Faculty of Education and Health

Reflective Waypoints and Relational Bridging

A phenomenological exploration of spiritualities in therapeutic relationships between women living with Borderline Personality Disorder and mental health nurses

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A Thesis Submitted to the University of Greenwich for the Degree of Doctor in Education

28th February 2017

DECLARATION

I certify that this work has not been accepted in substance for any degree and is not concurrently being submitted for any degree other than that of Doctorate in Education (EdD) being studied at the University of Greenwich. I also declare that this work is the result of my own investigations except where otherwise identified by references and that I have not plagiarised another's work.

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Abstract

Relational engagement with whole persons, body, mind and soul is the heart of compassionate recovery-orientated mental health nursing, yet spirituality continues to pose theoretical and practical dilemmas for service users, policy-makers, nurses and educators. This study examines ways in which the lived spiritual experience of women with borderline personality disorder (BPD) informs and influences their therapeutic relationships with mental health nurses (MHNs) and additionally provides lessons for mental health nursing practice and education.

Within a participatory phenomenological methodology, semi-structured dialogic interviews with five women, recovering from a diagnosis of BPD were combined with researcher reflections. Extensive narrative and dialectical thematic analysis uncovered unheard stories of rich relational complexity and transformation. Lived spiritualties of processual becoming-bridging-being or emerging-questing-voicing emerged in the shifting dimensions of self, relationships, space and recovery. A spiritual framework for BPD is drawn from the data focusing on the identified bridging experiences or transitional waypoints of BPD recovery represented thematically as, 'Reflective Self, Letting Go, Navigating Crossings and Serendipitous Seeking'.

The study proposes a symbiotic inter-spiritual educational approach that links bridging experiences in method and meaning, learning and recovery. The narratives of bridging and questing, voiced by the women, have wider implications for studying spiritualties, particularly in worlds of fragmentation and damage. These voices and spiritualties are integral to whole person approaches in mental health nurse education. The key discovery of the study is the creative potential of shared relational space in developing self-care and self-anchoring, fundamental in supporting and facilitating the emergence of unheard voices. Fluid, compassionate spaces of spiritual mutuality provide safe havens for learning and recovery. As one participant says:

> *'… you can develop wisdom regardless of the chaos around you and that hopefully transfers into your environment as well…'*

Acknowledgments

First, I would like to offer my gratitude to the women, whose lived experiences are the foundation for this study and for the privilege of being trusted as the conduit for telling their stories. Secondly, to my thesis supervisors Francia Kinchington, David Evans and Jennifer Patterson, without whose wisdom and kind attention, the work would not have been completed. I am also thankful to my colleagues at The University of Greenwich who generously filled in the gaps and supported me while I studied. Thank you to the students, in whose ambitious unfolding I am continually inspired.

Thank you to Christina Moore for administrative duties and support beyond the call of duty.

My family is my heart and their courage, tenacity, kindness and forbearance drives my ambition. I am thankful for the invaluable support of friends and neighbours. The women, who have danced, read and prayed with me and the healers and soul friends who have accompanied me. Your friendship is an ocean of compassion and wisdom.

Lastly, to my sons, Sam and Jed whose intrinsic and extrinsic shining is the constant light to my journey …

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Dedication

Owen Edwin Watkins

17th December 1922 – 19th June 2015

My beloved father died during the completion of the thesis and I am heartbroken not to be able to share these moments with him, in person.

In his loving gaze, and deep pride, I have always been able to find my North Star.

And for a fraction of a second,
You can't remember where you are
Just open your window
And follow your memories
Upstream
To the meadow in the mountain
Where we counted every falling star

I believe the light that shines on you
Will shine on you forever …

Dear Dad, meet you at the secret river …

Chapter 1: Introduction

The following chapter outlines the intent and complex critical contexts for the study. An overview is provided showing how the study has been organised.

1:1 Intent

Interpersonal mental health nursing is predicated on the development of relational trust between the one nursing and the one being nursed (Peplau, 1952; Barker, 2003). Wilkin (2008: 26) goes as far as to say that mental health nursing is "primarily being and becoming with people who are suffering the effects of disease and distress". The nursing craft therefore develops through understanding mental ill health from the perspective of the person having the experience, becoming "sensitively attuned" to them in shared encounters (Barker, 2003; McAndrew *et al*., 2014: 213). Such encounters are between whole persons, biopsychosocial - spiritual beings, occupying shared spaces for discovery and healing (Clarke, 2013). Mental health nurses (MHNs) join people in their journeys of recovery, in roles of facilitation and encouragement, but cannot make them recover or change. Rather, the caring craft exists in the creation of conditions where each individual may experience growth and change (Benner, 2000; Watson, 2005; Barker, 2003). Indeed, care as a term signifying kindness and caution, can only be valued by the person experiencing it, (Barker & Buchanan-Barker, 2011). From this perspective, MHN education is intentionally relational, other-focused and facilitative (Wilkin, 2003; Barker, 2003; Helm, 2003; Newman, 2008).

This study primarily seeks to re-direct attention to the quintessential spiritual nature of therapeutic relating in mental health nursing and consider the ways in which *being with* in the deepest sense means entering into or being-in-the-the-world of the other (Walsh, 1997; Wilkin, 2003; Barker, 2004b). My ultimate aim is to propose a pedagogical stance and an educational environment that will equip MHNs in developing spiritual approaches to their art and craft. This issue is addressed through an exploration of the lived experience of a group whose voice on spirituality is significant and under researched (Kaysen, 2000; Van Gelder, 2010; Carey, 2011). The study primarily explores mental ill heath, recovery and spirituality in the lived contexts of women with borderline personality disorder (BPD). Essential experiences of living

with BPD are uncovered in such a way as to provide opportunities to hear voices that are hitherto little explored in the research literature and mainstream discourse.

In form and intention, the study is an exploration of deep inner worlds, inhabiting other landscapes and optimising opportunities for the reader to be relationally engaged within the study. On occasion, it is hoped that the reader will be able to step right into those other worlds, in Buber's (2010) *I-Thou* sense, wholly with the other. Pre-existing personal and theoretical assumptions that might veil complex understandings are intentionally fused with lived story in order to explicate meaning. To achieve this, other possible discourses and new ways of thinking have been mined, so that the researcher is learning to speak and write reflectively as other. Drawing on researcher experience in nursing and nurse education the study seeks to illuminate elusive concepts, destabilising the existing prejudices found in practice and classroom settings, with a view to developing fresh compassionate perspectives and actions (van Manen, 1990; 1998). From this position, the thesis is an invitation for all those involved in mental health care, particularly those working with people with BPD, to hear differently, engage with new meanings and reconsider aspects of practice and learning (van Manen, 1990; 2014; Benner, 2000). My undiminished passion as a mental health nurse and nurse educator has been to make known that which is not known, adding creatively and compassionately to complex stories of human journeying.

1:2 Critical Contexts for the Study

1.2.1 'Silently Screaming' – *Borderline* Contexts

They put me in a four-walled room

But left me really out

My soul was tossed somewhere askew

My limbs were tossed here about

Linehan in Carey, 2011

This fragment of poetry written by a young woman, hospitalised and later diagnosed with BPD, powerfully evokes sensations of compulsion and passivity, being locked in

and enclosed while being left out and excluded. Such language resonates both with the researcher's professional experiences of individuals with BPD, and in the echoed expressions of borderline being written by lived experience authors Kaysen (2000) and Van Gelder (2010). Those who experience societal disenfranchisement and alienation through mental health issues have been described as living in the borderlines and margins of political and health discourse. In this study, the "*borderline*" refers to the lived experience of being diagnosed with BPD, much as it is depicted and embraced in "The Buddha and the Borderline" (Van Gelder, 2010), for example as a way of being, in relation to self, the world and others. The relationship between the two meanings of the term is, however, germane in this context.

Situating this poetic fragment at the contextual beginning is intended to ground the study in the lived experience of the particular otherness that is *borderline being*. The author of the poem is Marsha Linehan, BPD expert psychologist and therapist. Her treatment approaches are amongst those which have helped evolve a more hopeful BPD discourse (Linehan, 1993a; 1993b; 2014). As a clinician, Linehan had avoided the question and stigma of her own diagnosis, finally self-disclosing at an event reported in the New York Times in 2011 - *borderline* perspectives are rarely given such public coverage. The New York Times (Casey, 2011) reported Linehan's felt disconnection of body and soul, at once visceral and deeply spiritual. In the same article, Linehan locates the shoots of recovery in an intense Damascene moment of radical self-acceptance. Over time her own soulful journeying, helped her find new ways of being through lovingly coming towards the damaged parts of self, rather than fleeing from them (Casey, 2011). Linehan was clear that her unique journey would not suit everyone and was wary of a wider application. Van Gelder (2010), for example, in her memoir, delivers an altogether slower, bumpier personal ride.

Deegan (2005) and Swinton (2001) note the lack of lived mental health experience in research literature. Swinton (2001: 94) refers to the "silent voices" of service users, while Deegan (2005) notes a double silencing in having mental illness, receiving inadequate help, and being ignored on both counts. There is a particular silencing of the voices of individuals with BPD, with the clinical challenges posed by presenting in

crisis, being difficult to engage, leaving clinicians anxious and pessimistic (Winston, 2000). The characteristic externalising of inner distress can engender dissonant responses, lacking in useful help and comfort (DH, 2003; NCCMH, 2009; Furnham *et al.*, 2014). Women were thought to make up the majority of those diagnosed with BPD and still make up the majority of those in clinical populations (Coid, 2003; Paris, 2008). The *borderline* voice is perceived as female, emotionally charged, expansionist and intermittently explosive and fundamentally "different", in Gilligan's sense (1982) when measured against a normative discourse which is bio-medical, paternalistic, scientific and reductionist.

To paraphrase Irigaray, publically and professionally, *borderline* women remain consigned to a state where they "have no vision, have no insight, have no voice, have no action" (Irigaray, 1993: 71). This study examines the voices and experiences of women with BPD, addressing mental health and spiritualities in relational contexts, from the perspectives of some of those particular voices.

1.2.2 "Organic Fluidity" - Nursing Contexts

Historically and professionally, nursing includes a spiritual dimension, yet guidance is contradictory and praxis variable (Nolan & Crawford, 1997; McSherry, 2006; Clarke, 2009). Recent reviews clamour for a more useful inclusion of patient and public voices (DH, 2012; HEE, 2015). The catastrophe of neglect and poor care revealed by Francis (2013) demanded the fostering of a shared culture of putting the patient first, transparent both to those delivering and in receipt of services.

Educational standards for MHNs require compassionate practice cognisant of the values and spirituality of people experiencing mental health problems, sensitive to past trauma and potential power imbalances, mindful of mental health promotion and wellbeing (NMC, 2010). Further developments in specialist mental health practice is proposed with the continued honing of skills in interpersonal communication and therapeutic relationship building for MHNs (NMC, 2010; HEE, 2015). While Bradshaw's (1994: 332) imagined golden age of nursing and unity of purpose is unlikely to address todays complexities, her "shattered lamp" motif is resonant of a longer standing

professional disquiet. Relational approaches to nursing, under threat from current organisational and resourcing imperatives are further diminished by public perceptions of a crisis at the very heart of nursing (McAndrew *et al.*, 2014).

The fundamental importance of therapeutic relationships between nurse and patient are enshrined in professional guidance, research and theory, but in itself, this does not guarantee either its continuity or relevance to current practice (Peplau, 1952; Barker, 2003; Evans, 2005; NMC, 2010; Cahill *et al.,* 2013). While MHNs should be in a pivotal position to engage in therapeutic alliances, a paucity of therapeutic contact, which is out of keeping with the aspirations of service users, is often noted. Cameron *et al.* (2005) amongst others, propose strengthening the professional identity from within through deeper understanding of the patient experience. Peplau (1952: 16), seminally provided the developmental framework which defined mental health nursing as "a significant, therapeutic interpersonal process", capable of moving both nurse and patient towards more creative, productive possibilities. In her work, Forchuk celebrates the complimentary impact of the type of interpersonal nursing on patient outcomes, while identifying nurses feeling overwhelmed and burnt out as possible barriers (Forchuk, 1995; 2001; Forchuk *et al.,* 2000; 2005; Coatsworthy-Puspoky, *et al*., 2006).

Peplau (1952) conceptualises the nurse-patient relationship as an inter-relational journey of orientation, identification, exploitation and resolution. Commenting on therapeutic milieu, Haigh (2013) identified a quintessential relational process suggestive of the re-nurturing of primary emotional development and cognisant of the healing potential inherent in new experiences of attachment. The quintessence of inter-relational mental health nursing might require the development or "unfolding" of such experiences in the nurse as a precursor to patient engagement (Benner, 1984; Barker, 2003; Newman, 2008: 65). Unfolding, according to nurse theorist Newman (2008) is foundational in the transforming presence of nursing. Like Carper (1978) and others, she proposed that consciousness is a knowing-with process developing dialogically and relationally between persons. As yet, there is no coherent pedagogical theory for transformative presence and current organisational structures rarely afford

the reflective time and space to develop such meaning and mutuality.

Interpersonal nursing is linked with spirituality through the concepts of being-with and knowing–with, in safe sacred spaces, created to enable existential re-growing of damaged persons towards wholeness (Steele, 2014). Emerging from crisis, mental health service users describe comfort, presence and human support as the factors that have sustained them on their recovery journey (Barker & Buchanan-Barker, 2004b; 2011). As one service user puts it:

> I don't really care how my care plan is done, or the technicalities of anything, but I do care very much about how, when you're in one-to-one interaction with me, you know how you're being with me
>
> Trivedi, 2014.

There is little definitive clarity about spirituality in nursing (Clarke, 2009; 2013; Reinhart & Koenig, 2013). According to McSherry (2006) and Wilding *et al*., (2006) spirituality is identified by nurses as a unifying and harmonious force in their work. Adequate supporting structures to develop the confidence, knowledge and skills and maturity for bringing spirituality explicitly into patient care are variable and rare, however (Moody & Carroll, 1998; Barnum, 2011). Furthermore, Clarke (2013) posits that the use of more acceptable, less theological definitions for spirituality have led to the confusion of spiritual with psychosocial care, difficult to both explain and practice. Lacking opportunities to develop self-awareness and intentionality of practice, nurses often fail to take the necessary steps to experience deep learning with, and from, the patient in ways that might be helpful to both (Freshwater, 2002; Stickley & Freshwater, 2006; Barnum, 2011). Relationships between MHNs and patients are constructed within cultural, political and economic structures. In increasingly managerial, outcome driven, risk averse settings, interpersonal relationships can be overshadowed by the triadic positioning brought into relational care by powerful, external agendas. Such divisions are not new but seem to have become more overtly foregrounded (Colley, 2002).

Interpersonal nursing shares roots with psychotherapy. Dynamic psychotherapies aim to facilitate self-acceptance through, what Horney (1967) called the lifting of growth blockages; a relational self-concept developed through “organismal environmental interactions” (Horney, 1967: 13). Jung went so far as to say that the “self is relatedness”; not so much that we *are* self, as we “do the self”, in actions and relationships (Jung, 1955: 357). Relationality has significance for healing paradigms across histories and geographies, from the shaman in traditional healing (Jay, 2013; MacDiarmid, 2013) to the counsellor in person-centred approaches (Heron, 1999, 2001; Rogers, 2004). Rogers (2004) stated that his work was spiritual and loving, informed by a creative force for profound growth and healing. Lambert (1981) identified an *agapeistic*[1] *attitude*, in effective therapists, a quality of deep listening, as though one soul is speaking directly to another. Buber (2010) refers to the sacred *in-betweeness* of human minds, bodies and relationships as *I-Thou* relating. O’Brien (2011) referred to something similar as the *holy ground* of nursing. Rogers (2004) went on to say that he thought that the relevance and importance of this mystical dimension is often overlooked. This is a study of deeply attending to other worlds of lived experience and entering those in-between spaces. Entering other worlds is difficult and entering other spiritual worlds even more so, requiring stillness, patience and courage, what Buber (2010) referred to as deeper relational consciousness. The researcher adopted a stance of relational sharing with due regard, warmth and acceptance towards the personhood of the other and a genuine desire for their well-being (Bottorff, 2011).

While nursing is defined in terms of the other, and what is done to the other, the position is often conceptualised solely from the nursing perspective. This study is therefore intentionally other-focussed. The unique relational difficulties experienced by MHNs and people with BPD provide an opportunity to grasp a particular fragment, cutting through complexity to inform the debate. The intention is to develop an organic fluidity of praxis as replacement for the homogenous certainties of the past, which no longer apply. The study is informed by a construction of nursing that has

[1] *Greek* agape, *which translates into Latin as* caritas*, and English as charity or love*

consciousness-expanding potential with transformative and spiritual elements but remains mindful of intrinsic and extrinsic limitations (Newman, 2008; Watson, 2005). The purpose is to develop flexible yet robust approaches to the education of MHNs fit for diverse contemporary contexts, through the uncovering of spiritual and dynamic possibilities of lived experience and the reclamation of traditional wisdom. The merits of such creative pedagogical approaches lie in renewed possibilities to liberate existing frames of reference in nurse education and develop a new collaborative language (Mezirow, 1990; Irigaray, 2008).

1.2.3 "No Decision about Me, Without Me" – Policy Context (1999- 2015)

Standards for mental health care set out in the National Service Framework (NSF) (1999), preceded a raft of mental health policy reform in England, which ended in 2010 with the reform of the NHS and the establishment of NHS England. The ambitious policy agenda proposing to combat discrimination in mental health is a potent legacy, focussing positively on service user partnerships planning effective care with supported, empowered staff. In 2012, the government white paper, *Equity and Excellence: Liberating the NH*S (DH, 2012) set out the Government's vision of patient-centered healthcare, where "no decision about me, without me" is the mantra. Proposals were included to give everyone more say over their care and treatment with opportunities to make informed choices, as a means of securing better outcomes. The importance of providing accurate and accessible information in order for people to make informed choices and the need for a culture change to enable patient involvement to become routine in the NHS were recognised.

For personality disorders the publication of the National Institute for Mental Health (NIMHE) (2003a) guidance, *Personality Disorder: No Longer a Diagnosis of Exclusion*, promised to end the marginalisation of services and ameliorate the impact of stigma for people with this diagnosis. The guidance aimed to ensure that specialist services would be developed, that staff would be effectively trained and the DH would fund the initiatives required to implement the policy. The Personality Disorder Capabilities Framework (2003b) was developed to support the pump priming process, funding training that would develop capabilities in staff across the healthcare system

appropriate to interactions with people with personality disorder. The proposed training was to be intentionally values-based, inclusive of respect for the human rights and autonomy of service users, reflective of their views and, “aimed at breaking the cycle of rejection at all levels including self-rejection, the social support system, practitioners and the wider health and social care systems” (NIMHE, 2003b: 22).

