ek dit net meer begin express en goed soos dit. So, dit, aan die begin was die meer ietsie wat ek vir myself gehou het* [because others thought it was weird]*, maar dit het so baie geraak op 'n stadium, sou ek sê, soos want almal het geweet, ja, as daai sin maak. Toe besluit ek net ja, ek embrace dit net, dis nou, dis nou my ding.*

[I think yeah, in a way I thought like, like initially I was much more withdrawn about it [anime] *and then eventually I decided like whatever, like um, I just started to express it more and stuff like that. So, it, initially it was something that I kept to myself* [because others thought it was weird]*, but it got to a point where I would say everyone knew anyway, yeah, if that makes sense. So, I decided yes, I'm just going to embrace it, it's now, this is my thing.]*

	(Kelly)
ii)	**It makes me different:** *Soos byvoorbeeld, um, my styl klere te vind, en soos nie om in te pas by die norm nie, maar om my te wees en my klere te dra, my make-up te doen soos wat ek dit wil hê, en nie om by jou in te pas nie. Um, uit te figure by watse niche fit ek in, soos is ek meer van 'n hipster kind of is ek meer van 'n hippy kind of is ek kind of in between of 'n rockstar of what. Ek probeer nog daai hele ding uit te figure. Dis soos juis op Sims* [computer game]*, wanneer jy um, moet klere kies en character traits moet kies. Ek het nog nie daai heeltemal uit ge-figure nie, so daai staan nog vir my blank op die oomblik.* *[Like for example, um, finding my style of clothes and not like to fit in with the norm, but to be me and to wear my clothes, doing my make-up the way I want to, and not to fit in with you. Um, to figure out which niche I fit into, like am I more of a hipster kid or am I more a hippy kid or am I kind of in between a rockstar or what. I'm still trying to figure out that whole thing. It's just like on Sims* [computer game] *where you um, have to choose clothes and character traits. I haven't figured that out yet, so that is still a blank for me at this stage.]* (Carly)
iii)	**I like shocking people:** *So, so ek love dit! Ek like dit om rebels te wees, ek like dit om 'n impak te maak met mense, of hulle te verras, of hulle te um, shock.* *[So, so I love it! I like being rebellious. I like to make an impact on people, or to surprise them, or to um, shock them.]* (Steph – referring to her choice of fashion, tattoos, and piercings) *In 'n manier soos like ek dit nogal, dit klink baie soos morbid en goed soos dit, maar om mense so bietjie af te scare. Net soos met die manier wat ek soos aantrek en goed soos dit. Maar dis ook lekker om te sien hoe ou tannies vir jou staar, met hierdie* [pulls shocked face] *Satan kind!* [laughs]. *[In a way I kind of like it, it sounds very like morbid and stuff like that, but to scare people off a little. Just like by the way I dress and stuff like that. But I also enjoy to see how old ladies stare at you with this* [pulls shocked face] *Child of Satan!* [laughs].*]* (Kelly)

iv) I like making people happy:

Well, ek dink jy het my ook nou al so opgesom, ek hou daarvan om mense happy te sien, ek hou daarvan om mense happy te maak.
[Well, I think you also know this about me by now, I like seeing people happy, I like making people happy.] (Mandy)

Making people feel good about themselves makes me feel good about myself. Doing acts of service for people, it's actually selfish of me because it makes me feel good and that's why I do it. (Claire)

The experience of identity disturbance among people diagnosed with BPD is well-established in the literature (Fuchs, 2007; Jørgensen & Bøye, 2022; Kaufman & Meddaoui, 2021; Lind et al., 2019; Schmidt & Fuchs, 2021). Interdisciplinary research on the dynamics of identity disturbance among people diagnosed with BPD has revealed 'identity diffusion' as a prominent feature of the challenges faced by this population regarding identity disturbances (Fuchs, 2007; Jørgensen & Bøye, 2022; Lind et al., 2019; Schmidt & Fuchs, 2021). Fuchs (2007) describes identity diffusion as an individual's "inability to establish a coherent self-concept" and instead adopting a tendency to switch "from one present to the next and being totally identified with their momentary state of affect" (p. 381). Thus, people with BPD seem to be completely identified with their present affective states and have difficulty using past experiences to craft a consistent and integrated concept of themselves over time (Fuchs, 2007; Jørgensen & Bøye, 2022).

Exploring the experience of identity disturbance from the perspective of people living with BPD, Jørgensen and Bøye (2022) identified nine categories summarising the experiences of participants diagnosed with BPD in their study. Findings from their research indicated that participants experienced confusion and a lack of an established inner sense of who they were. Participants described this experience, or lack of knowledge of themselves, as being greatly influenced by BPD symptoms, such as fluctuating emotional states, chronic feelings of emptiness, and negative self-evaluations (Jørgensen & Bøye, 2022). Similarly, in the current study, Rebecca describes the same confusion and frustration with not being able to separate 'herself' from her diagnosis.

This is who I am. You know, it's like… You know, with depression, it's like, you know, you're living life and whatever and then it comes and, you know you take the medication or whatever and it's okay. But like with BPD [borderline personality disorder], it's everything. You know, it's the way you live life. It's the way you relate to people. It's the way you see yourself. It's the way you understand the world. It's everything… And I don't know… Is there a me outside of my mental illness? Doesn't feel like it. (Rebecca)

Furthermore, Jørgensen and Bøye (2022) findings described participants relying on masks and façades as survival tools and attempts to stabilise their sense of self. It resembles trying on different 'outfits' or playing different characters to see which works best to achieve connection or avoid abandonment. Megan shares a similar experience of 'losing herself' due to wearing different masks to garner social acceptance.

Want jy mirror elke persoon wat jy ontmoet. Dan mirror jy hulle reaksie of hoe hulle optree, dan tree jy soos hulle op, laat jy nie gaan voel hulle gaan jou uitstoot nie, want abandonment is 'n baie groot ding vir ons. So, ja… Dis nogal, jy't dan oor die jare het jy jouself net verloor, jy weet rerig nie meer wie jy is nie.
[Because you mirror each person you meet. Then you mirror their reactions or how they behave, then you behave like them, so you don't feel like they're going to push you out, because abandonment is a very big thing for us. So, yes… It's actually, you lose yourself over the years, you don't really know who you are anymore.] (Megan)

One example of this mask or façade employed by participants in Jørgensen and Bøye (2022) study was the use of body modifications, such as tattoos and piercings. Weiler et al. (2024) conducted a systematic review and analysis of the literature exploring the mental functions of body modification and decoration. Findings from their study indicated two main motivations for people who engage in this practice, the first being to indicate group affiliation and the second, interestingly semi-contradictory, to practice individuation (Weiler et al., 2024). Although this study was not conducted among individuals diagnosed with mental illness or BPD, it is notable that Jørgensen and Bøye (2022) found evidence among their participants diagnosed with BPD of a similar

contradiction. Participants indicated general feelings of exclusion and being on the outside, resulting in feelings of desperation for social acceptance while simultaneously fearing conformity and dependence (Jørgensen & Bøye, 2022).

Cone (2020) describes this phenomenon among people with BPD as a 'double-bind' referring to people with BPD being trapped in an irreconcilable circumstance resulting in the 'double-think' of having to deny this reality. The author continues to describe this reality as "a shapeshifter that involves the need for both merger and separation" (Cone, 2020, p. 295). Similarly, participants in the current study indicated the need to differentiate themselves from others (codes i, ii, iii) while still wanting to achieve social acceptance and approval (code iv). However, using alternative fashion statements and body modifications or body decorations could serve as a type of armour to avoid people who might judge or disapprove and specifically attract or connect with people who are less likely to judge or disapprove. Kelly, for example, describes her aesthetic as intentionally 'scaring' specific types of people off and keeping them at a distance (code iii).

From an occupational therapy perspective, the Model of Human Occupation (MOHO) provides fertile ground for discussions around identity. The main components described in this practice model relate to occupational identity and occupational competence and the interaction between these two concepts to achieve occupational adaptation (Taylor, 2017). Falklöf and Haglund (2010) applied the MOHO to explore the experiences of women diagnosed with BPD concerning their daily occupations and adaptation to daily life. Findings from their study indicated an overarching theme of participants having few organised daily activities and poor personal causation which resulted in difficulties making changes and adapting to daily life. Personal causation refers to one's "sense of personal capacity and self-efficacy" (Taylor, 2017, p. 473).

Furthermore, findings from Falklöf and Haglund (2010) indicated that participants had specific interests that gave meaning to their lives, however, descriptions of experiencing incompetence outweighed experiences of competency. Participants also described instances of experiences related to positive self-image, however, instances of negative self-evaluations and poor personal causation greatly outweighed positive experiences. The reasons for variations in the level of competence experienced by

participants related to their occupational engagement were identified as greatly being influenced by factors such as mood fluctuations (Falklöf & Haglund, 2010).

Similarly, in the current study, participants referenced specific occupations in which they experienced high levels of competency to the extent that they identified these occupations as ‘their thing’ (code i). However, at the same time, participants experienced themselves as incompetent to handle everyday life and the challenges it might bring. Claire describes herself as very confident in her abilities related to styling, fashion, and make-up (competency). She experiences herself as an intelligent person who gives great advice (competency), however, she cannot apply the advice she gives to others to herself (incompetency).

*I also love helping people with their own style, because I have a very good talent for it. I'm a very good stylist. So, styling people I, I just have a knack for fashion. And with beauty, I started modelling when I was, so this includes beauty and fashion, I started modelling when I was three years old. It's basically my whole identity. (*Claire)
I give great advice, but I don't always follow it. That is a big problem of mine. I don't know, I genuinely don't know. I think, it's part of like the borderline part of like self-sabotage and self-destructive behaviour. But I give the best advice and then I listen to myself talking to someone else and I'm like, you're, you're literally like mega mind! Why don't you follow this advice yourself, you idiot! (Claire)

Participants from a study by Potvin et al. (2019) diagnosed with a cluster B personality disorder described socially unsanctioned occupations such as substance use and excessive gaming as part of their identities despite facing disapproval from their loved ones concerning their engagement in these occupations. This is similar to Kelly's experience of identifying anime as ‘her thing’ despite facing judgment from her peers who viewed her engagement in this occupation as ‘weird,’ as well as her preference for a fashion aesthetic that others might view as scary or off-putting (code I and iii).

Findings from a study by Wasmuth et al. (2020) among a population of veterans diagnosed with BPD indicated participants over-identifying with their role as a person who is ‘mentally ill’ and that they experienced themselves as ‘different’ from others,

such as family members or peers, as they were people who ‘couldn’t cope’ with everyday life. When considering the overall difficulty of living life as someone diagnosed with BPD, experiencing low occupational competency and, therefore, an inconsistent occupational identity is hardly surprising. Symptoms and characteristics of BPD, such as fluctuating affective states, impulsiveness, and unsatisfying relationships would most certainly result in experiences of occupational incompetence and confusing occupational identity. Evidence suggests that disability can affect both identity and competence, however, its effects are more readily visible in competence (Taylor, 2017).

Occupational therapists have an important role to play in supporting people diagnosed with BPD to experience competence in occupational areas that are important and valuable to them. This can be impactful in creating an occupational identity that is not overshadowed by the negative experiences caused by the debilitating symptoms of BPD but potentially can transcend these experiences. The goal for collaboration between occupational therapists and people with BPD could be to create an occupational identity that is not only based on what we are trying to avoid or flee from but rather on what we would like to move towards.

b) Making sense of it all

The second and final sub-category describes participants' efforts through engagement in occupations to answer the question posed by this theme, ‘Who am I?’ by attempting to make sense of their emotions and experiences. The following verbatim quotes illustrate participants’ descriptions of engaging in occupations that provided opportunities for reflection and clarity.

i)	**Having someone put into words what you're feeling really helps:** *Like I, I feel validated mostly because I like…* [thinking] *Expressing emotions can be difficult, especially when they're like so big. So, you know, listening to music and having someone put into words what you're feeling really helps. You know, and it's just nice. I think that's, that's, it's the same with poetry like, you struggle to put something into words, but someone else can do it for you and you're like, yes! That is exactly how I feel. Thank you for that.* (Rebecca)
ii)	**Writing helps me make sense:** *Ek dink die dag as ek journal, help dit myself om bietjie te connect, veral as ek uit my kop uit kan kom, want my kop hardloop partykeer so. En actually 'n linnear gesprek hê met myself, in plaas van tien gesprekke gelyk en daar's nie eintlik 'n punt aan een van hulle nie.* *[I think the days I journal it helps me to connect with myself a little, especially if I can actually get out of my head because my head can sometimes just run. And I can actually have a linear conversation with myself, instead of ten conversations at the same time but there isn't actually a point to any of them.]* (Sam) *En as jy soos nou die aande gaan lees wat jy geskryf het, dan... Jy moet dit seker nie eintlik doen nie, want dan relive jy dit weer, en dan probeer jy nou uitfigure hoekom het dit my getrigger? Hoekom het hierdie spesifieke woord my getigger? Um, so, ek wil ook eendag kyk as dit nou bietjie meer onder beheer is, wat het ek daai tyd geskryf, en voel ek nog dieselfde of het ek al beter coping mechanisms uit ge-figure.* *[And when you go and read at night what you've written, then… You probably shouldn't actually do that, because then you relive it again, and then you try to figure out why did this trigger me? Why did this specific word trigger me? Um, so, I also want to someday see, when everything is more under control, what I wrote at that time, and do I still feel the same or have I figured out better coping mechanisms.]* (Megan)

iii)	**You put those emotions on paper:** *Maar meestal, my main theme sal wees ek, ek probeer my emosies uit kry in my kuns.* *[But mostly my main theme would be I, I'm trying to get my emotions out in my art.]* (Carly) *Jy sit daai emosie op papier, en dan hoop jy dit, dit vat bietjie daai emosie en daai druk van brein af, of jou liggam af weg*. *[You put those emotions on paper, and then you hope it, it takes that emotion and that pressure off your brain and your body.]* (Megan)

Participants' descriptions of engaging in occupations that provide opportunities to reflect on their thoughts, feelings, and behaviours, show similarities to the processes of certain psychotherapies employed in the treatment of BPD. The literature indicates a variety of psychotherapies, linked to meaning-making, employed in the treatment of BPD (Cristea et al., 2017). Mentalisation-based therapy and Dialectical Behaviour Therapy (DBT) have proven to be effective and were specifically developed for the treatment of BPD (Daubney & Bateman, 2015; Swales, 2000). Mentalising is described as "the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes" (Daubney & Bateman, 2015, p. 132). Similarly, DBT is a structured therapeutic program focused on skill attainment for the management of emotional dysregulation, self-destructive behaviour, and interpersonal relationship challenges (Daubney & Bateman, 2015; Swales, 2000).