In 2009, NICE (NCCMH, 2009) commissioned clinical guidance for BPD and a multidisciplinary team of experts from professional and lived experience backgrounds considered the best available evidence, to develop advice on the treatment and management of BPD. This guidance, as the first comprehensive national review of the disorder contains a useful overview with recommendations for planning high quality care and improving people's long-term outcomes. While acknowledging the exponential rise in available evidence-based treatments for BPD, the guideline notes the impact of stigma and poor experiences of care, suggesting innovative approaches to manage crises and configure services. While, the primary focus is on adults, the guideline considers emerging characteristics of BPD in younger people and children.

The resulting NICE guidance, “Borderline personality disorder: treatment and management” (NICE 2009) provided definitive recommendations to be used in primary, secondary and tertiary care with the aim of helping people with the diagnosis to manage distress and maintain close, stable relationships with others. The guidance recognised BPD as potentially seriously disabling with such individuals amongst the most likely to use mental health services. The disorder is characterised by emotions, which are up and down, feelings of emptiness and anger, difficulty in making and maintaining relationships, and self-harming. The guidance concludes that while people with BPD come from many different backgrounds, most will have suffered some kind of trauma or neglect as children (NICE, 2009). Epidemiologically, BPD is noted to be present in just under 1% of the UK population, with women presenting more often than men. BPD rates are estimated to be 23% among male remand prisoners, 14% among sentenced male prisoners and 20% among female prisoners in England and Wales, 60-70% of people with BPD attempt suicide and up to 10% of people with BPD will die from suicide (NICE, 2009).

The underpinning principles of the guidelines are that *all* people with BPD will have fair and equal access to service and not be excluded from any service due to diagnosis or self-harming. In keeping with recovery-orientated principles, professional are entreated to work openly and non-judgmentally, mindful of experiential trauma and rejection. Short and long-term interventions in community settings are recommended to avoid lengthy hospitalisations and drug treatments, focusing rather on the development of collaborative risk management plans and psychological therapies. Teams working with BPD are encouraged regularly review team members' tolerance and sensitivity to people who pose a risk to themselves and others. Psychological treatment is predicated on individual engagement and motivation to change within the boundaries of a therapeutic relationship. The guidance was published in 2009 and reviewed in 2015 with nothing new found affecting the recommendations. It will next be reviewed in 2017.

Elsewhere in mental health advances in treatment, changing attitudes and greater emphasis on human rights are transforming provision, expectations and the relationships between those living with mental illness and those caring for them. Poor mental health is now recognised as a major cause of disability worldwide, negatively effecting education, work and relationships for individuals and communities; links between physical and mental health are being better understood, as is the impact of stigma and marginalisation (WHO, 2016). In the UK, national guidance and service development has ambitiously highlighted the significance of promoting mental health and well-being in association with a recovery agenda (NIMHE, 2005; DH, 2009c; 2011a), culminating in the Five Year Forward Plan (NHS England, 2016). The plan puts the service user voice at the heart of provision, with an emphasis on improved outcomes, physical health, services for younger people and reductions in avoidable harm and stigma. The strategy has been widely welcomed and the positive rhetoric is hopeful that services will become increasingly focused on prevention, early intervention, improved access and an approach to service users, which values voice and partnership. One service user sums up these aspirations in the strategy document:

> Services and professionals listen to me and do not make assumptions about me. Those who work with me bring optimism to my care and treatment, so that I in turn can be optimistic that care will be effective. The staff I meet are trained to understand mental health conditions and able to help me as a whole person. Staff support me to be involved in decisions at the right level. They respond flexibly and change the way they work as my needs change.
>
> (NHS England, 2016: 43)

Attitudes are improving with growing mental health awareness. Mental illnesses are common in England, accounting for nearly half of all ill health in people under 65 and more debilitating than many chronic physical conditions, imposing significant economic and social costs (NHS England, 2012). Yet there are serious gaps in provision and parity of esteem with physical health is yet to be achieved (NHS England, 2012; 2016). Transformational leadership for best practice and service design is required to achieve a change of focus. Services that offer psychological interventions, tackle stigma and equitably distribute resources to manage the association between physical and mental disorders, are called for (NHS, England, 2012).

Shifts in political will and policy, impact on the roles and responsibilities of mental health nurses required to fill increasingly autonomous roles in multi-disciplinary teams and diverse settings. Significantly, nurse education continues to undergo fundamental change with demands for increased flexibility, co-productive relationships that genuinely value and respect the patient voice and a focus on care and compassion to reinvigorate core values and behaviours (Cummings & Bennet, 2012; Willis, 2012; NHS England, 2016). New plans for salaried apprenticeship nurse training are currently set against proposals to remove the nursing bursary in higher education, so that contradictory forces for increased academisation and professionalism vie with a return to more craft-based, in-house approaches (DH, 2015). The challenge in nurse education is to continue to facilitate the development of reflective self-awareness, therapeutic interpersonal skills, professional resilience and recovery-orientated approaches to meet contemporary service user demands. The integration of the patient voice into education and training and the development of co-productive programmes, however, has become an even more urgent priority if mental health

nursing is to remain relevant and valued.

This study reflects policy imperatives to develop optimistic, hopeful relationships with individuals with BPD, which will value their individuality, promoting autonomy, choice and therapeutic engagement. It is proposed that this study will help MHNs to refresh their approaches to complex interpersonal circumstances, reducing stigma and encouraging a discourse of deeper understanding.

1.2.4 "Original Singing" – Theoretical Context

Phenomenological hermeneutics capture both the descriptive and the interpretative, attending to things as they appear (phenomenology) and things as they are meaningfully (hermeneutically[2]) experienced, thus there is no such thing as "uninterpreted phenomena" (van Manen, 1990: 81). Understanding is achieved through engaging with unique perspectives of lived experience. For Heidegger (2010) such engagement is circular, as grasping a phenomenon's being (ontology) requires the very mode of being which has not yet defined, to have already been defined. This hermeneutic circle can be mediated through language in conversation with others in a circular process of interpretation (Gadamer, 1975). Similarly, mental health recovery frameworks emphasise the unique meaning and purpose of each experience. The recovery journey has a power to communicate across individual, social, cultural, historical boundaries yet only retains hermeneutic validity in a particular cultural and historical context (Anthony, 1993; Deegan, 1998).

The phenomenology of practice explores the mystical and wondrous on the one hand and the practical and pragmatic on the other (Merleau–Ponty, 1968; van Manen, 2002; 2014). Phenomenological methodologies are used in the study of spirituality, health and nursing and intentional entering into the inner world of the other can inform practice by uncovering rich insights into human experience (Swinton, 2001; van Manen, 2002; 2014; Todres, 2007). Phenomenology considers lived experience of, and

[2] *Hermeneutics, derived from the Greek:* hermeneuō*, meaning 'translate' or 'interpret'*

within, the world as the foundation of meaning in order to present "plausible insights" (van Manen, 1990: 9). This study intends to garner such insights in the promotion of action and change. For this reason, a relational phenomenological approach to data gathering is adopted to link the researcher as directly as possible to the experience of the other, reflectively integrating theoretical method and relational praxis (Swinton, 2001; Linehan, 1993a).

The uncovering story is likely to be fragile, at risk from over-interpretation and over-weighting, so the intention is use a light touch to retain a sense of otherness and mystery. At the same time, for the purposes of application the study retains a practical grounding with the researcher operating somewhere between the two (van Manen, 2014). Barker & Buchanan-Barker's (2015) Tidal Recovery Model entreats MHNs to "toggle" between personal and professional selves in therapeutic relationships. I have adopted this approach pragmatically in the study, between the '*researcher me'* and the '*nurse me'* epistemologically and methodologically. Denzin and Lincoln (2003a) suggest a *post*-postmodern synthesis for moral discourse and sacred enquiries to counter postmodern fragmentation. Heron (2006) offers a vision of diverse spiritualities, inclusive of ancient tradition and mythology, drawn from a rich well of disciplines of thought and practice. Van Manen (1990) describes his particular phenomenology of practice as the capture of *original singing* derived from the unique nature of each human situation, between ephemeral mystery (the women) and grounded praxis (the nurses). Feminist Jungian, Pinkola Estés (1993) believes that this process of gathering the bones of past truths and singing over them enables new truths to emerge. This thesis is my intentional way of *singing over the bones*.

1.2.5 "Knowing from Soul Hearing" - Personal Context

My own nursing practice is grounded in reflective, intuitive connectedness from humanist and psychodynamic psychology, honed during an experiential mental health nurse education in the 1980s, influenced by the work of Peplau (1952), Maslow (2000), Benner (2000) and Heron (2001). The praxis that developed over thirty years owes much to the wisdom warriors who shared it; the patients who taught me the craft and the colleagues who walked the difficult pathway alongside me. The wisdom of one

patient, profoundly Christian with bi-polar disorder and terminal bone cancer, is representative. Fearful of dying 'mad', cut off from God's grace, as she neared death, she shared her experience with me of coming and becoming closer to the heart of God. For me, however, understanding this as spiritual work came later through personal crisis, therapy and revelation. Studying Psychodynamic Psychotherapy helped me to develop deeper relational insights. My tutor, an ex-monk, psychiatrist and Jungian analyst, suggested that understanding the unconscious was a journey of discovery enabling the capacity to love. He thought that living well meant loving well, as he did (MacDiarmid, 2013).

I am especially mindful of the *borderline* women at once fragile and powerful whose stories have inspired this study. Working with them as a community nurse in the 1990s, I became increasingly concerned about clinical negativity and therapeutic reluctance surrounding this patient group. One, in particular, found hope and solace in her religion. In 2002, I compiled a report for developing local service for BPD. Using clinical connections, I collected stories from service users and practitioners discovering random, inconsistent provision and negative practitioner attitudes (Watkins, 2002). I have longed to return to these stories and discovering Van Gelder's (2010) memoir reignited that ambition.

As a nurse educator for over twelve years, I have been continually inspired by students at the beginning of their nursing adventure, only saddened to hear their stories of disappointment as the job they love is ensnared in bureaucracy and risk averse practices, denying them what Newman (2008) referred to as their professional "unfolding". My own nurse training took place in a hospital-based nursing school as part of a cohort of six students, quite different from current university provision in large cohorts and lecture halls distanced from clinical practice. Graduate nurse education continues to struggle with this theory-practice divide. Political rhetoric favoured the diversity of vocational degrees, the public, or at least the media were concerned about university-educated nurses while nurse academics and leaders took a more optimistic view. Learning to be a nurse teacher in higher education from 2003-2005, I was influenced by the professional and academic interests of the time, linked to an ongoing process for widening participation in universities. During my training at

the University of Greenwich, the complexities of integrating class and practice based learning caused nursing professor Meerabeau (2001) to lament the marginal position of nursing in higher education. Pedagogical and political pressures for an increasingly assessment-driven, product-focussed, higher education were seen as the development of "corporate-enterprise culture" in learning. These remain issues of conflict in nurse education (McNay, 2012: 5). For MHNs specifically, these new learning environments were not ideal places to facilitate self-awareness or relational connectedness and educators have struggled to develop coherent, sufficiently reflective educational spaces (Barker, 2003).

Personal and professional experience, losses and triumphs and (re)discovering spiritual paths has galvanised my belief in the healing potential of love and forgiveness and the tenacity of the human spirit. As Deegan states (2005), we are all in recovery from something. Walking together with people "in the strange land of madness" fuels my belief in the healing capacities of each of us (Swinton, 2007: 13). Having a particular Anglo-western, Judeo-Christian cultural reference, I have endeavoured to negotiate a tone, which is personal and suitable for expressions of newness and plurality (Housten, 1997). The intention is to influence on-going debates about relational nursing and spirituality to re-vitalise educational approaches. A personal narrative voice is purposefully developed to voice deeper ways of knowing, a "knowing from soul hearing" (Pinkola Estés, 1993: 35). The intention is to show that mental health work is soul work, shining a light of hope into dark places of distress and disenfranchisement.

1:3 Overview of the Study

1.3.1 Research Aim

The study primarily explores mental ill heath, recovery and spirituality in women who have been diagnosed with BPD. The secondary purpose is to re-direct attention to the possibilities for the spiritual nature of therapeutic relating in mental health nursing. This is a professional doctorate in education and the final aim is to consider how the study findings might influence the development of a pedagogical environment and stance that best serves this endeavor. It is an assumption of the study that these

spiritualities and perspectives are present. The study intends to locate and uncover hidden language, symbolism and experiences to inform and enhance practice.

1.3.2 Research Question

The key research question is:

> **How might an understanding of the lived experience of spirituality in women with borderline personality disorder inform and influence their therapeutic relationships with mental health nurses?**

This broad complex question has been broken down into the following subsidiary questions, to promote clarity and assist the research. These are:

I. What is the nature and essence of spirituality for women living with BPD?
II. What are the interrelationships between these spiritualities and therapeutic relationships for women living with BPD?
III. How might these spiritualities inform therapeutic relationships with MHNs?
IV. What educational strategies might be developed for the spiritual education of MHNs in the light of borderline relational spiritualities?

1.3.3 Research Approach

The study uses hermeneutical phenomenology to explore the spiritual landscapes, revealed through dialogic interviews, of women who have been given a diagnosis of BPD. Participants were expected to engage collaboratively with a researcher who is actively listening, through verbal and non-verbal cues, reflectively sharing revelatory experiences (Creswell, 2007). Each structured conversation provides a potential mirroring of therapeutic relational experiences, posing possibilities for mental health nursing practice. The reflections and reactions of the researcher are therefore included. The approach is intentionally exploratory and revelatory, and, at the same time, compassionate and optimistic. Every effort is made to minimise risk, limit negative experience and enhance positive experience for the participants.

1.3.4 Notes about Terminology

The word **borderline** is used to refer to people with the kinds of experiences associated with having a diagnosis of BPD, which will be more fully explained in Chapter 2:3. For clarity, the phrase will not be used to refer to broader borderline human experiences of discourse and epistemology. Generally, in such cases, the terms margins and marginality, borderlands and in-between are used.

In order to reflect respect for religious and other beliefs and clarity of expression, reference to particular belief traditions or individual faith, adopts a capitol letter at the beginning of terms for the **Divine**, **Ultimate Reality** and **God.** Where general points are made about gods, deities and conceptions of transcendence, lower case lettering is used.

1.3.5 Justification for the Study

Nursing is under scrutiny with current debate focussed inwardly and outwardly on professional care and compassion (Cummings & Bennett, 2012; DH, 2015; HEE, 2015) and a resurgence in spiritual approaches (McSherry & Ross; 2002; McSherry *et al.,* 2004; McSherry, 2006; NMC, 2008; RCN, 2011). MHNs are engaged in practice, which validates personal recovery, utilising service user experience, promoting growth, and healing through significant therapeutic relationships (Peplau, 1952). BPD creates chaos and confusion, sometimes challenging a sense of relational integrity with self and others (McGrath & Dowling, 2012). People with BPD seek effective therapeutic engagement, voicing spiritual seeking and need (NCCMH, 2009; Van Gelder, 2010). This research brings together these themes in a timely way to identify and explore spiritual contexts for promoting relational connections. For the researcher, who is both a mental health nurse and nurse educator, the study is justified by professional and clinical imperatives.

1.3.6 Originality and Positioning

Hart (2007) associates originality with the bringing ideas together in ways that are authentic and new in style and character (Hart, 2007). The location of spirituality in mental health discourse and the relational role of MHNs are intertwined in new ways in this study, challenging preconceptions, providing spaces for revival and renewal. The aim is to achieve a deeper understanding of the nature, essence and context for *borderline* spiritualities uncovering spiritual meanings in *borderline* lived experience. By aligning the central essence of spirituality with nursing principle and practice, it is anticipated that innovative frameworks for creative other-focussed interpersonal approaches might be developed. The originality of the thesis is therefore to be found in its positioning within these debates, as explicated in the figure below, adapted from Hart (2007:24).

Originality of the Study

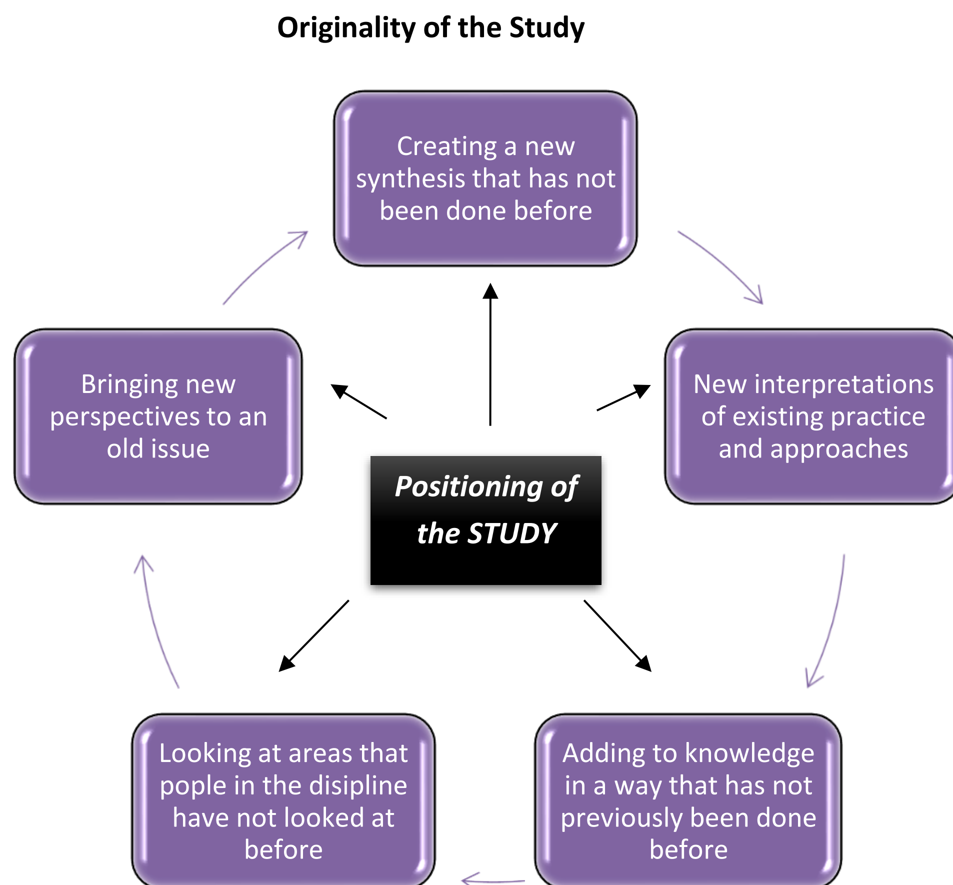

Figure 1:1 Originality of the Study adapted from Hart (2007:24)

1.3.7 Organisation of the Thesis

The thesis is organised into five chapters, delineated in Figure 1:2. The introductory chapter is followed by a review of research literature, chapter three analyses and discusses the methodology, chapter four discusses the findings and the final chapter provides a summary with possible future directions and a reflection.