The function and outcome of Mentalisation-based therapy and DBT share similarities with participants expressed experiences when engaging in occupations and activities that help them reflect on themselves and their emotions. For example, one focus of Mentalisation-based therapy is the improvement of self-awareness by differentiating between one's own emotions and those of others as well as fostering a clearer understanding of one's own mental states (Daubney & Bateman, 2015). Similarly, participants describe gaining more clarity and understanding of their own emotional states by being able to relate to descriptions and experiences expressed through song lyrics and poetry or writing and journaling about their thoughts and feelings (code i and

ii). DBT includes a focus on mindfulness, referring to being present with thoughts and feelings without judgment, and emotional regulation, referring to being able to express and experience emotions in a healthy way (Swales, 2000). This outcome seems similar to participants' descriptions of expressing their emotions through art and journaling. Although participants' engagement in occupations and activities that afford opportunities to reflect on their inner and outer worlds is not the same as these structured psychotherapies, it seems to provide some evidence as to why participants are naturally drawn to these types of activities and find them helpful.

From an occupational therapy perspective, occupations that allow for reflection on volition, habits, and performance patterns can help individuals consciously create an occupational identity that feels true to what they want for themselves and their relationships. Kielhofner's Model of Human Occupation (MOHO) describes the concept of occupational narrative, which refers to the "story of how a client's volition, habituation, performance capacity, and environment interact over time to influence what a client does with his or her life" (Taylor, 2017, p. 123). In the current study, Megan refers to writing and often re-reading what she wrote as an attempt to determine reasons for her feelings, behaviours, and thoughts over time (code ii). This seems to emulate what the MOHO describes as understanding the plot of an individual's occupational narrative (Taylor, 2017).

The overall theme identified by Falklöf and Haglund (2010) of their study of daily occupations and adaptation among women living with BPD revealed that participants struggled to organise their daily occupations and experienced poor personal causation. It is understandable how this might result in an occupational narrative over time that results in feelings of incompetence and negative self-evaluations. Using occupations as tools for reflection and understanding oneself can help organise occupations in a meaningful way that feels helpful in the present but is also aimed at realising future goals and ideals. Therefore, developing the plot of a person's occupational narrative and determining where they would like their story to go, especially in the face of adversity. Carly described using journaling to understand her current thoughts and feelings and help her focus on future goals and aspirations.

Journaling is vir my baie belangrik. Enigiets wat op pop van um, hoe jou dag was, of idees of future stuff, doesn't matter. Want my journal het ek self in vier in ge-split, vir goed wat gebeur het deur die dag, kind of like 'n diary ding. En dan het ek like 'n gedeelte van goals en affirmations en goed en al daai goedjies wat ek wil achieve, en hoe ek dit gaan achieve, soos 'n, kind of like a law of attraction type of thing wat aan gaan.
[Journaling is very important to me. Anything that pops up from, um, how your day was, or ideas of future stuff, doesn't matter. Because I split my journal into four parts myself, for stuff that happened throughout the day, kind of like a diary thing, and then I have a part for goals and affirmations and stuff and all those things that I want to achieve, and how I'm going to achieve it, like a, kind of like a law of attraction type of thing.] (Carly)

Considering that people with BPD seem to have difficulty experiencing occupational competency and building a unique occupational identity that would lead to achieving effective occupational adaptation (Falklöf & Haglund, 2010; Potvin et al., 2019; Wasmuth et al., 2020), using occupations as reflective tools can help address these challenges. It can serve as a concrete tool for people with BPD to reflect on their lives and experiences creatively and can serve as a road map of where they have been, where they are, and where they would like to go. As occupational therapists, we can collaborate with our patients and clients living with BPD to determine realistic and achievable goals and aspirations, as well as support and encourage the achievement of these goals. Ultimately this might result in experiences of occupational competence, crafting an occupational identity that feels right, and adapting to challenges and difficulties that accompany living with this diagnosis.

4.3.3.3. Summary theme 3: Creating meaning

The theme 'Creating meaning' illustrated participants' experiences of creating meaning in their lives through creativity and attempts to construct consistent identities. This theme was particularly interesting as 'meaning' is a concept that has continuously throughout the exploration of the literature on BPD, and the experience of meaning presented itself as an elusive experience for many people living with BPD. When putting all the parts together, it seems almost logical that a population of people

plagued by a collection of symptoms that result in frequent contradictory experiences throughout their histories and everyday lives would find it difficult to piece together a clear picture of who they are and what gives them meaning.

The first category, ‘You can create something beautiful’, described participants’ experiences of creativity and expression through art. Creativity and art are powerful mediums for expression and self-discovery as they involve ways of ‘knowing’ and ‘understanding’ that transcend words, and allow participants to communicate thoughts and feelings that might otherwise be difficult to articulate. It also provides opportunities for in-the-moment and tangible ways of ‘releasing’ overwhelming and challenging emotions. In *Man’s Search for Meaning*, Viktor Frankl (2008) writes about the importance of individuals connecting with something greater than themselves, if they are to find meaning in hardship. He writes about the power of creativity, whether art, music, poetry, writing, or other creative outlets, in allowing people to experience a sense of accomplishment and fulfilment even when faced with dire circumstances (Frankl, 2008). As previously discussed, living with the symptoms associated with BPD can be a challenging experience daily. As occupational therapists, we would want our patients and clients living with BPD to find connection and meaning beyond the burden of their symptoms, and it seems that creative occupations can be a powerful tool in directing us toward this goal.

The second category, ‘I don’t know who I am’, described participants’ challenges with establishing consistent identities for themselves. The sub-categories, ‘That’s my thing’ and ‘Making sense of it all’, described their attempts at finding ways to express who they are and understand their feelings, thoughts, and experiences. If your past and present experiences of yourself and others are tainted by overwhelming emotions, debilitating fear of being abandoned, and an unstable sense of self, it would result in a confusing picture of who you are and who you can become. As occupational therapists, we can collaborate with our patients and clients living with BPD to create opportunities to experience occupational competence in areas that are important and valuable to them and contribute to the creation of occupational identities that are not only built on what we are trying to avoid but also what provides meaning and purpose.

4.4. CONCLUSION

This chapter comprehensively presents and discusses the layers of findings of this research study. It provides an overview of the demographics of participants and presents the results of the three themes: ‘Living this life’, ‘Filling the void’, and ‘Creating meaning’. In the following chapter, it will be discussed how these themes addressed the purpose, aim, and objectives of the study.

CHAPTER 5: CONCLUSION

5.1. INTRODUCTION

In the previous chapter, the findings generated from this research study were presented and discussed in three themes, along with the interpretations and discussions of all the categories and sub-categories. In this final chapter of this research report (mini-thesis), conclusions will be drawn to address the research objectives; limitations of the study will be discussed; implications and recommendations for practice and future research will be presented and discussed. The research report will be concluded with final thoughts and reflections on the study.

5.2. ADDRESSING THE RESEARCH OBJECTIVES

Since this study aimed to explore how people living with borderline personality disorder (BPD) view and describe their experiences of their daily occupations, the following three objectives ensued from it: To describe the participants' perspectives on occupations they experienced as 1) meaningful, 2) purposeful, and 3) enabling or disabling (cf. Chapter 1, p. 6 for the full formulation of these objectives). However, when the participants were asked about which occupations they experienced as meaningful and purposeful, they also described experiences of the obstacles and challenges they face in achieving meaning and purpose in their everyday lives, rendering the responses far from neatly compartmentalised. Allowing the data to speak for itself, however, created an opportunity to sketch a clear picture of the experience of living life as someone diagnosed with BPD, providing a *context* within which to view their experiences of meaning and purpose. Considering the third objective, participants did not describe any occupations as disabling but rather their experience of the symptoms of BPD as disabling. The participants described engagement in certain occupations as enabling by serving as coping strategies to mitigate the disablement experienced due to the impact of BPD symptomology. Therefore, the enablement provided by these occupations is intertwined with the meaning and purpose of engaging in them. For these reasons, the objectives will not be discussed individually, rather the research question will be addressed in three parts: how people living with BPD view and describe 1) experiences of challenges in

their daily lives and occupations, and how they view and describe experiences 2) of purpose and 3) of meaning in their daily occupations. Table 5.1. illustrates how the themes, categories, and subcategories address the three parts of the research question.

Table 5.1. Summary of how the themes, subcategories, and categories relate to the research question.

Theme	Category	Subcategory	Part of the research question addressed
Theme 1: Living this life	Emotions control everything in my life	N/A	Challenges
	Everything judges you	N/A	
	Coping strategies	It's my comfort zone	Purpose
		It's an escape	
		It's just you and nature/your pet	
		It physically feels good	
Theme 2: Filling the void	It fills that feeling of emptiness	N/A	Purpose
	I don't know when to stop	N/A	Challenges
	I actually feel something	N/A	Purpose
	It's new and different	N/A	
Theme 3: Creating meaning	You can create something beautiful	N/A	Meaning
	I don't know who I am	That's my thing	
		Making sense of it all	

5.2.1. Experiences of challenges in their daily lives and occupations

The first two categories of the first theme painted a picture of everyday life from the participants' perspectives, including how their diagnosis influences most, and perhaps all areas of their lives. The participants described the symptomology they experienced

associated with BPD, significantly impacting ‘why’ and, in some instances, ‘how’ they engaged in occupation. These descriptions of ‘why’ or ‘how’ they engaged in occupations were generally depicted as strategies to cope with the symptoms of their diagnosis that they experienced as disabling or intolerable. Borderline personality disorder is a challenging diagnosis to live with, and participants engage in certain occupations in specific ways in some cases for survival and, in other cases, to ease the burden.

If we are to apply the conceptual foundations of our profession to view our clients and patients with BPD holistically and from a client-centred perspective (Kielhofner, 2009) we need to consider the impact of their diagnosis on their occupational lives. This is not to frame people living with BPD as not existing outside of their diagnosis but rather to acknowledge that their diagnosis is intertwined with their internal and external contexts in significant ways. The challenges of their diagnosis might warrant some ‘out of the box’ thinking and consideration for a population of people that might view themselves, the world around them, and their occupations in an ‘out of the box’ way.

As occupational therapists, we need to understand the challenges created by BPD symptomology from the perspectives and experiences of the clients and patients we serve. This is essential to crafting occupational therapy interventions that truly meet the needs of our patients and clients with BPD and contribute to meaningful occupational lives for this population. Harding (2020a) argues the role of occupational therapy in decreasing the stigma associated with personality disorders through a better understanding of why they engage in certain occupations and behaviours. Understanding the challenges faced by people living with BPD and ‘why’ they do it is essential in decreasing stigma towards this population for ‘what’ they do. As occupational therapists, we are more than qualified to take the lead in countering, if not confronting, the stigma associated with this population in our communities, among healthcare professionals, and within ourselves.

5.2.2. Experiences of purpose in their daily occupations

Traditionally, within the realms of occupational therapy and occupational science, ‘purpose’ as related to occupational engagement is a term associated with a positive

and goal-directed contribution to areas of occupational life considered important and meaningful (Hammell, 2004). Consequently, occupational science and occupational therapy literature tend to describe the purpose of engaging in occupations as caring for oneself (self-care), being productive by engaging in occupations that produce measurable positive results (productivity), and experiencing pleasure, fun, and enjoyment (leisure) (Hammell, 2009b, 2004).

However, participants' descriptions of why they engaged in certain occupations largely did not 'fit' into categorisations of occupations aimed at self-care, productivity, and leisure. This finding does not negate the usefulness of these categories, as participants also described engaging in occupations that do coincide with the purposes illustrated by these categories. Rather, it raises important questions and considerations about how occupation and the purpose of occupation are defined and understood within occupational therapy theory and practice. Participants described engaging in occupations that are traditionally socially disapproved of or considered inappropriate and unhealthy. However, participants described engagement in these occupations as functional tools for 'coping' with everyday life and, in some cases, even considered these occupations essential for psychological survival.

Occupations deemed non-sanctioned (Kiepek et al., 2019) or 'dark occupations' (Twinley, 2013, p. 1) serve a specific and much-needed purpose for people diagnosed with BPD. This challenges the fundamental assumptions in occupational science and occupational therapy literature that equate occupation to something positive, productive, and healthy (Twinley, 2013). As occupational therapists, we are challenged to evaluate and expand our understanding of occupations and their purpose and embrace a more nuanced view of occupation, theoretically and in practice. This is essential to be holistic and client-centred in our interventions with our patients and clients living with BPD.

5.2.3. Experiences of meaning in their daily occupations

The literature on BPD and the experiences shared by participants indicate that meaning is often an elusive experience for this population. Notably, the only times participants used the words 'meaning' or 'meaningful' in their descriptions of their

occupational engagement was within the context of creativity or engaging in creative occupations. Participants described finding meaning in being able to express themselves in impactful ways, understanding themselves, and being understood by others. This seems both practically and existentially meaningful.

Occupational therapy theory generally has demonstrated difficulty in differentiating between the concepts of ‘purpose’ and ‘meaning’ and has tended to use these terms interchangeably (Hammell, 2004). Participants' experiences clearly differentiated between ‘purpose’ and ‘meaning’ when describing their occupational engagement. The purpose of occupational engagement was mostly described as strategies to mitigate the challenging symptoms of their diagnosis or as a response to difficult experiences associated with their diagnosis. When describing the meaning of their occupational engagements, their descriptions seemed to transcend merely trying to alleviate struggles but rather creating something beautiful and impactful and being able to express parts of their identity to themselves and others. This is similar to Christiansen’s (1999) seminal assertions that occupations are key to creating and maintaining our identities within the contexts of our relationships and day-to-day activities.