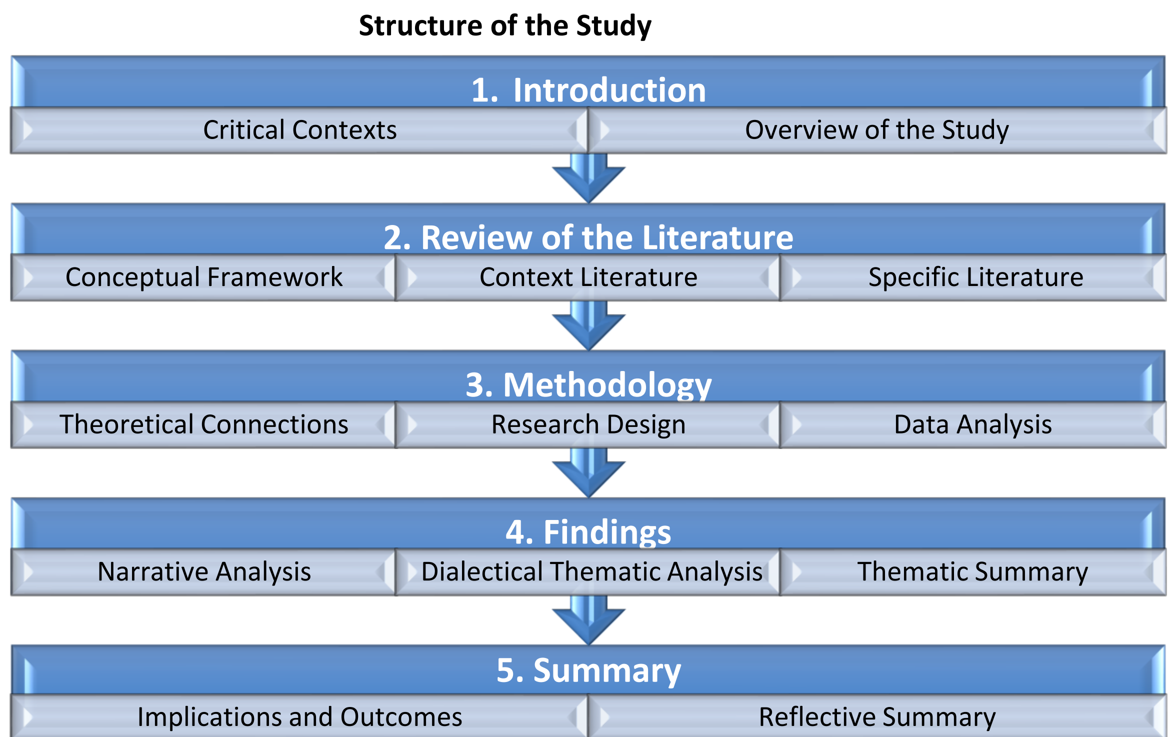

Figure 1:2 Structure of the Study adapted from Creswell (2007)

1:4 Conclusion

This chapter has drawn attention to complex and diverse study contexts, including spirituality, theology, mental health, nursing, psychotherapy and education. These discourses will be explored more fully in the following chapters. The study aims to tell stories, which reveal turning points, arising from situations and conversations and shifting perspectives, from that of silent victim to that of active agent, with choices and responsibilities to self and others (Brown & Kandirikira, 2007). These turning points in the lives of the women represent what Hannigan and Evans (2013: 43) have referred to as “critical junctures” in caring discourse; moments of pause and uncertainty, that might potentiate the development of alternative perspectives. This study is one such pause.

Chapter 2: Literature Review

This chapter presents three sections comprising a conceptual framework or process from carrying out the literature search, the second part comprises an examination of the wider literature providing a contextual grounding for the study and leading to the third section comprising of the literature related specifically to the research question. The chapter concludes with a summary of the implications of the literature review for the study. Each layer of this process builds on the one preceding it, thus:

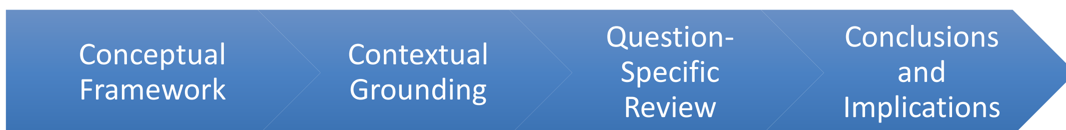

Figure 2:1 Literature Review Process

2:1 Section 1: Conceptual Framework

A conceptual framework (Figure 2:1) has been adapted from Gadamer's hermeneutic circle (1975) to demonstrate how intersections of experience, borderland epistemologies and fresh perspectives inform the literature search (Bernstein, 2005: Tlostanova, 2010). In this way, essential meanings link with unique lived story providing the space for the study (Hart, 2007; Fry, 2009; Malpas, 2015). Understandings gained from the literature are combined with existing experiential preconceptions from health and educational discourses so that the (imagined) whole changes as successive parts are uncovered (Heidegger, 2010; Gadamer, 2013). This hermeneutic process is traditionally depicted as circular, but the adaption here is in the form of a spiral, to represent the way that each uncovering potentiates others, both preceding it and following it. The first grasp represents engagement with familiar ways of knowing. Detailed inspection, through critical interpretation, accompanies this grasping. Historical, social and cultural influences are merged with new concepts. The resulting review forms a bridge across different horizons, merging them to reach deeper understanding and meaning. The figure below presents a specifically phenomenological process, an interpretative engagement with the literature (Gadamer, 1975; Fry, 2009).

Conceptual Framework for the Literature Review

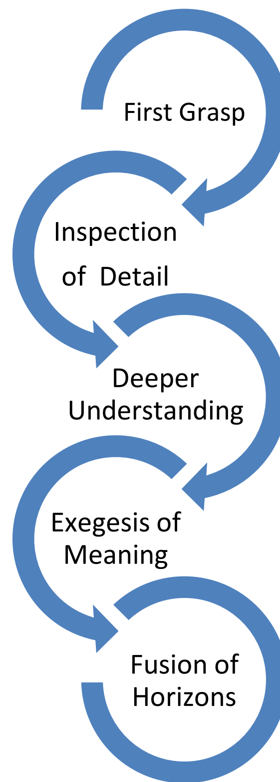

Figure 2:2 Suggested by Gadamer's Hermeneutical Cycle (1975)

2:2 Section 2: Contextual Grounding

There is considerable interest in spirituality in mental health and BPD, supported by a vast literature. A multi-layered review is drawn from seminal texts, key authors, current practice guidance, professional contacts and stories from lived experience to provide critical contexts for the study of spiritualities and BPD (Appendix 1). It is not the purpose of the review to revisit issues already well documented or incontestable, rather to uncover fresh perspectives to inform the topics under discussion.

2.2.1 Defining Spiritualities

2.2.1.1 Ancient and Modern

Postmodern definitions of spirituality are capacious and "slippery" (Swinton, 2001: 12; Pargament, 2011; Rowson, 2014). Of necessity, this study engages with existing

language and symbol. Carol Christ (1985) finds new meanings through the lens of traditional concepts. Indeed, new spiritualities develop from syncretic dialogues across faith, historical and cultural boundaries (Swinton, 2001; Denzin and Lincoln, 2003a; Daniels, 2005; Heron, 2006; Pargament, 2005; Cook *et al.,* 2009; Cook, 2013).

Contemporary approaches in practice and research have tended to make clear distinctions between spirituality and religion, to the detriment of the latter (Silberman, 2005; McSherry, 2006; Miller and Thoresen, 2003; Casey, 2013). This is not a new idea – Jung, for example, thought that religion might actually impede the growth of the human spirit (Jung, 1958). Spirituality is associated with fluidity and flexibility while religion is associated with culturally based practices and societal mores leading individuals increasingly to claim to be spiritual but not religious (Barker & Buchanan-Barker, 2004b). Religion can provide cultural or familial identity where alternative spiritual pathways can be divisive and limiting (Griffith, 2002; Heron, 2006). Fundamentalism, as a response to postmodern fragmentation, offers illusory certainty but may represent a shadow-side to a reflective spiritual life, while New Age spiritual approaches, freed from religious doctrine, can appear ungrounded and self-indulgent (Corbett, 2012; Moore, 2012). One study (King *et al.,* 2013) claimed poorer mental health in people who are spiritual but not religious, compared to other groups.

Bonelli & Koenig (2013) in a systematic review, describe a research literature dominated by a spirituality expressed through religious observance, such as church attendance, as being easier to measure. Indeed, Koenig, as a major researcher in this area, has been reluctant to disentangle religion and spirituality. The narrative of lived experience, however, presents an altogether messier concept relevant to the chaotic and confusing experiences of many and the women of this study, in particular (Miller & Thoresen 2003). Current research purports that religion and spirituality positively affect mental health outcomes bringing comfort, hope, and meaning (Swinton, 2001; Fallot 2007; Goldstein, 2007; Koenig, 2009; Casey, 2013; Bonelli & Koenig, 2013; Young, 2015). In a widely cited study, Koenig *et al.* (2001) found positive links to happiness, life satisfaction, optimism and self-esteem, findings supported by later studies (Bonelli & Koenig, 2013; Cook, 2013). Swinton (2001) identifies the beneficial impact of a religious-spiritual approach to recovery from clinical depression, noting

the significance of spiritual representations of bleakness and abandonment, the restoration of hope and identifying meaning. A review of the evidence base for mental disorders, religion and spirituality 1990 to 2010 by Bonelli & Koenig (2013) found a significant relationship between high levels of religious or spiritual involvement and less mental disorder, in particular with regard to dementia, suicide, stress related disorders, depression and substance abuse, with more mixed results for people with bi-polar disorder and schizophrenia. They found insufficient studies of personality disorder to draw conclusions, commenting that this lack of evidence did not mean that there is no association, merely that these relationships have not yet been studied. A review by Huguelet *et al*. (2016) found that in 26% of 175 patients, some of which had a diagnosis of BPD, spirituality was found to be essential in providing meaning in life, and was linked with better social functioning and values of universalism and benevolence. The results highlight the potential role of spirituality for recovery-orientated care.

Defining spirituality by positive emotional descriptors alone, however, pathologises human experiences of suffering, potentially marginalising the most vulnerable from the central ground of debates about spirituality and mental health (McSherry, 2006; Pesut, 2006). Newer spiritualities, which only focus on well-being and harmony, are unlikely to resonate with the lived realities of those who experience feeling fragmented and alienated. Research into behavioural observance alone is unlikely to capture the complex and subtle experiences of many. Rowson (2014) has suggested a relationship of partnership, estrangement and rivalry between religion and spirituality, engaging in a continuous dialectic of form and content. A dynamic, dialectical inter-relationship seems well suited to the aims and context of the study (Simmel, 1997; Pargament, 2007; Kavar, 2012; Rowson, 2014).

2.2.1.2 Spiritualities of Mental Well-being

Swinton (2001) has referred to spirituality as a “forgotten dimension” of mental health care. Spirituality has reclaimed something of its traditional place in contemporary health discourse with spiritual care defined as care for the “needs of the human spirit” (McSherry, 2006; DH, 2011; RCN, 2010; RCN, 2011 DH, 2011b: 13). Research over the

past two decades has linked spirituality with renewed hope, a sense of well-being, self-esteem, social support, motivation toward growth, as well as decreased depression, anxiety, and substance abuse (Swinton, 2001; Koenig, 2009; Bonelli & Koenig, 2013; Starina & Canda, 2014). Recent trends have been heralded as a clinical and ethical renaissance, a reversal in the shift *away* from spiritual healthcare (Miller & Thoresen, 2003; McSherry, 2006; Sims & Cook, 2009; Casey, 2013; Cook, 2013). A literature of spirituality and mental health has emerged in the work of academics (Swinton, 2001; Cornah, 2006), clinicians (Cook, 2013; Gilbert, 2007) and those with lived experience (Deegan, 1998; Trivedi & Wilson, 2011; Barker & Buchanan-Barker, 2004b). Reports from the Mental Health Foundation (2002; 2006; 2007a; 2007b; 2008), the establishment of a national forum for spirituality and mental health and the inception of a special interest group at the Royal College of Psychiatrists (RCP) denote a shift in attitudes and practice (Cook, 2013). Some psychiatrists are adopting holistic definitions which imply that biopsychosocial and spiritual approaches might be practiced harmoniously (Culliford, 2004; Verhagen & Cook, 2010).

Swinton (2001) implies that the current relationship between religion, spirituality and madness is healthy, if ambivalent. In clinical reality, practitioners consistently omit spiritual dimensions of mental health and spiritual approaches can cause conflict where bio-medical treatments and business-led service models dominate (McSherry, 2006; Cook *et al.,* 2009; Ferret, 2009; Dura`-Vila` *et al.,* 2011; Cook, 2013). In the UK, however, the growth of person-centred, recovery orientated mental health has been accompanied by widespread resurgence in spiritual interest, (Barker & Buchanan-Barker, 2004b; Cornah, 2006; Cook *et al*., 2009; Cook, 2013). Principles and practices of mental health recovery promote hope and meaning in lives damaged by experiences of stigma and victimisation (Jamieson, 1997; Deegan, 1998; 2005; Repper & Perkins, 2003). Recovery principles present a radical new conceptualisation, positioning the service user as the person in their own lives rather than the patient in our services, supported by a raft of national policy (Roberts & Boardman, 2014; Bailey & Williams, 2014; DH, 2001; 2009a; 2011a). Castillo's (2016) study suggests that such positive approaches can also be developed with and for, people with personality disorders. Recovery is one of a number of alternatives to competing psychiatric

paradigms, which have sometimes failed the most vulnerable, and the use of treatments linked to coercion and control (Szasz, 1973; 1974; Laing, 1976; Barnes & Berke, 1973; Bentall, 2004; 2010).

Mental health service users ask that their spirituality is addressed as part of the whole being that they experience themselves to be (Macmin & Foskett, 2004). Lived experience literature reveals a spiritual recovery narrative, some of which proposes that mental illness can be confused or combined with spiritual crisis (Deegan, 1998; 2005; Greene-McCreight, 2006; Leech, 2004; Van Gelder, 2010). Authentic narratives evoke subtle appreciation of “the almost ineffable, emergent story of the person’s life” (Leibrich in Barker & Buchanan-Barker, 2004a: 12). If, as Frankl (2004) proposes, the search for meaning is essential to human thriving, failure to achieve this is painful and critical. Alternatively, life experiences of hurt and crisis can provide the ground for spiritual maturing and the impetus for spiritual journeying (Moody & Carroll, 1998; Lewis, 2012; 2015). Quintessentially, mental illness, disorder and distress may potentiate and nurture spirituality through painful experiences of otherness and of being outside. A biopsychosocial-spiritual approach to mental health has been suggested, mindful of the complex interrelationships between all parts of the person (Miller & Thoresen, 2003; Winkelman, 2002; Swinton, 2001; McSherry, 2006). A rigorous critical debate with theoretical and linguistic clarity for such approaches has not yet emerged, however, and guidance for mental health nursing and education is sparse (Barnum, 2011; NMC, 2015). The comprehensive definition adopted by the Royal College of Psychiatrists (RCP) in their position statement on spirituality and religion is a particularly well balanced summary of these themes:

> Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately 'inner', immanent and personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values.
>
> Cook, 2004: 548-549

2.2.1.3 Diverse Spiritualities for Ill-being

Kavar (2012) defines spirituality as an essential intangible, integrating dimension of human living, *negotiating*, rather than alleviating, tensions between human experiences of transcendence and immanence. This view fits well with dialectical approaches used therapeutically to ease extremes of thinking and feeling in BPD (Linehan, 1993a). Other commentators identify a relational spirituality in intrapersonal, interpersonal and transpersonal human dimensions, which both transcends and inhabits self-hood (Reed, 1992; Swinton, 2001; McSherry, 2006; Cook, 2009; Sims & Cook, 2009; Clarke, 2013). Transcultural spiritualities value comfort and hope centred on hearth and home and a growing number of less hierarchical, non-patriarchal models highlight organic, complimentary relationships between health and spirituality (Durie, 1985; Barker, 2004b; Narayanasamy, 2006).

All definitions are challenging for people less able to experience universality, safety, hope or meaning. Etymologically[3], spirituality is far more fundamental, rooted in concepts of individual life force, the very essence of being (McSherry, 2006). Spirituality is correlated with searching, intrinsically and extrinsically for that which is variously referred to as Divine, Ultimate Reality, Great Spirit, the Ground of being, boundless, beyond and sacred (Goodall, 1999; Pargament & Mahoney, 2005; Pargament, *et al.*, 2005). Pargament (2011: 32) refers to a mysterious "sacred core" of existence, a process of sanctification, which imbues the ordinary with new extraordinary layers and dimensions. Spiritualities can therefore be accessed simply through the everyday experiences of work, nature and relationships, associated with self-improvement, kindness and compassion (Pargament & Mahoney, 2005; Goldstein, 2007). Kavar (2012) and Pargament (2011), amongst others, view spirituality as a core element of human character rooted in immanent, biopsychosocial drives and yearnings for something sacred and beyond, quintessentially necessary to existence.