Findings from this study point to a possible dynamic relationship between meaning, identity, and creativity. Creativity can be an incredibly useful and impactful tool for a population of people who seem to face significant challenges concerning identity disturbance and meaning-making, not only in the process of meaning-making but also as part of experiencing occupational competence and crafting an occupational identity that results in successful occupational adaptation (Taylor, 2017). As occupational therapists, we can use occupation in creative ways to inspire creativity among our patients and clients living with BPD to create meaningful identities, not despite the challenges associated with this diagnosis but, dare I say, perhaps even because of them.

5.3. LIMITATIONS OF THE STUDY

Several limitations influenced the findings of this study:

- All research endeavours include the risk of potential bias (albeit a deeply

quantitative term), and it is, therefore, important to acknowledge that risk is a potential limiting factor in the context of this research study as well. However,

- As far as possible, measures have been employed to enhance rigour and trustworthiness throughout the research process. Separation between the researcher and the research is considered less important, while upholding reflexivity and transparency is more so important in the qualitative research process (Galdas, 2017).
- The study used a qualitative approach and, therefore, included a small sample of thirteen participants. The findings from this study cannot be generalized to all people living with BPD. However, through strategies such as the use of rich descriptions, the reader is encouraged to reflect on how and to what extent the findings of this study can be applied in their specific contexts.
- Participants in this study were sampled from an inpatient context which requires consideration of the impact of currently being admitted on research findings and results. Future research should explore the occupational experiences of people living with BPD within community contexts as well.
- Although participants were diverse in age, the sample was not diverse in gender (twelve participants were female and one participant male) or culture and race (twelve participants were white and one participant was black). Though this was not the intention, it is possible that bias concerning gender in the diagnosis of BPD (cf. 2.4.) could be a potential contributing factor (Bozzatello et al., 2024) as well as considerations of cultural factors (cf. 2.3.) that influence the diagnosis of personality disorders (Gawda, 2018).
- Participants in this study were socio-economically homogenous as they all shared a middle-class background and lived in middle-class communities. Future research should consider the experiences of people living with borderline personality disorder in more culturally, racially, and gender-diverse contexts.

5.4. IMPLICATIONS AND RECOMMENDATIONS

Borderline personality disorder is undeniably a complex and multifaceted diagnosis. Therefore, the reader is encouraged to engage with the recommendations made with open-mindedness and creativity concerning how they might be applied in their unique

contexts.

5.4.1. Implications and recommendations for practice

Practice recommendations will be discussed according to the main findings from the study. Firstly, the findings from this study raised questions regarding fundamental assumptions of the relationship between occupation and health and well-being. Occupational therapists need to evaluate their understanding of how occupation is used to address meaning and purpose in the lives of the people we are rendering services to, including our patients and clients living with BPD. Findings from this study indicate that people can find meaning and purpose in occupations that might not be considered traditionally healthy, productive, or socially acceptable. If we are to understand and contribute to meaning in the occupational lives of the people, we render services to, we need to be cognisant of not enforcing our values and beliefs on what our patients and clients *should* find meaningful and purposeful. Rather we need to listen to what our patients and clients *tell us* they find meaningful and purposeful. This is not to say we need to encourage engagement in occupations that are harmful and dangerous but rather calls for expanding our understanding of what occupation is and can be, both theoretically and practically, as well as finding ways to incorporate these nuances of occupational engagement into our assessments and treatments. For example, rather than addressing engagement in occupations such as cannabis use with pre-conceived judgment and dismissal, perhaps understanding the meaning and purpose of cannabis use for a patient or client with BPD can result in collaboration to explore ways to manage the potential negative effects of cannabis use, encouraging responsibility and accountability while still respecting the value of this occupation in creating meaning in the everyday life of the patient or client.

Another important point for consideration is the role of occupational therapists in addressing the stigma associated with BPD. It has been established that BPD is a highly stigmatised diagnosis (cf. 2.6.), societally and among healthcare professionals. The stigmatisation of this population is predominantly related to the symptoms and behaviours associated with this diagnosis. Manipulation, splitting, sabotage, and attention seeking behaviours are often dismissed as pathological or ‘just being borderline’ instead of approached with curiosity and a willingness to understand the

intention and needs expressed through such behaviours. Harding and Berrigan (2024) argue that these are often manifestations of patients and clients attempting to communicate, connect, and have their needs met the best way they know how. Knowing that healthcare practitioners, including occupational therapists, vilianise and judge these attempts as manipulative, sabotaging, and attention seeking, does not provide fruitful landscapes for building meaningful therapeutic relationships with our patients and clients living with BPD.

Occupational therapists have a significant role to play in fighting the stigmatisation of this population by providing valuable insights and knowledge concerning occupational choices among people diagnosed with BPD. A greater understanding of the meaning and purpose of certain behaviours and trends in occupational engagement for this population can inspire greater compassion and understanding from occupational therapy colleagues, other healthcare professionals, and the larger society to decrease the stigmatisation of people living with BPD. Occupational therapists are encouraged to step into their roles as advocates for our patients and clients living with BPD. This involves critically evaluating and changing the language we use when referring to and discussing our patients and clients. It might also involve challenging our multi-disciplinary colleagues to evaluate the way they view, speak about, and manage their patients and clients with BPD (Harding & Berrigan, 2024).

Another important consideration is emphasising the foundational importance of the therapeutic relationships we have with our patients and clients with BPD. Harding and Berrigan (2024) describe building therapeutic relationships with our patients and clients with BPD as ‘the work’. This suggests that the relationship we have with our patients and clients is potentially a strong healing site where we can approach ways of interacting, that might very well be different from our own ways of being, with empathy and compassion. Building therapeutic relationships with our patients and clients that provide opportunities for healing and skill building, also involves an increased awareness of our own skill building, or perhaps sometimes lack thereof. We have a responsibility to investigate our own skills concerning boundary setting, communication, and ‘trigger’ management if are to be effective in supporting, understanding, and helping our patients and clients with BPD. The relationships we build with our patients and clients can be a powerful therapeutic intervention tool if

approached with authenticity and an intention to embrace, not to judge or push away (Harding & Berrigan, 2024).

5.4.2. Implications and recommendations for future research

There is limited research on the occupational experiences of people living with BPD, especially within a South African context. Therefore, I make the following recommendations for future research:

- Future research should focus on the experiences of occupation among people diagnosed with BPD in more culturally, racially, and socio-economically diverse populations. Especially within a South African context, as this would be more representative of the diversity within the population of our country.
- There is limited research, internationally and within South African literature, on the experiences of occupations among men living with BPD. Future research should investigate and explore potential differences related to gender in the experiences and presentation of BPD among men.
- Findings from this study gave voice to alternative understandings and experiences of occupation that urge reconsiderations of taken-for-granted assumptions about the role and nature of occupation and its relationship to health and well-being. Future research should focus on expanding the concept of occupation, which includes the study of non-sanctioned or 'dark occupations' (Kiepek et al., 2019; Twinley, 2013) as well as a critical evaluation of the current categorisation of occupations.
- An interesting finding from this study relates to the potential dynamic relationship between creativity, meaning-making, identity, and occupation. This might be especially significant among populations, such as people with BPD, that experience challenges in meaning-making due to the impact of their diagnosis. Future research could investigate the role and use of creativity, including and beyond creative occupations, in constructing meaning in life that transcends disability and impairment.

5.5. VALUE OF THE STUDY

This study has contributed to the knowledge base and occupational therapy literature

on the experiences of people with BPD and their occupational engagement. It is by no means representative of a 'universal truth' of how people with BPD experience the role, purpose, and meaning of their occupations and it is only a drop in the ocean of understanding the complexities of this diagnosis. However, findings from this study serve as a valuable conversation starter in critically evaluating and reconsidering our assumptions about occupation and how it can be used, as well as our assumptions about those often referred to as 'the borderlines'. Throughout this research process, I have engaged in valuable conversations with my fellow occupational therapy colleagues and other multi-disciplinary team members. This has added to depth and compassion when considering our patients and clients with BPD. This study also contributes to the larger conversation around the conceptualisation of occupation. Human beings are continuously evolving, and as occupational therapists, we are encouraged to evolve our theoretical and practical understanding of occupation as well if we are to collaborate with our patients and clients in ways that matter and make a difference.

5.6. FINAL REFLECTIONS AND CLOSURE

The process of this research study has profoundly contributed to my professional and personal growth in ways for which I am incredibly grateful. I have read countless academic articles, books, and blogs describing the experiences of people diagnosed with BPD. I listened to the experiences of thirteen people living with BPD who generously shared their stories with me, and I transcribed and coded each interview myself. I found it interesting that a sentence in my own words, which I transcribed multiple times throughout all thirteen interviews, was 'that makes a lot of sense'. As an occupational therapist, it has challenged me to reconsider how I view and understand the patients and clients I work with, regardless of their diagnoses. It helped me to engage critically with questions of 'right' and 'wrong,' 'good' and 'bad,' and 'healthy' or 'unhealthy.' I realised that these value-laden and binary labels are not necessarily helpful in collaborating with patients and clients to create lives worth living. Human beings are complex. Therefore, my understanding and application of the role of occupation need to respect and represent this complexity as well. I have been encouraged to step into my role as an advocate for patients and clients who engage in life and its challenges in alternative ways, and I've realised there is so much to be

learned from them.

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APPENDIX A: PARTICIPANT INFORMATION SHEET

PARTICIPANT INFORMATION SHEET

Dear Reader

I, Anika van der Linde, am a student completing my Master of Science in Occupational Therapy at the University of Witwatersrand. The research project is titled: “Exploring descriptions of occupational experiences among people living with borderline personality disorder: An interpretive enquiry”. This study aims to describe and understand the unique perspective on occupations, from people living with borderline personality disorder, that they find purposeful and meaningful. In occupational therapy, “occupations” do not refer to a job or profession, but rather the ordinary and everyday activities you do that are necessary, important, or meaningful to you. In doing this research, we can give a voice to these experiences and gain insight that can support a better understanding of how to use occupations to promote the health and well-being of people living with borderline personality disorder.

The global prevalence of personality disorders is estimated at 7.8%. Of this, borderline personality disorder is the most prevalent in psychiatric treatment facilities, with a prevalence of up to 20%. Yet, there is not a lot of information and evidence in occupational therapy literature that represents the voices of this population, especially when it comes to their experience of occupations, which is central to occupational therapy. In occupational therapy, occupations refer to everyday things you do, to occupy your time, that bring purpose and meaning to your life.

You have been identified as a potential participant and are invited to participate in this research study.

Who is eligible?

Male and female participants, 18 years and older, diagnosed with borderline personality disorder. It must be at least your second admission to this specific hospital. You must be able to understand English.

What is involved in the study?

You will be asked to fill out a form to give some background information about yourself. Thereafter, a time will be scheduled during your second week of admission for a private interview, no longer than 90 minutes, during which you will be asked to describe and talk about occupations that provide meaning and purpose to your life. If necessary, we might schedule a second interview, no longer than 90 minutes. The interview will be recorded and typed out. Some of what you say, may be quoted in the presentation and publication of this research.

Are there any risks to taking part in the study?

Interviews will be conducted in a private and secure room to ensure confidentiality. All information will be kept confidential, with any identifying information (such as names, places, etc.) changed or removed. You can withdraw from the study at any time. COVID-19 protocols will be observed throughout. A potential risk to taking part in this study is that of research-induced distress. A registered counsellor will be available if necessary. Contact details for a registered counsellor in case of any distress is as follows: Mrs Debra Smuts available at 012 998 6062.

What are the benefits of taking part in the study?

There will be no direct benefits to participants for taking part in this research study. By participating in this study, you will be contributing to the knowledge base that can promote the health and well-being of people diagnosed with borderline personality disorder. Generalized results, with all identifiable information removed, will be available to all participants with completion of the study. No remuneration will be given for participation in this study.

How will access to the information be controlled?

All your information will be treated as highly confidential. This means all documents

will be marked with a code instead of your name. Your privacy will be protected by changing names, places, and any other identifying information. All documents will be kept safe and private on a password protected device, with the researcher and research supervisor solely being allowed access to any information. If transcription services are to be used to transcribe the audio recordings, the transcriber will sign a confidentiality agreement and will not be allowed to keep or copy any of the audio recordings. You can request that your data be withdrawn from the study by emailing the primary researcher Anika van der Linde (2596966@students.wits.ac.za), within a month after you have completed the study. You will suffer no repercussions if you decide to withdraw.

Information related to the use of your data in future research projects:

Will access to my data be controlled?

Any identifying information, such as your name, surname, and contact information, will be removed from the data and a number will be allocated to your data. Data will be stored on a password-protected external storage device and will only be accessible by the researcher and research supervisor.

Where will my data be stored?

All data will be stored using only an identifying number and no personal information, on a password-protected external storage device, that will be kept in a safe and secure place. Your data will be kept for two years if published or six years if not published, after this period the data will be destroyed.

How will researchers gain access to my data in the future?

Should researchers want to use your data in a future research project, they will apply for ethical clearance prior to research being conducted. The motivation, intention and a sound protocol will be considered by the primary researcher and research supervisor before access will be granted to your data. Should you prefer not to allow for you data to be used in either the current and/or future research projects, you will not suffer any repercussions. You are free to withdraw your consent for the use of your data at any time by sending an email to the primary researcher, Anika van der Linde (2596966@students.wits.ac.za).

You are welcome to contact myself or my supervisor if you have any questions or concerns. If you agree to participate in the research study, please fill in and sign the informed consent form on the next page as well as the form to obtain background information about you. Thank you for your consideration.

Kind regards,

Anika van der Linde (researcher)

2596966@students.wits.ac.za

012 998 6062

Dr Tania Rauch-van der Merwe

tania.vandermerwe@wits.ac.za

011 717 2093

For more information regarding any ethical queries contact the Human Research Ethics Committee of the University of Witwatersrand, with the following contact details:

Professor CB Penny, Chairperson of Human Research Ethics Committee (Medical) at the University of Witwatersrand.
Telephone: 011 717 2301
Email: Clement.Penny@wits.ac.za
Ms. Z Ndlovu / Mr. Rhulani Mkansi, Committee Secretariat. Telephone: 011 717 2700 / 011 717 1234
Email: Zanele.Ndlovu@wits.ac.za / Rhulani.Mkansi@wits.ac.za

APPENDIX B: INFORMED CONSENT

INFORMED CONSENT

I _____ hereby agree to participate in this study and for my data to be used as stipulated below:

*I agree for my data to be used as part of the research project described in the information sheet and titled: "**Exploring descriptions of occupational experiences among people living with borderline personality disorder: An interpretive enquiry**."*

☐ *Yes*

☐ *No*

I am aware that I can request for my data to be withdrawn from this research study. This should be done within a month (30 days) from participating in the study. I am aware that I will not suffer any repercussions should I decide to withdraw from the study.