[3] *Latin* 'spiritus'*, Greek* 'pneuma' *Hebrew* 'ru-ach' *meaning breath or life-giving force*

Lived mental health literature links meaning and recovery. The personal narratives of Leibrich (2002) and Coyte (2010) highlight the importance to survivors of the mental health system of being listened to in the way of their choosing. Leibrich's testimony (2000) draws a sharp contrast between his recovery experiences and a professional communication style of restriction and control. His writing, like that of Deegan (1998), Clay (2004), Leech (2004) and Van Gelder (2010), equates mental illness with spiritual rising. Coyte (2010) links experiences of recovery with being and becoming. She proposes that other people's view can be confounded through the act of story- telling. Lived experience activist, Premila Trivedi (2008; 2011; 2014) develops a narrative of joy and cooperation to counteract negative discourses of suffering. Her spiritual and mental recovery is grounded equally in rediscovering cultural and familial heritage and contemporary relationships with kind helpers and friends. These autobiographical testimonies reveal truths from within, about mental illness, spirituality and recovery. Any shortcomings in theoretical consistency and structural framework are made up in wisdom and depth (Gilbert, 2007).

2.2.1.4 Feminist Spiritualities of Fullness and Flow

Western spiritual discourse retains in part, the androcentric, hierarchical influence of Judeo-Christian and classical roots; traditions unlikely to speak fully to the lives of women who have experienced abuse, rejection and abandonment. Alternative less structured processes exhibit a more fluid spirituality, less controlled and more part of the everyday (Daniels, 2005; Heron, 2006). Feminist discourses resurrect ancient female deities and a connected circle or web of creation to produce spiritualities more appropriate to human diversity, mindful of the wider dimensions of human oppression (Stone, 1976; Paglia, 1993; Christ, 1995; Raphael, 1996; Jantzen, 1998; Campra, 2005). Freed from traditional hierarchies, spiritual journeying can be intrinsic, downwards and inwards as well as extrinsic, upwards and outwards (Swinton *et al.,* 2011). Movement is fluid. Theologian Paul Murray (2014) used the term "falling towards grace", exemplified in Christian female mysticism, to describe deep spiritual engagement with a world we think we know, "turned upside-down". Such understandings are helpful to a study of lived worlds turned upside down emotionally, physically and spiritually, lacking in cohesion and control.

Historically, women have been more closely associated with the physical and the earth and therefore of lesser spiritual value in cultures which value the metaphysical and the non-physical (Radford Ruether, 1990; Paglia, 1993; Lauver, 2000; Campra, 2005). Spiritual paths, which either separate body from spirit or promote body purity and wholeness, are unlikely to comfort struggling emotional and physical identities. Embodied, integrated spiritualities avoid fragmentation and potential damage to mental and physical ill health (Beeching, 2014). Paglia (1990: 23) promotes woman's body as a secret sacred place, the "veiled Holy of Holies, magic and hidden", developing a female spiritual imagery conducive to feminine self-esteem and spiritual striving. Feminist spiritualities deconstruct historical ideas and rituals that have not been women-centred to create new ones that are (Lerner, 1993; Jantzen, 1998; Irigaray, 1985). While the heroic is traditionally masculinised it remains a strong cultural metaphor for individual success. Spiritual metaphors of individual quest are enhanced with feminist concepts of cooperation and mutuality, using metaphors of quilting and webbing to supplement individuation (Lauver, 2000; Ray and McFadden, 2001; Manning, 2012). Quest remains a powerful metaphor for spiritual and healing journeys towards recovery, though it is far from triumphant. Van Gelder's (2010) testimony of living with BPD, for example, is both relational and transitional. Moments of doubt and many false starts carve out a pathway towards her spiritual goals.

Some gendered approaches propose that where women's spiritual experience varies from that of men, it is in affirmations of the inherent spiritual connectedness with feminine nature, embodied, vulnerable and eroticised (Coakley, 2002; Gilligan; 1982). Geertsma & Cummings (2004) and Manning (2010) celebrate a spirituality developed in the transition points and autonomy of women's lives. Heath (2006) proposes that spiritually orientated self-healing, in part, results from the mitigation of the lasting effects of a sense of betrayal, particularly for black women. Housten (1997), Gilligan (1982) and Heron (2006) link feminine spirituality with human experiences of growth and fullness, in contrast to the self-emptying or spiritual catharsis often sought in mystical traditions. Housten (1997) is a feminist author who actively develops alterative concepts and language from traditional concepts celebrating spiritual "plerosis", meaning (ful) filling by gathering in everything from a wide and wondrous

"pluriverse". Others, like Radford Ruether (1990; 1998; 2002) are engaged in re-workings of women's spirituality which honour fundamental relationships found in moments in-between a life and lives, lived. Mythological stories have also been re-worked to uncover fresh approaches to feminine sacredness and wisdom. Paglia (1993) and Pinkola Estés (1993) re-tell myths and legends to propose that women be more truly themselves rather than seeking to become something else. Jungian analyst and story teller, Pinkola Estés (1993:6), invites women to explore their inner wild 'wolf' nature, for as 'outsiders in their own cultures … the goal must be the retrieval and succour of women's beauteous and natural psychic form.' Other discourses re-imagine religious stories, seeking out new meaning in ancient texts. Bourgeault (2010) is foremost amongst contemporary re-conceptualisations of gnostic gospels to reveal the feminine Divine in the Christian New Testament where through the person of Mary Magdalene the sacred imbalance is transformed, and restored. Such debates are significant to the study of spiritualities of otherness, for women who experience emotional and geographical rootlessness, feeling both chronically empty and over-full, embodied and out of body, whose lives are at once too much and too little.

2.2.1.5 Spritualities for the Study

Spiritualties for mental health is resonate with recognition of the concerns of the whole person and the quintessential needs of the human spirit. These are not the spritualities of well-being but also of ill-being with the potential to link positions of greatest difficulty with positions of search, growth and recovery. An inter-relational, dimensional dialectical discourse of spritualities emerges from the literature, concerned with individual meaning, values and existential growth. Growth outwards towards the sacred can find ways to be rooted to hearth and home; Growth inwards can develop deep creative connections imbued with meaning and purpose. These spritualities are set in relational and cultural contexts, yet able to move away and beyond them. A summary of these spritualities is provided in figure 2:3 which summarises the key elements from the literature.

Spiritualities for Mental Health	
i.	**Intrapersonal** – identity, purpose, meaning, essence, values, hope, motivation, happiness, life satisfaction, self-healing, wholeness (Swinton, 2001; McSherry, 2006, Fallot, 2007; Goldstein, 2007; Koenig, 2009; Sims & Cook, 2009; Cook, 2013; Bonelli & Koenig, 2013).
ii.	**Interpersonal** – connection, harmony, value, forgiveness, comfort, joy (Swinton, 2001; McSherry, 2006, Sims & Cook, 2009; Cook, 2013; Bonelli & Koenig, 2013).
iii.	**Transpersonal** – transcendent, beyond boundaries, search for sacred, faith, prayer (Swinton, 2001; McSherry, 2006; Koenig, 2009; Sims & Cook, 2009; Pargament, 2011; Cook, 2013).
iv.	**Ill-being** - existential growth, bleakness, fragmentation, abandonment, emptiness, alienation, spiritual rising, vulnerable, embodied (Raphael, 1996; Jantzen, 1998; Leibrich, 2004; Heron, 2006; Pesut, 2006).
v.	**Recovery** – being and becoming, restorative, transition, self-healing, searching, maturing, creating, restoration of hope, fluidity and flow, fullness, journey, balance, transformation (Housten, 1997; Deegan, 1998; 2005; Barker & Buchanan-Barker, 2004; Van Gelder, 2010, Swinton, 2011).

Figure 2:3 Spritualities for Mental Health

These themes represent the expanded definitions of spiritualities of critical relevance to mental health and will be compared to the discussion of spiritualities in the specific context of BPD, later in this chapter.

2.2.2 Borderline Discourses and Voices

2.2.2.1 Surplus Stigma

In England, national guidance to improve outcomes for people with BPD (DH, 2003; NCCMH, 2009; NICE, 2009), has had limited success in removing the "surplus stigma" associated with it (Hoffman, 2007). Clinical Practice Guidelines, commissioned by NICE, developed by a multidisciplinary group of health professionals and service users provide an exemplary summary of best knowledge about the epidemiology, impact, treatment and management of the disorder (NCCMH, 2009). The guidelines address concerns, echoed in my own locally commissioned report, including negative labelling,

lack of staff training and service user unmet requests for support and clinical presence (Watkins, 2002). Similarly, clinical guidance for the recognition and treatment of BPD (NICE, 2009) propose that people with BPD are not be excluded from any health or social care service because of their diagnosis or because they have self-harmed. Treatment recommendations are presented alongside relational and recovery-orientated approaches, including autonomy, choice and partnership.

Consistent therapeutic relationships are thought to aid recovery, yet service users with BPD often experience poor care and prejudicial staff attitudes (DH, 2003; NCCMH, 2009). MHNs describe particular difficulties working with these patients (James & Cowman, 2007; Wollaston & Hixenbaugh, 2008; Ma *et al.,* 2009; McGrath, & Dowling, 2012). Haigh, writing in the NICE guidance (2009) emphatically states that standard psychiatric approaches are not suitable for people with these conditions, who generally have complex trauma histories and disordered emotional development, reinforcing the need for long-term and coherently delivered treatment. The evidence supporting the guidance was reviewed in January 2015 and nothing new was found, affecting the recommendations.

2.2.2.2 Contested Label

Personalities are said to be disordered when long standing ways of perceiving and relating to environment, self and others, are inflexible and maladaptive, causing significant functional difficulty or subjective distress (Norman & Ryrie, 2013; APA, 2000). Personality disorder is common, about 1: 20 of UK population, associated with raised mortality, significant economic costs, unmet health needs, high unemployment, co-morbid mental illness and crime (Moran, 2002; Coid, *et al.,* 2006; Winship & Hardy, 2007). BPD is the most prevalent of all personality disorders with a conservatively estimated 3% of the population meeting the diagnostic criteria at any one time (Winston, 2000; Moran, 2002; Winship & Hardy, 2007; Gunderson, 2011); with up to 75% of clinical cases women (Widiger & Weissman, 1991; APA, 2000). People with BPD make up to 10% of service users in outpatient settings and 15% to 20% of psychiatric inpatients (Winston, 2000; McGrath & Dowling, 2012); MHNs are likely to meet them

in all work settings (Gravitt, 2011; Bowen, 2013). BPD is complex, devastating and debilitating with up to 10% of those diagnosed, dying from suicide (Gunderson, 2011).

Historically, the term emerged from clinical observations of people with patterns of excessively intense emotions, self-destructive acts, and stormy interpersonal relationships (Hill, 2005; Gunderson & Singer, 1975). BPD referenced atypical or borderline variants of other diagnoses and continues to be defined in relation to other categories, in-between neurosis and psychosis, personality and mental illness, sanity and madness (Wirth-Cauchon, 2001; Gunderson, 2011). As such, it is a label associated with otherness, transgressing known categories and boundaries (Nelson, 1994). BPD has often been considered a female malady. Recent studies however, have challenged the notion of gender disparity, finding little or no difference in the prevalence of BPD among men and women when studying general rather than clinical populations (Coid *et al.,* 2006; Gunderson, 2011). Others note that while exaggerated expressions of dependent and demanding behaviour increase the likelihood of being diagnosed with BPD in women, they tend to be overlooked in men (Nehls, 1998; 2000; Castillo, 2016). Alternative explanations look to gendered socialisation with regard to expressions of dependency and rejection and the gender bias of clinicians in relation to diagnosis and treatment (Showalter, 1987; Nehls, 1998; 2000; Appignanesi, 2008; Potter, 2009; Gunderson, 2011). Shifting perceptions and methodologically improved studies suggest that BPD is more common than previously thought with better potential outcomes. One community study, which included a substantial sample of over 34,000 people and interviews to evaluate BPD among participants, found lifetime prevalence of BPD to be 5.9%, with no significant difference in prevalence between males and females (Grant, *et al.,* 2008). Another 10-year longitudinal study (Gunderson *et al.,* 2011) found high rates of remission among patients with BPD, at ten years, 85% of patients were in remission.

BPD is recognised but contested in psychiatric classification systems, characterised by difficulties of self-image and attachment (APA, 2000; WHO, 2010; Allan, 2013). These include volatile, interpersonal relationships, desperate efforts to avoid abandonment, the idealising or devaluing of others, self-damaging impulsivity, recurrent suicidal threats and acts of self-harm and deep, longstanding feelings of emptiness (APA, 2000;

WHO, 2010). In the Diagnostic Statistical Manual V (DSM V) (APA, 2013), BPD is characterised by impairments in self-functioning including poorly developed or unstable self-image, excessive self-criticism, chronic feelings of emptiness, dissociative states under stress and a lack of self-direction leading to a complete breakdown of self-concept in some instances. The International Classification of Diseases 10 (ICD 10) (WHO, 2016) refers to Borderline, or Emotionally Unstable Personality Disorder characterised by impulsivity, self-harm, feelings of emptiness, unstable relationships and a tendency to feel paranoid, depressed or hear voices when under stress. The participants in this study have been diagnosed following one or other of these systems. Classifications are shifting, however. In the USA debates about a reviewed diagnosis focussing on identity, empathy, self-direction and intimacy have stagnated and in the UK a simpler continuum approach is being considered (Allan, 2013; APA, 2013).

While the study participants were aware of the diagnosis and able to relate to elements of it in themselves, they dreaded the associated shame. Persons with BPD constitute a vulnerable population, not only because of the natural course of the disorder, but also because they can be stigmatised by those who are entrusted with their care. Paradoxically, treatments have tended to make things worse rather than better leading to the blame for this lack of success, falling on the patient (Kaysen, 2000; Van Gelder, 2010; McGrath and Dowling, 2012; Allan, 2013). Collectively, and as individuals, persons with BPD are viewed as manipulative and noncompliant, publically and professionally misunderstood (DH, 2003; NCCMH, 2009; Furnham *et al.,* 2014). Sometimes people think that they have been labelled with BPD either because they do not fit in anywhere else or because accepted treatments are failing them (NCCMH, 2009; Allan, 2013). Of all the neglected, stigmatised people with mental health problems, those with BPD suffer a particular form of discrimination associated with misunderstanding about how the disorder develops, controversies over the legitimacy of the condition, pessimism about outcomes and the refusal of some mental health professionals to treat individuals with BPD (DH, 2003; Thornicroft, 2006; Hoffman, 2007; NCCMH, 2009). Service users have an ambivalent relationship with their diagnosis. Some are grateful to have their distress acknowledged with the

associated access to beneficial treatment and support while others describe it as a way for services to reject and withdraw from them (NCCMH, 2009; Linehan, 2012; Van Gelder, 2012). Families and friends lobby to retain the label and improve services (NCCMH, 2009; Kreger & Mason, 2010). Certainly, in medically orientated, resource-stretched service models, it is unlikely that people will get treatment without a medical diagnosis.

From a position of limited success, there has been considerable contemporary progress in treatment for BPD. The developing evidence base, notes the beneficial effects of psychotherapeutic interventions for BPD impacting on core pathology and associated general psychopathology; psychotherapy is recommended by NICE (2009) and in a Cochrane Review (Stoffers et al., 2012). Dialectical behaviour therapy (DBT) has been studied most intensely, followed by Mentalisation-based treatment. Linehan has developed a biosocial explanation for BPD and with it, an innovative, evidence-based treatment, which she has called DBT. Founded on stress-vulnerability concepts, Linehan's model (1993a; 1993b; 2014) proposes a biological sensitivity to emotion cues in the context of an invalidating social environment, which is a poor fit for the infant temperament. Similarly, NICE guidance (NCCMH, 2009) notes the occurrence of BPD in vulnerable individuals, whose social cognitions are negatively impacted by neglect in early relationships. The resulting impaired abilities both to represent and to modulate affect and control attentional capacity, potentiating structural and functional changes in the developing brain, leading to BPD, if not managed.

DBT aims to facilitate emotion regulation using individual therapy, skills training and mindfulness. Mentalisation focuses on a therapeutic alliance of shared goals, mutual liking and respect, with a therapist who is hopeful and compassionate. A reflective, mindful approach is taken in mentalisation whereby the person with BPD is encouraged to observe and participate in experiences and chose a different course of action if they wish to. Accepting thoughts, identifying valued actions and theoretically consistency and commitment are central (Bateman & Fonagy, 1999; 2006; Bateman & Krawitz, 2013). DBT and Mentalisation draw on the principles of cognitive behavioural therapy to challenge habitual ways of thinking and behaving and both recognise the

central importance of the therapeutic relationships in recovery. In a critical consideration of therapeutic milieu for vulnerable and complex mental health conditions, Haigh (1999; 2013) proposes developing cultures of belonging, safety, openness, participation and empowerment. From these authorities, common themes of long-term therapeutic alliance and the adoption of energetic positions of hopeful commitment in the therapist, emerge.

2.2.2.3 Gendered *Borderlines*

In critical mental health discourse, the cost to deep human experience of overly scientific approaches are regretted and feminist commentators have argued that gender-based values about feminine behaviour are the drivers for particular categorisations including BPD (2009; Appignanesi, 2008). Psychologically, Jung (1971) stressed the struggle for harmony in the reconciliation male and female in each individual. Horney (1939) reinterpreted the focus on emotional and psychic frailty in women as social rather than psychological, born out of cultural constraints of access to security, prestige and power. For the purposes of this study, the significance of gender to the prevalence and aetiology of mental disorder is less important than questions about the experiences of women living with mental illness; how they are labelled and reacted to, and the quality of their helping relationships.

The assumption that BPD is over represented among women is a misconception not supported by recent research data that shows that the condition occurs in the same numbers of men as women (Coid *et al.,* 2006; Gunderson *et al.,* 2011). Skodol & Bender (2003) propose that and the elevated base rate of women in clinical settings may be the reason why clinicians perceive more women to have BPD. Post-modern approaches demand the re-examination and reattribution of concepts such as separations, self-efficacy, independence and locus of control, which are so pertinent to this particular diagnosis. Feminists argue that studies of women are distorted through the lens of othering and sexism, with women's minds and bodies problematised in health discourse (Bordo, 2003; Becker, 2007; Appignanesi, 2008). It has been suggested that gendered diagnosing of exaggerated stereotypical feminine qualities of dependence and passivity explaining why, historically, more women than

men have been diagnosed with BPD (Simmons, 1992). Nehls (1997) proposed that feminist perspectives are needed “. . . to correct both the invisibility and distortion of female experience in ways relevant to ending women’s unequal social position” (Lather cited in Nehls, 1997: 107).