☐ *Yes*

☐ *No*

I understand that my participation in this study is voluntary, and I am not obliged, in any way, to take part in this study.

☐ *Yes*

☐ *No*

I understand that there are no monetary rewards, and I will not receive any renumeration for participating in this study or allowing my data to be used as part of this research study.

☐ *Yes*

☐ *No*

I understand that a potential risk for participation in this study is research induced distress and that a registered counsellor, Mrs Debra Smuts is available in such a case upon request, if necessary, at 012 998 6062.

☐ *Yes*

☐ *No*

I agree that my data, after any identifying information has been removed, may be reused in future research projects without my additional informed consent (tick all that apply).

☐ *Yes, my data can be stored and re-used for an unlimited period of time.*

☐ *Yes, my data can be stored and re-used for a limited period of time with an end date specified here: _____(DD/MM/YYYY).*

☐ *Yes, my data can be re-used as part of a project of any type which has received ethical clearance except for topics such as: _____ (leave blank if not applicable).*

☐ *No, I do not agree for my data to be used in future research projects.*

Signed at _____ (place), on _____

(date), by _____(name and surname).

_____ _____

Signature of participant Signature of researcher

For more information regarding any ethical queries contact the Human Research Ethics Committee of the University of Witwatersrand, with the following contact details:

Professor CB Penny, Chairperson of Human Research Ethics Committee
(Medical) at the University of Witwatersrand.
Telephone: 011 717 2301
Email: Clement.Penny@wits.ac.za

Ms. Z Ndlovu / Mr. Rhulani Mkansi, Committee Secretariat. Telephone:
011 717 2700 / 011 717 1234
Email: Zanele.Ndlovu@wits.ac.za / Rhulani.Mkansi@wits.ac.za

APPENDIX C: BACKGROUND INFORMATION

BACKGROUND INFORMATION

The following questions are aimed at obtaining background information about you to provide information on the type of people participating in this research study. The information will be kept confidential.

If any information is not applicable to you, please write n/a. Please complete all questions in pen.

Participant number		
Contact number		
Date of birth (yyyy/mm/dd)		
Highest level of education (Please mark the appropriate option)	Less than grade 12 (please specify)	
	Grade 12 (Matric)	
	Certificate	
	Diploma	
	University degree	
	Other (please specify below)	
Employment/occupation		
Relationship status (Please mark the appropriate option)	Single	
	In a relationship	
	Engaged	
	Married	

	Divorced	
	Widowed	
	Other (please specify below)	
Perceived impact of condition on overall daily functioning (Please mark the appropriate option)	Very light	
	Mild	
	Moderate	
	Severe	
	Very severe	

Thank you!

APPENDIX D: CONSENT TO BE AUDIO RECORDED

INFORMED CONSENT FORM FOR AUDIO RECORDING OF INTERVIEW

I, ____ hereby give consent for my interview to be audio recorded. I understand that the recordings will be kept confidential and will only be shown to the researcher's supervisor if needed. I understand that the audio recordings will be kept safe on a password protected device and destroyed after 6 years to maintain confidentiality. I also understand that if transcription services were to be used in the transcribing of the audio recordings, the transcriber will sign a confidentiality agreement and will not be allowed to copy keep any audio recordings.

Signed at _____(place), on the_____(date), by

_____(name and surname).

_____ _____

Signature of participant Signature of researcher

Contact information:

Anika van der Linde (researcher)
Email: 2596966@students.wits.ac.za
012 998 6062

Dr Tania Rauch-van der Merwe (supervisor)
tania.vandermerwe@wits.ac.za
011 717 2093

For more information regarding any ethical queries contact the Human Research

Ethics Committee of the University of Witwatersrand, with the following contact details:

Professor CB Penny, Chairperson of Human Research Ethics Committee (Medical) at the University of Witwatersrand.
Telephone: 011 717 2301
Email: Clement.Penny@wits.ac.za
Ms. Z Ndlovu / Mr. Rhulani Mkansi, Committee Secretariat.
Telephone: 011 717 2700 / 011 717 1234
Email: Zanele.Ndlovu@wits.ac.za / Rhulani.Mkansi@wits.ac.za

APPENDIX E: INTERVIEW SCHEME

Greeting

- Introduce self
- Confirm that participant is still willing to participate in the interview
- Confirm with the participant if they consent to being recorded during the course of the interview
- Thank participant for participating and consenting
- Confirm with the participant that the interview will be 90min long
- Confirm whether they have read and understood the information sheet
- Explain how the interview process is going to work

Interview

Before asking make statement: purpose of research is to understand what kind of things are meaningful to you etc… Give context (example things you do everyday)
If example is used use same example for every interview

Ask participant: Tell me about everyday activities or things you do, either alone, with your family, with other loved ones, with friends or anyone else, to occupy your time and bring meaning and purpose to your life.

Possible prompts related to question:

- What or how is this important/valuable/worthwhile for you?
- What or how does this give you a sense of accomplishment?
- What or how does this give you a sense of control?
- What or how does this reflect who you are?
- What or how does this you enable you, or prevent you to do other things?

Possible general prompts throughout

- Where do you participate in these activities/things?
- How often do you participate in these activities/things?
- How much time do you spend on these activities/things?
- Who do you do these activities/things with?
- What is it about these activities/things that make it important to you?
- What do you gain/get from participating in these activities/things?
- How do these activities/things help or hinder you?
- How do other people in your life experience your engagement in these activities/things?

Conclusion

- Ask the participant if there is anything else they would like to add
- Thank the participant for their time and participation
- Explain to the participant that they will be contacted to verify information at a later stage

Interview techniques

- Detail orientated probes
- Asking for elaboration
- Clarification (through paraphrasing)
- Allowing for silence

APPENDIX F: ETHICAL CLEARANCE CERTIFICATE

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R49 Ms A van der Linde

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M220903

NAME: (Principal Investigator)	Ms A van der Linde
DEPARTMENT:	School of Therapeutic Sciences Department of Occupational Therapy Medical School University
PROJECT TITLE:	*Exploring descriptions of occupational experiences amongst people living with borderline personality disorder: an interpretive enquiry*
DATE CONSIDERED:	2022/09/30
DECISION:	Approved unconditionally
CONDITIONS:	
NOTE:	If contact information regarding student study participants is required, please contact the Registrar's office - <Nicoleen.Potgieter@wits.ac.za>
SUPERVISOR:	Dr T Rauch van der Merwe
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	2022/11/18

This Clearance Certificate is valid for 5 years from the date of approval. An extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office secretariat on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to submit details to the Committee. I agree to submit a yearly progress report. When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in **September** and therefore reports and re-certification will be due in the month of **September** each year. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

Signature of Principal Investigator

2022-11-18
Date

APPENDIX G: PERMISSION LETTER FROM HOSPITAL

MEDICLINIC

MEDICLINIC CORPORATE OFFICE
35 DU TOIT STREET
STELLENBOSCH
7600

PO BOX 456
STELLENBOSCH
7599

T +27 21 809 6600

www.mediclinic.co.za

Ref: 20220831- Anika van der Linde – Wits
Date: 16 February 2023
Ms Anika van der Linde
E-mail: 259666@students.wits.ac.za
Copies to: Research@mediclinic.co.za and Izaan.vanColler@Mediclinic.co.za

Dear Ms Anika van der Linde,

APPROVAL TO CONDUCT RESEARCH AT MEDICLINIC DENMAR

Your research proposal entitled "***Exploring descriptions of occupational experience among people living with borderline personality disorder. An interpretive enquiry***" refers

1. Degree level: Masters

2. Study Aim: To explore how people with borderline personality disorder view and describe their experience of their daily occupations

3. Study design and methodology: Qualitative research and semi – structured interview

4. Mediclinic contact person: Miss Nomfundo Maseko, Research Coordinator

5. Conditions:

- Please liaise directly with the appropriate psychiatrists at Mediclinic Denmar to arrange research information sessions and handing out research information sheet.

Kindly submit a written summary/closing report to research@mediclinic.co.za within 30 days of the study end date stipulated in the protocol. Should your research period surpass the initial period indicated in the protocol ending, you will be required to apply for an extension

Kind regards,

DR MELANIE STANDER
Chairperson: Clinical Research Committee

APPENDIX H: DATA MANAGEMENT PLAN

0. Proposal name

Exploring descriptions of occupational experiences among people living with borderline personality disorder: An interpretive enquiry

1. Description of the data

1.1 Type of study
Exploratory study is based on a descriptive interpretive methodology, using an inductive approach.

1.2 Types of data
Descriptive data by means of a semi-structured interview, to be coded and thematically analysed.

2. Data collection / generation

2.1 Methodologies for data collection / generation
Semi-structured interview, with questions focusing on descriptions of occupations that participants find meaningful, purposeful, and functional. Data will be analysed, themes identified and inductively coded, using in vivo coding and will consist of two rounds of coding. MaxQDA will be used as an analytical tool as it is available in the School of Therapeutic Sciences.

3. Data management, documentation and curation

3.1 Managing, storing and curating data.
An information letter will be provided and consent written consent (for participation in study and audio recording of interview, respectively) will be obtained before participation in the study.
Following the conduction and completion of interviews, within 24 hours, all recordings will be transferred to a computer, saved in a password protected folder, and removed from external recording devices. Recordings will be saved using only participant's number and the researcher alone will have access to the recordings. Recordings will also be backed up on a secure, external, and password protected device, to minimise the risk of loss of data.
Transcription of the recordings will be done by the researcher and/or an independent professional transcriber, if necessary due to time constraints. If the service of an independent professional transcriber is used, recordings provided to transcriber will be permanently deleted on all platforms, and no copies of recordings will be kept by the transcriber. The transcriber will also be required to sign a confidentiality form in accordance with all necessary steps to protect the confidentiality of data collected.

All transcriptions will be stored in a password protected folder on a secure, and password protected device. Any identifying information in transcriptions (such as names of person's or places) will be replaced with general descriptors to support and protect confidentiality and privacy of participants.

3.2 Data preservation strategy and standards
After conclusion of the research study, all data will be stored on an external, secure, and password protected device for two years if findings are published, and six years if no publication arises from the study. After this period, data will be destroyed accordingly.

4. Data security and confidentiality of potentially disclosive information

4.1 Formal information/data security standards
The University of the Witwatersrand is a public university and is compliant with the International Organisation for Standardisation (ISO) ISO 27001 Information Security. Data will be stored on an external, secure, and password protected device, in a password protected folder, with only the primary researcher and research supervisor having access.
Data will not be destroyed unless required for ethical or legal reasons in which case the University of the Witwatersrand's Central Records Office will be consulted for advice on expertise. For destruction of physical data, the guidance on Biobanks is followed. For destruction of data on the internet, the University of the Witwatersrand follows the guidance of the South African National Research Network: Computer Security Incident Response Team.

4.2 Main risks to data security
Any identifying information in transcriptions (such as names of person's or places) will be replaced with general descriptors to support and protect confidentiality and privacy of participants. Participants will only be identified by a participant number. We therefore do not foresee risks to data security related to this project.

5. Data sharing and access

5.1 Suitability for sharing
The data from this project is not suitable for sharing as it is specific to the research department.

5.2 Discovery by potential users of the research data
Should researchers want to use the data in a future research project, they will apply for ethical clearance prior to research being conducted. The motivation, intention and a sound protocol will be considered by the primary researcher and research supervisor before access will be granted to the data.

5.3 Governance of access
The primary researcher and research supervisor will solely have access to data. A transcriber will have access to data, for transcription purposes, if transcription

services are used. If the service of an independent professional transcriber is used, recordings provided to transcriber will be permanently deleted on all platforms, and no copies of recordings will be kept by the transcriber. The transcriber will also be required to sign a confidentiality form in accordance with all necessary steps to protect the confidentiality of data collected.

5.4 The study team's exclusive use of the data
The data collection period aims to end in April 2023, as detailed in the time tabled planning of the research project.

5.5 Restrictions or delays to sharing, with planned actions to limit such restrictions
Not applicable, this data set will not be shared.

5.6 Regulation of responsibilities of users
The primary researcher and research supervisor will solely have access to data. In the case where transcription services are used, the necessary confidentiality agreements will be completed as described in point 5.3.

6. Responsibilities

The primary researcher and research supervisor is responsible for the data management, and data security as no formal, paid data management services are currently available.

7. Relevant institutional, departmental or study policies on data sharing and data security

The following documents were considered in the development of this data management plan:

- Wits Sport and Health Research Group Data Management and Sharing Guide
- Wits Data Classification Policy
- Wits Research Data Policy draft 1 (8 July 2020)
- Protection of Personal Information Act (POPIA)
- Intellectual Property Policy C2012/228

8. Author of this Data Management Plan (Name) and, if different to that of the Principal Investigator, their **telephone & email contact details**

Anika van der Linde (primary researcher)
Dr Tania Rauch van der Merwe (research supervisor): tania.vandermerwe@wits.ac.za

APPENDIX I: TURNITIN REPORT

2596966 Final Research Report

ORIGINALITY REPORT

15%	9%	12%	3%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	scholar.ufs.ac.za Internet Source	2%
2	Submitted to Queensland Health Student Paper	<1%
3	scholar.ufs.ac.za:8080 Internet Source	<1%
4	Nicky Morris. "Dramatherapy for Borderline Personality Disorder - Empowering and Nurturing People Through Creativity", Routledge, 2018 Publication	<1%
5	www.hindawi.com Internet Source	<1%
6	Submitted to National Louis University Student Paper	<1%
7	Kitcey-Muir, Hannah Grace. "A Voice-Centered Qualitative Exploration of Borderline Personality Disorder", Point Park University, 2023 Publication	<1%