That women have comprised 75% of BPD clinical populations, a 3:1 gender ratio (APA, 2000), is thought to be a question of bias in sampling or diagnosis (Bjorklund, 2006). Gendered expressions of mental distress and help-seeking behaviour show that women are more likely to express emotional distress verbally and through self-harm and men are less likely to seek help, exhibiting more substance use, aggression and crime; women ‘act in’, men ‘act out’ (Moran, 2002; Paris, 2008). In a scholarly guide to evidence-based practice for BPD, Paris (2008) highlights several difficulties with the diagnosis. In his opening diagnostic chapter, of seven case studies, six are women. Noting that research identifies as many men and women with the disorder, his own research found men difficult to recruit, yet exhibiting exactly the same characteristics as women with BPD. Paris (2008) amongst others thinks that women are more likely to seek help than men and finds evidence for this in higher rates of completed suicides in men. In an examination of sex and age differences in borderline personality syndromes, Sansone & Sansone (2011) amongst 1,503 primary care patients, found little significant difference in terms of symptomology but that women were more likely than men to seek treatment.

Concerns about women’s mental health nationally and internationally are linked to gendered roles and positioning. The World Health Organisation (WHO) (2016) notes marked gender differences in the patterns and determinants of mental illness. Epidemiological surveys consistently report higher rates of anxiety and mood disorders among women and higher rates of substance use disorders among men (Seedat *at al.,* 2009). Gender based violence, socioeconomic disadvantage, subordinate social status and unremitting care responsibilities prove to be significant risk factors affecting women’s mental health. Sexual violence and domestic abuse make women particularly vulnerable to Post Traumatic Stress Disorder (PTSD) (WHO, 2016) and BPD is closely linked to childhood trauma and prolonged abuse, notably

childhood sexual abuse. Herman (2015) proposes that childhood trauma is experienced by up to 81% of individuals with BPD and increasingly regards the disorder as a complex variant of PTSD and advocate trauma-based therapeutic approaches. In England imperatives to improve mental health service delivery for women has focussed on safety, support and choice. The identification of different risk and protective factors for women and men has led to women-only services focussing on relational security and protection against potential repeated trauma and abuse (DH, 2002). 'Personality Disorder: No longer a diagnosis of exclusion' (NIMHE 2003), noted the specific complex needs of women with BPD which included self-harm, eating disorders, episodic psychosis and a compulsion to engage in abusive relationships.

The resultant debate is critical in the examination of gendered mental health, providing an environment for understanding the role that sociocultural factors play in the expression of mental disorder (Becker, 1997; Wirth Cauchon, 2001; Bjorklund, 2006). In the UK, even where recent years have seen a decrease for men and an increase for women, the male suicide rate is three times that of females, with suicide as the third highest cause of death in men aged 45 to 59 (Office for National Statistics (ONS), 2016; Scowcroft, 2016). Nehls (1997) proposed that BPD has come to fill the diagnostic position previously occupied by the derogatory and now defunct label of hysteria. These arguments support the position of BPD as a biological, psychological, and constructed sociocultural condition in need of support from practitioners who understand the phenomenon at a level of complexity to provide appropriate care. It is proposed that future work will include the less-heard voice of the men.

2.2.2.4 Alternative Discourses

Alternative discourses explaining BPD include that of lived experience and a narrative of raw poeticism, suffering and desperation. Marsha Linehan talks about being utterly overwhelmed, as though she was in hell (Linehan, 2011). Distraught, she habitually attacked herself and, once secluded in a room with no visible means of hurting herself, she did the only thing he could and banged her head hard against the wall and the floor. Linehan's unhelpful treatment in Tulsa, USA in the 1960s resonates with

Kaysen's memoir of treatment in the same decade and Van Gelder's memoir published in 2010. Gunn and Potter (2015) offering new perspectives on this diagnosis emphasise holistic approaches to managing emotional chaos in the therapeutic relationship. Borderline life experience is often crisis-driven, however, so that "crisis becomes the rule and calm the exception" (Santoro & Cohen, 1997: 54), requiring safe relational boundaries to resist the pull of extremes. Moran (2011) described it as being like a vehicle whose engines run hot and brakes don't work, Linehan (1991) stated that people with BPD function like emotional burn victims and Zanarini (1998) like emotional epileptics. Van Gelder (2010; 2012) and Reiland (2004) depict experiences of inner and outer turbulence and a lack of boundary integrity. Van Gelder (2012:16) described the feeling of "being poisoned by what's inside and vulnerable to everything outside", so that the psychological and physical relief from cutting and breaking the skin to let pain out is counteracted by the letting in of toxic relationships to fill existential emptiness.

2.2.2.5 Spiritual Possibilities

In 1998, Schwartz-Salant suggested a spiritual understanding for BPD. Drawing from classical mythology and case study, he likened the borderline feeling of too full and too empty, to an exceptional intuitive awareness of being positioned in-between the numinous (transcendent) and the archetypal ground of being (immanent). He argued that borderline people are especially vulnerable to the overwhelming aspects of the numinous, which they often experience as demonic, finding themselves "enmeshed in psychic levels of extreme intensity that bear intimate relation to many of the great archetypal themes in history — battles between god and the devil, life and death, rebirth and renewal" (Schwartz-Salant, 1989: 9). A spiritual borderline is described, as predisposed towards disembodied transcendence, rising above and going beyond, but lacking the necessary containment of immanence, grounding and incarnation. Although, Sansone *et al*. (2012) found less spirituality in borderline states Schwartz-Salant (1998) conversely appears to suggest that there is almost too much.

Nelson (1994: 54) suggests something similar, referring to the *borderline* position, as being like the "walking wounded in the universal battle to find a secure place in the

self". He argued that the experience of indistinct self-hood makes people with BPD vulnerable, both to merging with other people, and merging with the Ground; an amelioration of the experienced feeling that "alone, I cease to exist" (1994: 54). Early failure to establish adequate boundaries between self and other leads to the desire to be cared for by powerful others and the inclusion of others as part of self. The resulting self is constructed partially, from potentially damaged bits of core self, mixed with bits of various others, leaving gaps in the psyche for heady energies to rush in, from their own subconscious and beyond.

The fundamental bias in the work of Nelson (1994) and Schwartz-Salant (1998) resonates powerfully with the spiritual positioning found in Van Gelder's account (2010), identifying alternative perspectives for the remarkable sensitivity of *borderline* people to the thoughts, feeling and plight of others. For Nelson (1994: 384), the failure of many therapeutic approaches is the creation of dependency which (re)exposes infantile yearnings where consolidation of a stable, independent self-hood, "facilitating spiritual growth through worldly empowerment", is needed. Nelson promoted physical release techniques and the development of self-soothing skills for managing intense grief and rage which now form part of contemporary treatments (Linehan, 1993a; 1993b; 2014).

2.2.2.6 Feminist Understandings

The experience of being labelled with BPD, has been likened to other borderline or *in-between* experiences, including worlds of gender, mental health and spirituality, through normative positioning. These borderlands in mental health discourse leave spaces in knowledge, understanding and care (Swinton & Pattison, 2010; Swinton *et. al.,* 2011). In her feminist (re) interpretation of the borderline diagnosis, Wirth-Cauchon (2011: 16) proposed that analysing borderline narrative provides a "rich landscape in which to examine the contradictions of subjectivity and how it is represented" (2001: 116). Mainstream research so often fails to reveal what Freshwater (2002: 177) referred to as the "plaintive voice of that silent minority whose voice is unheard" and the tenuous positioning of women with BPD might shed new light on a range of complex, mutable issues in spirituality and mental health.

Becker (1997) and Wirth Cauchon (2001) analyse the relationship between the diagnosis of BPD in women and gendered approaches to psychological distress. Becker (1997) recalls that early in her enculturation as a mental health professional, she became aware of the preponderance of gender bias and pejorative labelling for patients who did not respond well to limit setting. She draws on historical and philosophical discourses of madness, clinical experience and poetry to develop a fuller picture of BPD, making interesting links with women marked and stigmatised due to perceived societal transgressions throughout history. She explains self-harm markings, the the cuts and burns, as attempts to prove existence rather than attempts to manipulate others. She contrasts diverse, socially sanctioned forms of sacrifice and sanctification with less socially acceptable forms of self-harming to resolve pain and personal conflicts and a way of being known through visible emotional pain (Becker 1997).

Feminist sociologist, Wirth-Cauchon (2001) considers the shifting boundaries and intersections between gendered discourses as fruitful ground for an analysis of ambiguous constructions of disordered self-hood. She views BPD in women as "an embodiment of gender construction", equating *borderline* emptiness to fundamental feminine experiences that there is something missing (2001: 167). In a phrase reminiscent of tidal approaches in mental health, she proposes an affinity with water metaphors, a "language of liquids" to describe the *borderline* sense of nothingness, a fluid vacillation accompanied by desperate attempts to "anchor" identity (Barker & Buchanan-Barker, 2005; Wirth-Cauchon, 2001: 97). Wirth-Cauchon considers *borderline* women as an exaggeration of a feminine split, oscillating between cultural constructions of being being passively dependent on the one hand while powerfully autonomous on the other and unsettled in either position. Critiquing the terminology of inner chaos and emptiness, she points out that feeling empty is not the same as being empty, and that fluidity need not be met with hardness and containment, but can be therapeutically matched by fluidity. She leaves little room, however, for the empirical evidence that explains diagnostic gender differences as anything other than a discussion of the way women cross the boundaries of psychiatrically constructed

notions of normal femininity (Bjorklund, 2006). Taken to extremes this would preclude women with this condition from seeking and receiving help.

The work of Becker (1997) and Wirth-Cauchon (2001) places concepts of unstable fragmented *borderline* self in the context of a more general female difficulty in finding space, place and voice in the world. Post-modern thinking has taken us towards plurality and critical feminism reveals how self might mask itself in order to fit in with realities constructed by powerful other(s). *Borderline* self-position is even more intensely damaged and fragmented, lacking "a certain solidarity of self" (Van Gelder, 2010: 137) and exhibiting a tenuous grip on external and internal reality. This experience provides a uniquely vivid marginality of self with permeable barriers between internal and external boundaries. As demonstrated, Wirth-Cauchon (2001) views this marginality as culturally symbolic, offering an extreme version of a more common experience. Alternative discourses and voices contend with the disease model of BPD, placing it in the context of broader social and cultural constructions of gender, mental health and power dynamics. Spiritual sensitivity and fullness symbolically replace insensitivity and emptiness, drawing on fluidity of metaphor, language and approach, suggesting therapeutic relational anchoring and grounding rather than clinical limit setting.

2.2.3 Fusing Horizons

Diverse spiritualities provide opportunities to for alterative, flexible interpretations and approaches. Spiritualities, which emphasise soothing and release, acknowledging deep distress, fullness as well as emptiness, ambivalence and darkness as well as lightness become available. While well-being and holism are linked with mental health recovery, such approaches potentially exclude those unable to experience coherent self-hood. Irigaray (1985; 2013) thought that women can experience Divine Becoming in the birthing of their new spiritualities by positioning themselves as uniquely other, yet connected. Spiritualities that break with binary poles whether, male/ female, good /evil, full/ empty, whole/ fragmented, provide spaces for explorations of ambivalence and mutable self-hood (Christ, 1980). Such fluid paradigms owe as much to traditional, ancient belief as to post-modern fragmentation, both unconnected and connected,

well-suited to complex and fragmented lives. Differing perspectives of BPD help to develop creative ways of thinking about the disorder and how best to help. Therapeutic approaches that offer hopeful alliances and enable reflective evaluation, incorporating self-acceptance and validation are effective in *borderline* recovery.

2:3 Section 3: Question-Specific Review

Having examined the wider contexts, this section examines the literature in relation to the research question, namely

> **How might the lived spiritual experience of women with borderline personality disorder inform and influence their therapeutic relationships with mental health nurses?**

In addition, the literature has been explored in relation to the subsidiary questions:

I. What is the nature and essence of spirituality for women living with BPD?
II. What are the interrelationships between these spiritualities and therapeutic relationships for women living with BPD?
III. How might these spiritualities inform therapeutic relationships with MHNs?
IV. What educational strategies might be developed for the spiritual education of MHNs in the light of borderline relational spiritualities?

A comprehensive search of databases has been conducted using key search terms (Appendix 2). The databases searched included: EBSCOhost, Education Databases, Gender/Sexuality Databases, Health Sciences Research Databases, Psychology/ Sociology Databases, including Academic Search Premier, CINAHL Plus with Full Text, Education Research Complete, Humanities International Complete, Psychology and Behavioral Sciences Collection, PsycINFO, Teacher Reference Center, MEDLINE, PsycARTICLES, Swetswise, Springerlink, Cochrane DataBase. The literature found which directly related to BPD, spirituality was sparse so additional search terms based on existing subject knowledge, and extensive reading were added. Finally, a third search which explicitly explored the research of BPD lived experience was included in

order to provide a wide and informed discussion and capture voiced experience from the study group. The search terms are presented in the following table:

Key Search Terms
Initial Key Search Terms (1)
spirituality, spirituality and religion, mental health, borderline personality disorder, mental health nursing, therapeutic relationships, therapeutic alliance, therapeutic communication, nurse education.
Additional Search (2) 'BPD–type' issues
spirituality, spirituality and religion, psychological trauma, sexual abuse, attachment, locus of control, self-harm
Additional Search (3) BPD lived experience
borderline personality disorder, lived experience, phenomenology, narrative

Figure 2:4 Initial and Additional Search Terms

Alongside database searches, an examination of the references of research papers was used to identify additional literature. Papers have been included on the grounds of clinical and academic relevancy, filtered through the specific study contexts, from a reading of titles and abstracts and, all have been peer reviewed. Commentaries from service user and perspectives have been specifically included due to their rarity and unique contribution. The search has been organised into distinct study components and presented in relation to each of the subsidiary research questions, diagrammatically represented in Appendix 2. These components are reintegrated thematically synthesised in the concluding discussion of the implications of the review. Subject complexity has impaired the cohesion of the literature review to some extent and the small numbers of topic-specific research studies has proved challenging in formulating robust answers to the research question. The dominance of qualitative studies and some striking lived experience literature, however, has provided meaningful insights, which inform and drive the study.

2.3.1 BPD and Spiritualities

2.3.1.1. *Borderline* Spiritualities

In a comprehensive review, Bonelli and Koenig (2013) found insufficient studies of any personality disorder, including BPD, for inclusion. In their review, Bennett *et al.,* (2013)

agreed that the the number of studies are limited and highlighted potential positive link between religious and spiritual well-being and mental health for people with BPD, recommending further exploration. Conversely, research by Sansone *et al.* (2013), acknowledged the small number of studies but posited a growing interest in this area and an emergent pattern of spiritual well-being in people with borderline personality traits. Van Gelder's memoir (2010) explores spiritual searching, faith and prayer as powerful elements in the lived experience of recovery from BPD. In "the Buddha and Borderline", she links her own recovery to a combination of Dialectical Behavioural Therapy (DBT) and spiritual awakening, emergence and transformation. She finds containment, individually through meditation and relationally through group spiritual and social support. In my own nursing practice, people with this diagnosis were as likely as any other group to find religious or spiritual solace and support.

A search of the research literature yielded just four papers; Sansone *et al*. (2012), Gravitt (2011), Goodman & Manierre (2008) and Sansone & Wiederman (2013) (APPENDIX 2a). All four papers were from the USA, from similar theoretical and religious perspectives. Studies which specifically investigated the relationship between spirituality and BPD have reached two main conclusions, both negative; namely that borderline people are less religious and spiritual than others (Sansone *et al.,* 2012) and that their spiritual expression is characterised by Divine punishment, linked to self-hate and self-harm (Gravitt, 2011; Goodman & Manierre, 2008; Sansone & Wiederman, 2013).

Sansone *et al.* (2012) in a survey of selected participants with BPD, found a significant negative correlation, such that, as borderline personality traits increased, the overall religious and spiritual well-being scores decreased (Sansone *et al.,* 2012). They sampled 308 BPD outpatients in the USA; overwhelmingly female (74.0%) and white (86.9%) 18 to 92 years, finding that individuals with BPD demonstrate lower levels of spiritual well-being and postulate that they might be less spiritual than others. They indicate that this might be instrumental in the failing of treatments that target spiritual well-being. People with BPD are often subject to early traumatizing experiences as well as current re-victimisation experiences. The proposal is that the existence of a higher power is doubted when childhood abuse and trauma has been *allowed* to

happen to them. A psychodynamic explanation is the introjection of early trauma projected onto the transcendent or that negative views of self and other are reflected internally, externally and transcendentally.

Interestingly, a survey of 140 American graduate students finds something similar from a different perspective. In a sample of distressed adults, Jankowskia & Sandage (2012) found that those with higher levels of Differentiation of Self (DoS) demonstrated greater capacities for spiritual and interpersonal intimacy and perseverance in difficulty. They hypothesise that the mechanism by which spiritual *in-dwelling* is associated with well-being involves the capacity to regulate negative emotions, a notable feature of BPD. This study is limited by being overly specific in method of measurement and population that is using DoS in a predominantly Euro-American group from a Christian-affiliated university in the Midwestern US. There is a useful suggestion, however, that spiritual maturity is a process of integrating spiritual searching and spiritual *in-dwelling* which, in turn, leads to well-being. Conversely, reviewing the literature of individuals with low psychological wellbeing, Bennet *et al.* (2013) postulated that spiritual well-being remained high in studies of personality focusing borderline personality traits, suggesting spirituality as an interesting area for further exploration.

In other studies, perceptions of the Divine are linked with balance and well-being. In interviews with nine psychiatric in-patients with BPD, Goodman & Manierre (2008) found two distinct representations of God. One corresponding closely with parental figures was punitive, judgemental and rigid while the other was more abstract, represented by natural elements such as flowing water and wind, a description that seemed to compensate for early experience. The study found that those in the first grouping were more likely to be able to work therapeutically towards a balanced view of God and self, while those in the latter, seemed unable to do so.

Gravitt (2011) explored the concept of an entrapping, destructive deal made with God, which she called “God's ruthless embrace” in her study of religious belief in three women with BPD. As a nurse, Gravitt hoped that her study would influence the nursing care of people with BPD by contributing to their spiritual and psychological well-being.

Gravitt (2011) found patterns of religious relating similar to those associated with insecure attachment or as Gravitt (2011: 301) puts it "re-enactment of a dysfunctional mother-infant dyad". Using a psychodynamic paradigm, she concludes that participants share a faith style resulting from early relational difficulties. Specifically, the character of God is inescapable and magical but ultimately unreliable. The relationship with God is in the form of a deal which rewards dependency. This paper, while written from a particular theoretical perspective presents a compelling argument and themes about the personification of God resonate with those found elsewhere (Sansone *et al.,* 2012; Goodman & Manierre, 2008).

Sansone & Weiderman (2013) examine whether purposefully "Distancing oneself from God" is self-punishment representing a form of self-harm. Of the 1511, outpatient respondents, 165 (10.9%) indicated having intentionally distanced themselves from God as punishment. From this, Sansone and Weiderman (2013) contend that self-harm behaviour may be manifested in religious/ spiritual conflict. Like Gunderson (1984), they acknowledge that self-harm has diverse psychological functions, including a desire to engage the support and care of others. Generating difficulties in one's relationship with God might engage additional pastoral support (Sansone & Wiederman, 2013) but may also be an attempt to get God's attention.

2.3.1.2 *Borderline-type* Spiritualities

Existing knowledge and experience informed additional search using terminology suggestive of borderline-type issues (Heron, 2006) and yielded a further nine papers in answer to this question (APPENDIX 2b). This literature was similarly dominated by papers from the USA, with two papers from the UK, two from Australia and one from New Zealand. From these thirteen papers, four studies have gathered personal narrative through exploratory interview (Gravitt, 2011; de Castella & Graetz Simmonds, 2013; Knapik *et al.,* 2008) and group interaction (Goodman & Manierre, 2008). There are two in the form of personal narrative (Coyte, 2010 and Leibrich, 2002). Eight papers are qualitative, largely exploratory, phenomenological and narrative perspectives, and five papers used quantitative methods. There were no

papers, which explicitly looked at the role of spirituality in therapeutic relating, and this issue will be considered more fully in other sections of the review.

Marsden *et al.* (2007) seek potential links between eating disorders and religious asceticism in a phenomenological study of ten Christian women with eating disorders. Five categories emerged from this study: locus of control, sacrifice, self-image, salvation, maturation. Control of appetite held moral connotations for these women, with treatment as salvation, and treatment failure as a threat to faith. Religious beliefs and spiritual practices were found to impact positively on recovery and motivation for some of them, while others experienced difficulty in untangling aspects of religious practice from their illness. Marsden *et al.* (2007) determined that clinician sensitivity was significant to the influence of beliefs on clinical outcomes. Ryan & Francis (2013) explicitly investigated associative relationships between religious functioning, locus of control (LOC) and health in 122 (79 women, 43 men) predominately Catholic, individuals. They found awareness of God and internal LOC was associated with better health, whereas external LOC and instability was associated with poorer health. Moreover, the results from this study support claims that religious functioning can ameliorate symptoms of poor mental health or even help avoid mental illness altogether (Koenig 2008). It is a slightly confusing study but proposes an interesting positive relationship between internal LOC and health. Both studies, Marsden *et al.* (2007) and Ryan & Francis (2013), report the significance of attitudes and attribution in determining the relationships between spirituality and recovery.

Four papers were selected which investigated the relationship between coping with trauma and spirituality (de Castella & Graetz Simmonds, 2013; Hall, 2003; Knapik *et al.,* 2008; Murray-Swank & Pargament, 2005). De Castella and Graetz Simmonds collected the stories of 10 women reporting an experience of trauma one year prior to the study, who had experienced positive religious or spiritual growth following event. They found that religion provided a framework for managing change in suffering. Trauma prompted a process of questioning and meaning making that facilitated deeply experienced personal and spiritual growth, the strengthening of religious and spiritual beliefs, personal growth and spiritual healing.

Hall (2003) sought themes of positive self-transitions in women survivors of childhood abuse, collecting the stories of 55 low-income African American women in recovery from substance abuse. She found coping processes of epiphanies, maintaining momentum and self-change, enhanced through self-centring, ownership, interpersonal insulation, wilfulness and spiritual connection. The participants often used the word connection, referring to the existence of it rather than the object of it, meaning that it was the experience of connection that was important. Hall (2003) takes an explicit stance of solidarity with participants revealing voices in ways that enhance resilience and social critiques, rather than perpetuating victimisation.

Knapik *et al.* (2008) carried out a grounded theory study proposing a theoretical framework to describe how women and men use spirituality to respond to experiences of sexual violence. The fifty participants (27 women, 23 men) were specifically asked about their experiences of being rescued or set free from the effects of sexual violence by a spiritual being or power, as defined by the individual. The study developed a theoretical framework for "Being Delivered" composed of spiritual connection, journey and transformation. The survivors' relationship with a divine being, the spiritual path they took and the possibility of transformative spiritual experience were significant to healing and recovery.

Murray-Swank & Pargament (2005) evaluated the effectiveness of spiritually integrated interventions with two women survivors of sexual abuse, to demonstrate the importance of intervening with clients in the midst of spiritual struggles to facilitate mental, physical and spiritual recovery. Both clients increased in positive religious coping, spiritual well-being, and positive images of God. In addition, the intervention analyses revealed significant changes during course of intervention (e.g. increased daily use of positive religious coping). They concluded that spiritually integrated programs show promise in enhancing spiritual recovery from childhood sexual abuse. This is a rare attempt to evaluate a spiritual intervention.

2.3.1.3 Summarising the Research Literature of *Borderline* Spiritualities

The sparse literature explicitly addressing *Borderline* and *Borderline*-type spiritualities is qualitative, phenomenological, narrative and, in a mirror image of clinical populations overwhelmingly female (Figure 2:5).

Characterising the Research Literature for *Borderline* Spiritualities		
Number of Papers - 13	Methodologies	Participant Gender
Borderline Spiritualities – 4	*Phenomenology* *Exploratory* *Psychodynamic* *Quantitative* *Quantitative*	*3 women* *9 women* *Mixed – (74% women: 26% men)* *Mixed – 2:1 women*
Borderline-type Spiritualties - 9	Methodologies	Participant Gender
	Narrative *Phenomenology* *Feminist Narrative* *Grounded Theory* *Autobiographical* *Narrative* *Exploratory* *Phenomenology IPA* *Quantitative* *Quantitative*	*1 woman* *10 women* *55 women* *Mixed – 27 women* *I man* *2 women* *10 women* *Mixed (not stated)* *Mixed (79 women: 43 men)*

Figure 2: 5 Research Literature for Borderline Spiritualities

Rather than benefitting from holistic concepts for mental health, complimented by diverse spiritualities from a range of geographical, cultural and political traditions, this research literature lacks diversity, having a specifically Christian perspective in the selection and questioning of participants (Gravitt, 2011; Goodman & Manierre, 2008; Sansone & Wiederman, 2013). One grounded study (Knapik *et al.,* 2008) openly asks for examples of spirituality defined by participants, producing rich well-presented data, but is limited by the lack of diversity in the respondents who are all Christian. The research literature finds people with BPD and similar relational difficulties to be either less spiritual than others or in ambivalent and punitive relationships with the Divine. Studies of trauma and abuse, however, find recovery potential in meaning-making, connection, epiphanies and self-change which facilitate personal and spiritual

awakening. Integration and maturity are linked to spiritual attribution, spiritual searching and spiritual *in-dwelling* which, in turn, lead to well-being.

In response to this finding, an additional search has been undertaken to specifically identify *borderline* voices in the research literature, specifically a search for phenomenology, narrative and lived experience of BPD (Figure 2:4), finding eleven papers. (APPENDICES 2fi and 2fii). This literature is also composed of an overwhelmingly female voice (Figure 2:6).

Gender in BPD Lived Experience Literature	
Women only 7 studies of women only	Mixed: 4 'mixed' studies: in one, males formed the minority and in other three studies, only one male participant was included.

Figure 2:6 Incidence of gender within the Research Literature of Lived Experience

Fallon (2003: 394) noted that, "For a group so often vilified by clinicians few studies have sought to redress the balance and give them a voice". There is however, a growing literature and a great deal of interest in BPD. A number of book titles with a *borderline* perspective, are presented by people with the disorder their families and clinicians. Two books specifically address the study brief, depicting reflective self-disclosure and are extensively referred to in the thesis. These are *Girl Interrupted* by Susanna Kaysen (*Kaysen, 2000)* and *The Buddha and the Borderline by* Kierra Van Gelder (Van Gelder, 2010). The gender bias has been variously explained; some authors state their intention to study women (Goldstein, 2014), some find that women predominate their inpatient and outpatient populations (Black *et al.,* 2014; Ntshingila *et al*., 2015) and some find men difficult to recruit (Helleman *et al.,* 2014). Only Fallon (2004) achieves a good mix with three men and four women.

Within the research literature, a particular view of *borderline* experience emerges with implications for the study in the counter-balancing of aspects of hope and despair. An influential study by Nehls (1999) interviewed thirty women diagnosed with BPD, in receipt if mental health services. Thematically analysed narratives, uncovered feelings of being ignored, distrusted, and discredited by mental health clinicians, with

confusion about their diagnosis and what might help them. This approach has been influential in much of the research that has followed uncovering similar contemporary themes. All eleven selected papers used in-depth, face-to-face interviews, structured loosely on broad questions relating to lived experience. Hermeneutic interpretations of being diagnosed with BPD, being treated for BPD and living with BPD are thematically presented. Despite the negativity and destructive impulses, which characterise their experiences, women living with BPD value relationships, which help them, contain unmanageable emotions and long for change and what Ntshingila *et al.* (2016) refer to as *facilitation* in their lives. Emerging from lived experience research is a narrative of despair and hope summarised in Figure 2.6, which informs the study questions and the understanding of spiritualities of vulnerability and struggle.

Polarised Despair-Hope themes emerging from an analysis of the BPD lived experience literature	
Living with Despair	**Living with Hope**
Hopeless and helpless	Longing for love and fellowship
Poor sense of self	Human relatedness
Detrimental relationships with others	Trust and safety
Stigma	Being valued
Self-destructive behaviour	Containing relationships with others
Negative staff attitudes	Collaborative care
Unendurable suffering	Deep listening and validation
Travelling through a maze	Occupation and daily routine
Ambivalent relationship with death	Desire for change and progress
Emptiness	Struggle to live
Boundary violations	Betrayal
(Nehls, 1999; Fallon, 2003; Perseius, *et al.* 2005; Walker, 2009; Ntshingila *et al.,* 2015)	(Perseius, *et al.* 2005; McDonald *et al.,* 2010; Holm & Severinsson, 2011; Helleman *et al.,* 2014; Ntshingila *et al.,* 2015)

Figure 2: 7 Summary of Polarised Despair-Hope themes

Despair and hope are thematically polarised in these studies in a way, which echoes other conceptions of BPD lived experience and informing and underpinning the study.

These are combined with understandings of spiritualities from all of the research literature and presented in the summary Figure 2:8.

2.3.2. "Caring across the thorns": Interrelationships between spiritualities and therapeutic relationships for women with BPD

In nursing, the linking of spirituality to good care and enhanced awareness of patient need has not been matched with clarity of meaning, (Koslander & Arvidsson, 2005; Clarke, 2009; 2013). In the absence of any specific studies, I interrogated research literature for spirituality and therapeutic relating in other contexts. Four papers were selected, Pargament *et al*., 2011; Gockel, 2011; Dura`-Vila` *et al*., 2011 and Brown *et al.,* 2012. Of the four research papers, two are from professional perspectives, one is from lived experience perspective and one is mixed.

The Greek roots of the psychotherapy are psyche *soul* and therapy *healing*. The psychoanalytic uncovering of the unconscious might have been considered as a location for the soul, yet twentieth century ideas about the inner life in Europe distanced psychotherapy from religion (Ellenberger, 1970; MacDiarmid, 2013; BBC Radio 4, 2015). Freud viewed God as illusion and religion as obsessional neurosis (Freud, 1939; O'Hanlon, 2006; Dura`-Vila` *et al*., 2011). Alternatively, Jung (1995) saw the absence of religion as a factor in psychological disorders, identifying a natural individual religious function connected to the collective unconscious. He thought that individuals became mentally ill because of their inability to express and connect, and proposed a God archetype, an absolute, transcendent authority as a fundamental dimension of being human. Frankl (2004) proposed a will to meaning as the driver for existence in place of Freud's pleasure principle. Frankl (2004) was interested in the why rather than the how of life, identifying love as the goal of human existence, with the role of therapy as the uncovering of unique meaning.

Transpersonal and humanist psychological approaches aim to be generative and transformative. James (1985) celebrates accounts of people being healed from fragmenting self-division through sudden or gradually occurring oneness with God; transformations mediated by unconscious, *transmarginal* places in the mind. Bion (1962; 1992) also talked about transformation in psychoanalytic therapeutic space. He

entreated therapists to develop *at-one-ment'* between themselves and their patients. Bion described therapy as a shift from what cannot be known – which he variously called "O" or "the formless infinite" – to the knowable. Humanist person-centred approaches put the helper in the role of empathetic wholeness, promoting self-acceptance (Rogers, 2004). Heron, (1996; 1999; 2001) theoretically and practically embraces spiritual and cooperative elements of helping others, which he calls the *helping grace*[4]. Thus historical attempts to individuate (Jung, 1985) find meaning (Frankl, 2004) access the Divine (James, 1985) know the unknowable (Bion, 1962) and centre attention on the other (Rogers, 2004) evidence restorative, relational therapeutic approaches. MacDiarmid (2013) and Heron (2006) make positive links between psychotherapy and traditional spiritual forms of healing which connect mind, body and spirit, linking of diverse traditions and the growth of mysticism in new psycho-spiritual approaches.

In mental health settings, service users value open trusting relationships with people who look after them (Gilburt, 2015) yet few research studies disentangle the effects of the therapeutic relationship from that of the intervention being delivered. Therapeutic relating is value-laden, culturally constructed and theoretically driven with diverse traditions, for example, psychoanalysis values distance while interpersonal approaches value connection (Peplau, 1952; Freshwater, 2002; Barker, 2008). Buber's (2010) theoretical text uses the terminology *I-Thou-It* to differentiate the ways in which individuals relate to self, world and other. When the other is seen, not as an object, but as an equally valuable subject, an authentic, *I-Thou* dialogue can replace the more usual objectifying, *I-It.* Nouwen (1975; 1994) recommends a deepening of therapeutic involvement to the point of immersion with other. Ontological immersion is challenging and everyday clinical immersion is potentially overwhelming. Nurses risk stress and burnout without the support and supervision required for deep personal work (Sloane, 2006) and immersion in *borderline* functioning is not recommended (Nelson, 1994; Kreger & Mason, 2010). Nouwen

[4] *Grace from Greek* charis*, but is similar in output to the dimension of love referred to as* agape *(beloved of the early Christians), and the Latin* caritas- *charity, so linked to the Golden Rule: "Do unto others as you would have them do unto you.", found in various forms in all religious traditions and expressed in Christianity thus: "So whatever you wish that others would do to you, do also to them, for this is the Law and the Prophets." Matthew 7:12*

(1994: 92), recommends making a therapeutic, friendly space with and for the other, through self-anchoring or grounding self, physically and psychologically. If we enable others to enter into the space created for them, they might learn to 'dance their own dance sing their own song and speak their own language without fear', he suggests. Nurse theorists call for the creation of authentic interpersonal relationships in which the nurse is truly present, caring in and of the moment (Peplau, 1952; Watson, 2005; Barker, 2008; Udo *et al.,* 2012).

Pargament *et al*. (2011) in a seminal and widely cited study researched sacred moments in psychotherapy from provider and user perspectives. Fifty-eight providers and five hundred and nineteen clients were surveyed in relation to an important moment in therapy in the past year and the degree to which they attributed sacred qualities to that moment. Over half of the therapists indicated that their important moment was sacred, findings that were largely replicated in the clients' survey. The research concluded that sacred moments in treatment represent a potentially important resource for the well-being of providers and clients, in therapeutic relationship. This is a detailed study from reputable researcher in this field, with results validated by a second study, drawing on recent events from diverse a sample of health professionals, most of whom were religiously unaffiliated. While, none of the therapist respondents were nurses, some of the clients surveyed were seeing nurses. There is no evidence to suggest that any of these clients had BPD although 4% of respondents identified 'personality' issues and 8% identified trauma related difficulties, so some of them might have been. While the findings are consistent with the strongly stated views of the researchers, the results do indicate significant spiritual dimensions to therapist/ client relationships.

Two further studies (Brown *et al.,* 2012 and Dura`-Vila` *et al.,* 2011) examine the relationship between therapeutic work and spirituality, exploring the views of counselling psychologists and psychiatrists respectively. Both highlight concerns about professional boundaries and competency as barriers to addressing spiritual aspects of the work. In a study which supports the findings of Pargament *et al.* (2011), Brown *et al.* (2013) use focus groups and purposive sampling to explore the willingness of fifteen South African psychologists to integrate religion and spirituality in therapy.

They found that most participants were willing to discuss religion and spirituality with their clients, although the study does not differentiate the spiritual from the psychosocial very well and issues of ethnicity, culture and diversity are not explored. Participants highlighted specific enablers and barriers to incorporating religion and spirituality in psychotherapy. Barriers were chiefly boundary and competency issues with requests for more knowledge, understanding and training. Significant enablers included exploring the client's journey and demonstrating core conditions such as being empathetic, non-judgemental and accepting (Rogers, 2004).

Dura`-Vila`, *et al.* (2011) interviewed 20 psychiatrists to explore their beliefs and attitudes to religion and spirituality and how such attitudes affect therapeutic relationships and the management of patients with religious beliefs. This study is of particular interest as it is set in the UK and sought to interview a diverse group of psychiatrists, equally mixed men and women of varied ethnicity and religious status, working across mental health settings. The study found that there was a significant degree of dissonance amongst migrant psychiatrists between their practice in their home countries (incorporating patients' religious beliefs) and in the UK (excluding them). The study highlights a fear of being thought unscientific and unprofessional by colleagues and supervisors, a finding which resonates with nursing attitudes (Wilding *et al*., 2011; Greasley *et al.,* 2001). The study recommends training and support for the inclusion and exploration of spiritual matters in psychiatric practice.

Finally, Gockel (2011) uses a narrative methodology for a detailed exploration of the counselling experiences of 12 spiritually committed clients, with the intention of shedding new light on spiritual dimensions in psychotherapy. The respondents, purposely recruited through advertising in non-denominational settings, were questioned using a variety of terms including God, spirit or energy. Spirituality was found to be integral to therapy and healing was largely understood as a process of integrating the mental, emotional, physical, and spiritual aspects of the self. Findings indicate that clients who may not identify as traditionally religious may still view the entire process of psychotherapy through a spiritual lens and that this perspective guides their expectations of the therapist and treatment.

In conclusion, there is some research evidence for a spiritual dimension in therapeutic relationships that is valued by, and of value to, clients. Significant concepts are those of the therapist being anchored, fully present in the moment, hopeful about change and able to journey with the patient are noted; training, support and supervision in spiritual matters are required.

2.3.3 "Soul Healing": Informing therapeutic relationships with MHNs

In a systematic literature review, Dickens *et al.* (2015) were concerned to find few studies of high quality about the attitudes of MHNs towards people with BPD. They conclude that since, MHNs hold the poorest attitudes of professional disciplines involved in the care of this group, that this is a serious omission. To address the question adequately, the research literature relating both MHNs and other professionals is explored, and thirteen research papers selected (APPENDIX 2c).

From lived experience perspectives, Van Gelder (2010) and Reiland (2004) acknowledge that all relationships on the *borderline* are fraught with danger for both parties, a view supported by Kreger & Mason (2010) from the family and carer perspective. Treatment research demonstrates that professional relationships can be iatrogenic and actually make things worse (Bateman & Fonagy, 2006; Linehan, 1993a; 1993b; 2014). Current guidance for people with BPD recommends against hospital admission but notes that brief admissions may be unavoidable and even beneficial in crisis (NICE, 2009; Moran 2002). Service exclusion is not deemed acceptable practice (NICE, 2009; NCCMH, 2009) and MHNs in all settings are likely to regularly nurse people with BPD. Of the thirteen papers identified six deal specifically with difficulties faced by MHNs, four consider the perspectives of other professionals and the remaining four explore helping relationships from a lived experience perspective.

McGrath & Dowling's (2012:7) survey of seventeen MHNs found that the BPD diagnosis creates 'chaos and confusion', challenging the integrity and coherence of relationships. Their study identified four themed responses, which were that MHNs found them challenging and difficult, exhibiting 'manipulative, destructive and threatening behaviour', liable to prey on the vulnerable, splitting staff and other service users, and presenting boundary difficulties. Most participants demonstrated

low levels of empathy with this group and a picture of negative relating emerges from the literature, hampered by issues of stigma, blame and control (Westwood & Baker, 2010). Many clinicians feel that support for people with BPD is inadequate and that there is scope for considerable improvement (Cleary *et al*., 2002; James & Cowman, 2007; Koekkoek *et al*., 2009; O'Connell, & Dowling, 2013). Some studies conclude that additional training and supervision would be beneficial (Cleary et al., 2002; Ma et al., 2009; O'Connell & Dowling, 2013; McGrath & Dowling, 2012), while James & Cowman (2007) state that additional specialist intervention and provision is essential. Most studies acknowledge that a change in attitudes, values and communication would be helpful (Bowen, 2013; Fallon, 2003; Forsythe, 2007; Hill, 2005; Langley & Klopper, 2005; Wollaston & Hixenbaugh, 2008; Wright & Jones, 2012).

Cleary *et al.,* (2002) explored the experience, knowledge and attitudes of 229 Australian mental health professionals, finding that they define BPD as meaning difficult, attention seeking, manipulative and disruptive. These findings are replicated by other studies (McGrath & Dowling, 2012; O'Connell & Dowling, 2013; Wollaston & Hixenbaugh, 2008; Markham, 2003) and BPD is often used as a derogatory term, sometimes applied without diagnosis, proper assessment, understanding or knowledge. Markham's (2003) study of attitudes towards patients with a diagnosis of BPD found that the qualified nursing staff expressed more negativity about working with this group compared to the other patient groups. MHNs expressed less social rejection towards patients with a diagnosis of schizophrenia to those with a diagnosis of BPD perceiving the former to be less dangerous. Generally, MHNs reported poor experience and poor knowledge and understanding of borderline functioning and relating. Perceptions of individuals with BPD often include an overly pessimistic view of treatment and opportunities for improvement coupled with an overly optimistic view of behaviour control, out of keeping with current treatability research (Markham, 2003).

McGrath & Dowling (2012) and O'Connell & Dowling (2013) found low empathy, avoidance, minimal care provision and increased challenge and confusion in clinicians. Over time, Wollaston & Hixenbaugh (2008) suggest a negative feedback loop leading nurses to develop stereotypical perceptions and reactions. Markham (2003) however,

did not find years of experience as significant as other factors in negative relating and other reports have found practice experience to be positive (Ma *et al*., 2009; NCCMH, 2009). One respondent for the NCCMH report (2009) noted a feeling of safety when working with more experienced staff, who are more consistent and psychotherapeutically skilled. This particular service user had learned to adapt through helpful professional relationships to manage other relationships and improve self-coping.

Interestingly, some nursing staff, other clinicians and researchers, avoid using the term BPD altogether as they experience it as pejorative and indicative of low chances for improvement (O'Connell & Dowling, 2013; Markham, 2003). Lack of knowledge and skill may contribute to such low expectations and are likely to impact negatively on patients. As one lived experience author, writes, in a paper she wrote collaboratively with a community nurse: "Rightly or wrongly, I interpreted the label as a sign that I was fundamentally flawed, that the bad parts of me far outweighed any good attributes that might also be part of my personality" (Wright & Jones, 2012: 34). The position that diagnosis is a route to gaining knowledge and accessing successful treatment is largely absent in this literature.

Forsythe (2007) presented twenty-six health workers with vignettes for patients, including some with BPD, where attributions for behaviour were considered stable and controllable. The main finding was that practitioners exhibited higher anger, lower empathy and less helping when the causes of behaviour were perceived as due to factors within the individual's control. The study also suggested that practitioners feel pressured to intervene when confronted with distress and when unable to help, blame the lack of success on the patient. There is little evidence of understanding that successful treatment may require more expertise and longer term relationships (Forsyth, 2007; Langley & Klopper, 2005). Nurses, in particular, are likely to assume a parental caring style with all the attendant attachment, dependency and transference issues (Koekkoek, *et al.,* 2009). When patients do not recover as expected nurses, are more likely to negative reactions of hopelessness and anger, born out of emotional investment in these patients. Six studies found a lack of understanding of BPD or a coherent treatment philosophy and pessimistic views about recovery, which are not

in keeping with current evidence to the contrary (Forsyth, 2007; Langley & Klopper, 2005; Koekkoek, *et al*., 2009; Markham, 2003).

Such attitudes affect nursing care, potentially negating outcomes for people with BPD (Ma *et al*., 2009). One study refers to BPD as a Destructive Whirlwind, echoing a nursing perception of a powerful, unrelenting force that leaves a trail of destruction in its wake (Wollaston & Hixenbaugh, 2008). These strong feelings are attributed to the unpleasant interactions and lack of skills experienced by nurses working with this group. Wollaston & Hixenbaugh (2008) indicate that nurses want to improve their relationships with BPD patients. The studies however, show that these patients are often experienced as having a huge, disruptive presence, producing overriding feelings of being unable to cope and a suspicion of being manipulated and threatened in clinicians (Wollaston & Hixenbaugh, 2008; Ma *et al.,* 2009). Ma *et al.* (2009) identified a staged descent into perceived unworkability, shifting from a honeymoon to a chaos stage, with nursing expectations deteriorating from positive to negative outcomes. They suggest that individualised nursing care, timely support from team members and adopting attitudes that are more positive would produce better patient outcomes. O'Connell & Dowling's (2013) study of ten community psychiatric nurses (CPNs) found diverse understanding of BPD and caring experiences. Participants were able to identify a number of useful specific skills but bemoaned the absence of formal clinical supervision and training. Although CPNs found working with these individuals challenging, they also reported significant rewards in seeing clients making progress. Listening in an open, honest and empathetic way, were the core skills that participants identified as being important in establishing a therapeutic relationship (O'Connell, & Dowling, 2013).

From lived experience literature, the main issues are the experience of negative attitudes and sensitivity to judgmental attitudes (Fallon, 2003; Langley & Klopper, 2005; Nathan, 2006; Wright & Jones, 2012). Travelling through the mental health system is ambivalent, confusing and frightening (Fallon, 2003). People with BPD valued their contact with psychiatric services despite negative experiences and staff attitudes, however, and relationships with others are vital in containing distressing emotions. Overcoming these paradoxes was achieved through consistent long-term

involvement with experienced staff, containing relationships, and participatory approaches to treatment (Fallon, 2003; Wright & Jones, 2012; NCCMH, 2009). Establishing trust is of paramount value in the forming of therapeutic approaches with recovery potential (Langley & Klopper, 2005; Wright & Jones, 2012). Supporting this literature are the lived experience scenarios of fear, poor support, confusion and misinformation, which inform current NICE guidance (NCCMH, 2009; NICE, 2009).

Fiona Jones (Wright & Jones, 2012) identifies turning points or serendipitous events, which promote recovery, illustrated by the story of her own therapeutic relationship with a trusted practitioner. She advocates that nurses need to find a connection, a genuine shared interest that is not threatening or intrusive, making the time together valuable and recognising the person rather than seeing the case file. Nurses who are open, honest, flexible and empathetic with the ability to listen calmly and patiently, are best positioned to help people living with BPD and further in their quest for mental health (O'Connell & Dowling, 2013). Those who are supported by their mental health care practitioners develop a greater sense of responsibility for their own lives and futures with better outcomes (Bowen, 2013).

2.3.4. "Caught not taught?" - Educational strategies for MHNs

Spiritual care is subtle, complex and diverse and it is possible that nurses are at different stages of spiritual development and maturity to their patients (Moody & Carroll, 1998; McSherry, 2006). The drive to seek certainty in nursing practice hampers practices, which value diversity, fluidity and flow (McSherry, 2006; Barnum, 2011; O'Brien, 2011). The relation between religion and spirituality and mental health has shown generally positive associations, but the complexities of this emotion-laden field of study have generated few practical conclusions (Baetz & Toews, 2009). McSherry (2006), found nurses to perceive spirituality as universal and multi-faceted, defined by personal philosophy and shaped by complex social, cultural and ideological factors. He noted a concerted campaign in the 1980s and 1990s by nurse educators for the formal integration of spirituality into nurse programmes. Pedagogical or learning strategies, which satisfy theoretical and practice demands, are yet to be designed, and current professional guidelines leave out spirituality altogether (NMC, 2015). Personal interest

is often the driver for course design and innovation, making provision variable (Nolan & Crawford, 1997; McSherry, 2006). Research demonstrates that health care professionals and nurses in particular, feel ill prepared to meet the spiritual needs of patients (McSherry, 1997; 2006; Dura`-Vila` *et al*., 2011; Brown *et al*., 2012). Many nurses lack insight or basic knowledge of this as an aspect of care (McSherry, 1997; McSherry & Jamieson, 2013) and guidance promoting spirituality (DH, 2011; NMC 2012) is not supported by a research literature or large-scale evaluations of the skills and competencies required for spiritual care. The literature exploring a specific spirituality for MHNs and educational approaches is sparse, with only six relevant papers selected, three qualitative studies of the spirituality of MHNs and three exploring nurse education.

Greasley *et al.* (2001) set up a series of moderated focus groups comprised of service users, carers and MHNs to obtain views on concepts of spirituality in mental health care. For all groups, spirituality was associated with God, religion, metaphysical beliefs and finding life purpose. Service users and carers associated spirituality with inner peace and hope, while staff valued personal well-being and self-fulfilment. Spiritual care was associated with interpersonal elements, especially love and compassion. All participants in this study voiced concerns that the nursing care was becoming less personal and more mechanical. Greasley *et al*. (2001) proposed that this might be symptomatic of a slide towards an increasingly medical culture in which more readily observable, measurable elements assumed prominence over the subjective and personal. These findings are consistent with Gockel (2011) who found that service users perceive close links between spirituality, care and love.

Ray & McGee (2006) explored the spirituality of MHNs during a service amalgamation, being a stressful time of organisational and role change. For the forty-six Canadian nurses in the study, spirituality was associated with being hopeful, having belief, maintaining relatedness and connectedness. Themes identified as supporting spiritual needs at work were communication, offering hope, being valued and getting support from spiritual sources. MHNs denoted spirituality as a significant element in their personal and professional lives and particularly valued spiritual support at work. This paper is an unusual revelation of the MHN spiritual story and notes the importance of

spirituality to MHNs as a coping mechanism. Findings were supported by the work of Pargament *et al.* (2014) and Greasley *et al.* (2001).

Wilding *et al.* (2006) sought to gain understanding of the phenomenon of spirituality for people with a mental illness. Like Swinton (2001), this study found that spirituality is of paramount importance to individuals when mentally unwell, and is experienced powerfully and uniquely. Service users were concerned about the perceived disinterest or disregard for their spirituality in their interactions with MHNs. They felt unheard and misunderstood, as though their beliefs were thought to be inauthentic, unimportant and unacceptable. The paper concludes that MHNs must be better prepared to discuss spiritual needs.

Developing a spiritual pedagogy in mental health nurse education is likely to draw on institutional, organisational and professional values as much as spiritual ones. Experiential and exploratory strategies are likely to be more helpful than purely didactic approaches, however, and what Barnum (2011) refers to as a more playful, creative style of teaching and learning. Interestingly, the recent Annual Symposium of National Teaching Fellows (ANTF, 2016) was themed as the significance of play in learning across higher education. A nursing educational model built less on content and more on the interrelating of persons engaged in a therapeutic healing process is suggested in the literature (Nolan & Crawford, 1997; Barker, 2003). McSherry (2006: 195) argues that spiritual awareness comes about from experiences of advancing clinical practice in the company of skilled mentors and teachers, being 'caught' rather than 'taught'. Spiritual nurse education is positively grounded in recovery approaches developed though co-productive partnerships between service users, students and teachers (Boardman & Roeg, 2015; HEE, 2015; NHS England, 2016).

McSherry & Jamieson (2013) carried out an online survey of 4054 RCN members, over half of whom provided additional comments. They wanted to ascertain nursing understanding of spirituality and spiritual care. The following key themes emerged: theoretical and conceptual understanding of spirituality; fundamental aspects of nursing; notions of integrated care; education; professional development; religious belief and professional practice. Findings suggest diverse understandings with a

majority considering spirituality integral to the nursing role. The respondents reported inclusive, universal approaches to spirituality whilst expressing uncertainty about maintaining boundaries between personal belief and professional practice. There was a strong steer towards the formal inclusion of spirituality in nurse education. While this is a large sample, it is likely to represent the views of nurses with a particular spiritual interest, wishing to be heard on this issue and there is no way to know whether any of those surveyed were MHNs. This survey reveals a specifically nursing perspective with a fundamental place for spirituality and interest in additional education and training in this area.

Narayanasamy (2006) investigated the impact of empirical studies of spirituality and culture on nurse education. Using a variety of action research approaches to capture the holistic and complex nature of spirituality, he developed models for spiritual and cultural care. Two possible educational models evolved: ACCESS (Assessment, Communication, Cultural Negotiation, Establishing Rapport, Sensitivity and Safety) for transcultural practice and ASSET (Actioning Spirituality and Spiritual Care Education and Training in Nursing) for spiritual care education. While there is no evidence for the efficacy of these models, Narayanasamy does propose ways in which spiritual questions can be integrated into nursing care process, favouring reflective practice for gaining insights into the nursing role in spiritual care interventions. Significantly, he directs educators to develop self- awareness, value clarification and communication skills in students with spiritual nursing showing nurse as comforter, enhancing hope and facilitating meaning, is advanced in Narayanasamy's work (1999; 2001; 2006).

Pesut (2006) analysed fundamental nursing textbooks to ascertain what was being taught about spiritual care to American nursing students. She found comprehensive content and definitions of spirituality, which used positive emotional descriptors alone, concluding that such approaches pathologise human experiences of suffering and marginalise the vulnerable. I reviewed the content of three key texts for UK MHN students. The texts, Norman & Ryrie, (2013), Callaghan *et al*. (2009), Barker (2003) had no specific sections about spirituality. Spirituality, if it comes up at all is part of recovery-orientated literature (Repper & Perkins, 2003; Watkins, 2008; Slade, 2009). In spite of positive rhetoric, spirituality is not prioritised in MHN education.

2.4 Implications for the Study

Interpretative engagement with the literature has provided contextual grounding in the key concerns of the study. Spaces in understanding *borderline* spiritualities, therapeutic relationships with MHNs and the spiritual education of MHNs have emerged though a question-specific interrogation of research literature. Spiritualities for mental health have been defined within intra-, inter- and trans- personal human dimensions as well as the related areas of experiential ill-being and recovery (Figure 2:3). While these themes have relevance and applicability for BPD, the literature also suggests the emergence of *borderline*-specific elements. These are now presented in the groupings of intra-, inter- and trans-personal dimensions and recovery. Ill-being is omitted as a distinct grouping as not being representing a different state of being in a *borderline* focussed literature, already concerned with states of ill-being.

***Borderline* Spiritualities**	
I.	**Intrapersonal -** suffering, self-harm, sacrifice, poor sense of self, emergence, motion, growth from trauma, self-centering, meaning-making, searching (Hall, 2003; Perseius *et al.,* 2005; Marsden, *et al.,* 2007; McDonald *et al.,* 2009; Walker, 2009; Jankowskia & Sandage, 2012; Ryan & Francis, 2013; Black *et al.,* 2014; Ntshingila *et al.,* 2015).
I.	**Interpersonal –** detrimental, chaos, confusion, destructive, connection, containment, support (Nehls, 1999; Perseius *et al.,* 2005Knapik *et al.*, 2008; Goldstein, 2014).
II.	**Transpersonal -** in-dwelling, awakening, emergence, epiphany, elemental – water and wind, punitive, parental, introjected, judgemental, negative, compensatory (Hall, 2003; Murray & Pargament, 2005; Goodman & Manierre, 2008; Van Gelder, 2010; Gravitt, 2011; Sansone *et al.* 2012; Sansone & Weiderman, 2013).
III.	**Recovery** – being and becoming, restorative, transformational, maintaining momentum, attribution, meaning-making, connection, self-transition (Fallon, 2003; Knapik, 2008; Van Gelder, 2010; Larivière *et al*, 2011; de Castella & Graetz Simmonds, 2013).

Figure 2:8 Borderline Spiritualities emerging form the Research Literature

The literature demonstrates that all commentators in this field are at once encouraged and limited by their own values and belief systems in the character, design and production of their work. While researcher bias is detrimental to balance it is useful in generating engagement with the complex subject matter and compassion for

vulnerable participants. Research about the relationship between mental health and spirituality supports the desire of those with lived experience for this to be address as part of recovery but therapeutic relating is largely researched from practitioner perspectives.

On reflection, the literature review has been a spiritual and intellectual quest, an exercise of, “listening for the silences, the lacunae, the sounds from the margins which have the potential to disrupt prevailing discourse and transform the world” Irigaray (1985: 159). It is in these margins that *borderline* spiritualities have been uncovered; re-imagining and re-naming spaces for spiritual discourse more suited to fragmented lived experience. The current study involves an in-depth exploration of the spirituality of women living with BPD. Detailed analytic interpretations will provide new perspectives of inter-relationality with MHNs, to reveal perspectives currently hidden from view.

Chapter 3: Methodology

This chapter includes the following elements, an overview of the methodological structure, the philosophical framing for the methodology and the research design.

3:1 Overview of the Methodological Structure

3.1.1 Introduction

Locating methodologies best suited to address the research question and clarify the study's key issues without damaging the integrity of intention is tricky; topic complexity and subject bias can cause such slippery concepts to unravel under scrutiny (Heschel, 1997; Swinton, 2001; 2010). Contested mental health and spiritual contexts, are bound up in complex theoretical constructs and diverse practice models. Study participants are located in shifting impermeable spaces and contradictory relational styles. Conceptually, this is a study of complexity and spaces in-between dimensions, people, and things. The challenge, then, has been to find exploratory methods subtle enough to capture such ineffability, yet robust and straightforward enough to provide the study with structure, clarity and relevance. This chapter explains how the study has been conceived and designed both theoretically and practically. This includes a critical discussion of the four inter-related elements, which make up the scaffolding of the study; the methods, methodology, theoretical perspective and epistemologies.

This overview presents the study structure, with a critical consideration of justification bias and choices. The methods employed are consistent with the intention to give a voice to those less heard, and the professional background of the researcher as a nurse and educator. These are semi-structured dialogic interviews, adapted conversationally and reflectively, as a mutual, synergistic process (Russell & Kelly, 2002). The interviews are discussed in detail, indicating how the study themes emerged. Data are analysed in two ways, firstly as individual narrative, respecting voice, reflexivity and individuality; secondly as thematically shared uncovering, denoting consistency and community (Denzin & Lincoln, 2003a; Creswell, 2007). Choices have been shaped by the explicit intention of attempting to view things from alternative viewpoints and fresh perspectives. The theoretical perspectives are

phenomenological and feminist, providing a context which is intentional, relational and rooted in concepts of otherness. The epistemology is participatory, respecting the shared nature of experience and knowing (Heron, 2006). Epistemologically and theoretically, the study puts researcher and reader, reflexively and empathetically in the position of the other.

The figure below reworks Crotty's (2003) stepped structure as a spiral, indicative of interactive processes, with each of the four elements in constant dynamic inter-play. In summary, this is an entirely qualitative study, with a collaborative participatory intention, located in narrative phenomenological perspectives and feminist thinking, using techniques which are dialogic, empathic, reflective and relational.

Methodological Structure for the Study: Heremeneutic Spiral

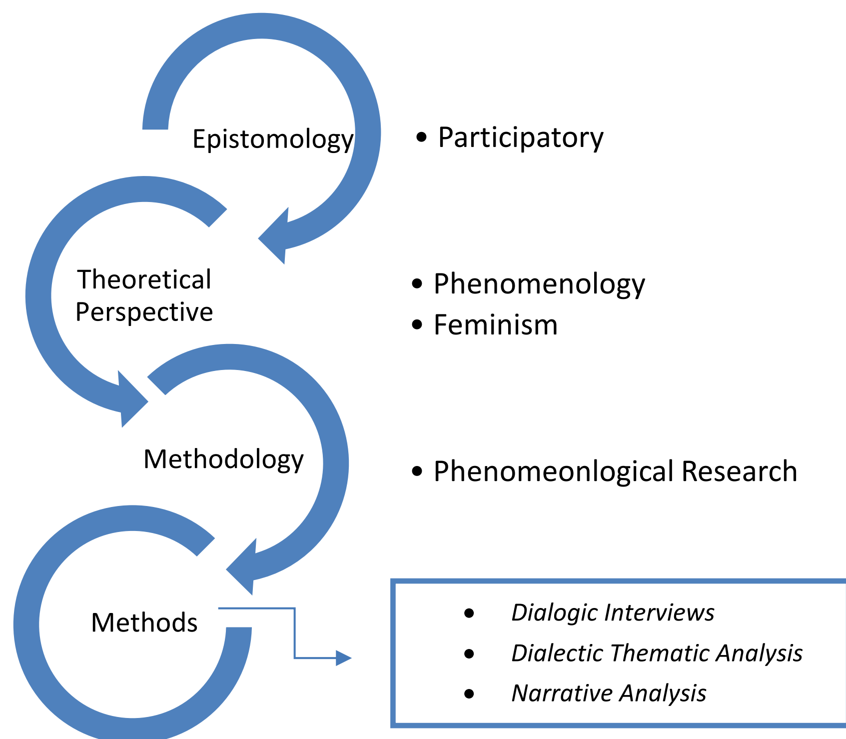

Fig 3:1 Methodological Structure following Crotty (2003) and Creswell (2007)

3.1.2 Justification for the Design

The study explores spirituality in the lived experience of women with BPD in order to inform the relational and spiritual practice and education of MHNs. A study of people's lives, deepest experiences and developmental potential, is by nature a qualitative study and all qualitative approaches have been considered as potential candidates. Utilising the nursing principle of *fit for purpose* (NMC, 2014), the researcher deemed a phenomenological perspective most fit to meet research principles of hoped for outcome and a lack of visibility in this area of study (Creswell, 2007). The hoped for outcome of the study is an examination of the meaning of experience, uncovering hidden meanings from less heard sources with innovative applications practice and education. Phenomenology as the study of lived meaning provides the project with the right tools, authority and authenticity to achieve this.

Phenomenology as a way of studying mental health and spirituality is externally validated. Swinton's (2001) seminal study, for example took a significantly *Gadamerian*, heuristic approach to the revelation of spirituality in the lived experience of Depression. Phenomenological approaches are widely use to study spirituality in health and nursing contexts, providing insights which inform and transform professional practice (Cameron, 2002; van Manen, 1996; 1998; 2002; McSherry, 2006; Todres, 2007). A phenomenological philosophical stance is favoured by notable nursing theorists, who work in developmental and spiritual modalities (Benner, 2000; Watson, 2005). An intuitive preference for phenomenology developed early in the study design, as flexibility of meaning, essence and the impact of personal, social and cultural experiences on interpretation are pertinent to the question (Creswell, 2007).

The stance and approach of van Manen (2014) has been specifically selected as a way of integrating theory and practice while maintaining a sense of wonder and discovery, appropriate to the subject matter. Intentionally, this approach seeks to interpret everyday events while considering the ineffable and elusive. Phenomenological traditions facilitate the exploration of the mystical and wondrous (Merleau–Ponty, 1964; van Manen, 2002; 2014) as well as the practical and pragmatic (Swinton, 2001; van Manen, 2014). Van Manen (2002) proposes that methodologies for nursing

research emerge from reflective practice-based ethics. Specifically, he identifies a meaningful phenomenology of practice, proposing that:

> Phenomenology is a project of sober reflection on the lived experience of human existence– sober, in the sense that reflecting on experience must be thoughtful, and as much as possible, free from theoretical, prejudicial and suppositional intoxications. But, phenomenology is also a project that is driven by fascination: being swept up in a spell of wonder, a fascination with meaning.
>
> Van Manen (2007: 12)

Thoughtful reflexivity, centred in personal and professional sensitivity, informs the research findings and opens up possibilities and formative relationships between being and acting. Individual processes of reflection act in concert with shared processes in a mirror image of dialogic data collection. In this way, conversations with the women are critically explored, and validated in dialogic experiences with colleagues and supervisors.

Genuine curiosity motivates the study, driven forward by the desire of both participants and the researcher to improve lives through activation of the transformative potential of each lived experience. The intention has been to pay high regard to ways of knowing and techniques which are intuitive, experiential, reflective and revelatory (Carper, 1978; Johns, 2004; Bolton, 2005). Methods which draw on narrative and grounded traditions have been used in processes of data collection and reflective analysis to produce the richest multi-layered findings, the outward gaze into the world of the other, reflectively viewed through what Heidegger (2010) referred to as *inbeing*. The research seeks to capture the immediacy of lived experience, torn between the moment itself and the reflective experience both in and on, the moment. Where it is impossible to capture the first of these, the study references it reflectively through the latter (Schön, 1987; van Manen, 2014). Shifts in the power dynamic between researcher and researched are acknowledged rather than avoided, so generating different ways of thinking about such relationships (Spencer-Wood, 2007).

3.1.3 Overweighting, Limitations and Bias

Studies of belief systems and ideas about beliefs carry an advanced threat of over-attribution or overweighting (Bell, 2005). It is incumbent on the researcher to identify

personal bias and reflectively separate it from, or integrate it into, the analysis in such a way as to provide clarity of presence and intention (Creswell, 2007; van Manen, 2014). Moments of joy accompany experiences where particular strand or idea seems just to fit the data or the data fits with presuppositions of the researcher and it is easy to be mistaken at such moments. The researcher is required to be vigilant, keep a balance and set aside prejudgments (Creswell, 2006). One way of achieving this is through the elimination of the personal through the 'bracketing' out presuppositions and intrusive contamination (Patton, 1990). This study, however, takes an altogether more positive position in an acknowledgement that the elimination of the personal in research constitutes another form of *othering*, which would be inappropriate in a study preoccupied with the impact of othering.

De Beauvoir's (1972) proposition of 'other' and 'othering' as representations of opposing concepts of the self has taken hold in postmodern study. In nursing, the use of power in caring relationships has been identified, as 'exclusionary othering' associated with consequences of implicit inequality, alienation and marginalisation in healthcare settings (Canales, 2010: 19). Such processes can have psychological and political implications forming borders between the self/ in-group and other/ out-group. It is important to be mindful of potential othering in work with and for vulnerable people, and it has already been proposed that the study group are particularly *othered*. Such critical positioning is essential to qualitative research, in interpersonal data collection methods such as those used in the study. The researcher is in a position to make certain assumptions about the participant that influence the interpretations of the data and the findings. Canales (2010) recommends that nursing research moves beyond othering towards authentic engagement. One critical step is for the researcher to resist being other to the other (Krumer-Nevo, 2002). Avoiding the temptation of each attempt to socially define or construct the other will go some way towards achieving credible interpretations and engender greater fluidity in power relationships.

The selected modes of data collection, analysis and writing have been chosen because they have the potential to resist an othering, which suggests inferiority. Therefore,

narrative aims to retrieve voice; dialogue reveals participant history and interpretation, and reflexivity includes the researcher's story, feeling and experiences in relation to the research participants (Krumer-Nevo & Sidi, 2012). The impact of the researcher's intentions and ways of knowing on the reporting of the lived experiences of others, calls for reflexive gaze and re-presentation of messy methodological and relational spaces. It is within such messiness that the author frames and re-frames her approaches in allegiance with participant representations, acknowledging processes of being framed herself in the process. The research has therefore been presented as narrative phenomenology, yet shares many characteristics with critical ethnography, taking a particular value-based stance towards the people being studied, advocating for their empowerment and liberation. The main reason for not using ethnography was a lack of clarity about the cultural integrity of this diverse group.

In this study, therefore, rather than seeking to eliminate a bias that is always present, positioning offers a means of rendering the individual researcher's bias more transparently combined with interpretation through knowledge, as suggested by Denzin and Lincoln, amongst others (2003a; 2003b). Meanings are, therefore reinterpreted constantly through reading and reflection to develop a structural synthesis, containing the bones of the experience for all involved. Syntheses are managed by sensitive, reflexive vigilance, reading and re-reading data, findings and conclusions, conversations with critical expert friends and supervisors, returning repeatedly to the original voices.

The researcher acknowledges the biases inherent in the choices of what to study and how it is studied and this is a study of passionate interest. One limitation of this approach is over-involvement through empathic discourse with the participants, such that a psychologically defensive pairing takes place and both parties appear to be of one accord (Bion, 1961). The point of the study is to touch other worlds, not damage their integrity, to uncover new perspectives and not re-work old assumptions. Each conversation, each reading of the data and each analysis is intended as permeation rather than mingling; the appropriate humility and respect in regards to each individual, separately and as a group, is attended to throughout. Inherent challenges to accepted power dynamics arise in attempting any co-productive endeavour,

particularly while meeting the demands of completing a doctoral thesis. This has engendered a more authoritarian voice and research design than the researcher would have preferred.

Finally, such subtle enquiries are in danger of vagueness in attempts to explore the ineffable (Heron, 2006). Dialectically, the project has required equal place for the dual facilities of both reason and wonder, holding onto empirical approaches, and to what Hershel refers to as “radical amazement”. To paraphrase Hershel (1997), in this worldview, “there are no proofs only witnesses”. This is a study of the testimony of those witnesses.

3.1.4 Reflection and Validity

The study is ethically and intentionally reflexive, authoritative and authentic in method and approach. To achieve a mutuality over the course of the study, the dual voices of the narrative story teller and the research story teller are heard. Using both voices implies a powerful relationship between the researcher and the researched, characterised by consultancy and collaboration (McCabe & Holmes, 2009). The inclusion of reflexivity and voice as integral to the methodology has engendered creative ways to incorporate my own voice, history and perspective into the study. Such self-disclosure shares much with ethnographic approaches, juxtaposing the self and subject, to enrich the data and provide both cultural and personal positioning. The primary aim of this approach is to gain a coherent application to practice principles and experience to the stories, closely allied to vocational knowledge. This study aims to inform professional relationships between nurses and patients, so is structured as a study of a research relationship between a nurse and a patient.

In order to change the structure of social and professional relations, Virginia Woolf (cited in England, 1994) urged reflection on the spatial fabric of the everyday. Van Manen (2007) amongst others promotes pragmatic reflection on lived experience. Reflecting on the *continuum* of space between researcher and researched identifies the in-betweeness, where the research is conducted. Ideally, the reflexive encounter is structured in such a way as to transform each participant, including the researcher

through the experience (England, 1994). Methodologically, the research design, using dialogic interviews and dialogic reflexivity is illustrative of this encounter. Aiming to go beyond a little further than qualitative validity, the reflexive approach aims to critically liberate researcher understandings through the ways that data collection is carried out and findings are presented (Cloke *et al.,* 2000).

3:2 Philosophical and Conceptual Framing

3.2.1 Entering Other Worlds with Wonder

Phenomenological studies draw on diverse contexts and disciplines of both thought and practice - philosophical, theological, and psychological to uncover the meanings in the everyday (Creswell, 2007). This study intends to focus on, and stay grounded in, relevant nursing and educational praxis. Spiritual and psychological approaches compliment approaches which seek the celebration of human being and becoming, or 'the fulfilment of our human nature: to become more fully who we are' (van Manen, 1990: 12). To explore the lived experiences of spirituality and access deep inner experience in ways meaningful to practice is difficult, requiring the observer to adopt ways of seeing the world that break with the familiar acceptance of it (Merle-Ponty, 1964). This means challenging reductive models of health (biomedical) and education (nurse training) to adopt alternative approaches. The position of the study is to concur wholeheartedly with Friedan (2010) that the personal is indeed, deeply and experientially, political. Translating personal experiences into understandable texts, however, can endanger the very depth which is sought. The approach taken in this study has been to, sometimes follow tradition and sometimes to break with it, in order to engage with exciting new approaches (Crotty, 2003).

Phenomenology engages in the meaning of a particular aspect of experience, assuming that through dialogue, interpretation and critical reflection the essential meaning of the experience will be revealed (van Manen, 1990). For the researcher the why and how are as important as the what, intentionality being essential to research ethics of value and purpose. Creswell (1998: 52) puts it this way:

> Researchers search for essentials, invariant structure (or essence) or the central underlying meaning of the experience and emphasise the intentionality of consciousness where experiences contain both the outward appearance and inward consciousness based on memory, image and meaning.

Theoretically, such a phenomenology embraces the transcendent or what is far outside us, and the imminent, or what is deeply within us (van Manen, 2014; Kavar, 2012). These concepts are conjoined through lived meaning as coexistent, mutable dimensions of existence. The Heideggerian view is that all humans are interconnected with their environment and "thrown" into context, (Heidegger, 2010). Experiencing *thrownness* creates a sense of threat and anguish, from which individuals seek refuge in a conventional, inauthentic life. Pathways towards authenticity and wholeness, are much written about and variously described. Jung (1985) describes a psychological journey of individuation, while Irigaray (1993) describes a spiritual journey of Divine becoming. Additional difficulties are experienced in lives characterised by chaos and marginalisation. The journey of mental health recovery has been likened to spiritual searching, a profound way to recover, if not the authentic life, then a better one (Deegan, 1998; Brandon, 2013; Casey, 2013). For those experiencing the brokenness, journeys are characterised by fluidity and additional twists and turns. Methodological flexibility is intended to enable and report such movements.

For the researcher, entering into other worlds has been honed through a nursing practice of deep encounter with other, described by Watson (2005) as engagement with 'existential-phenomenological forces.' She outlines a *carative* approach to nursing, whereby compassion is demonstrated in every caring moment spent with a patient. Significantly, this study reveals the compassionate care of the participants towards the researcher. A phenomenology of 'wonder, worlds and world' (van Manen, 2014: 13) is well suited to a study uncovering essential mysteries at the heart of human experience; the very 'enigma of being' (van Manen, 2014: 17).

3.2.2 Pragmatic Bridging

In addition to the illumination of mystery, the study engages in a pragmatic phenomenology of practice engaging with multiple, holistic realities (Swinton, 2001; Creswell, 2007; van Manen, 2014). Practice, like inquiry, comprises values as well as

evidence-based and interpretations, which however carefully and respectfully revealed, are nevertheless choices made through a particular social, cultural and historical lens (Woodbridge and Fulford, 2004). In mental health and spirituality, dominant discourses, bio-medical and Judeo-Christian respectively, have held sway. Nurse education teeters between paradigms, requiring a skills-based vocational training, a reflexive academic criticality and a humanistic interpersonal self-awareness, depending on viewpoint. Participatory paradigms favour collaborative approaches where meanings are flexible and negotiated depending on perception, knowledge and power; an alternative approach is one that is deeply and experientially personal. Quintessentially, truth dialogically and dialectically emerges from engagement with diverse realities, each story revealing a different perspective or dimension. In this study, a relational approach informs the research, forming a bridge directly to the lived experience of the other through (re)constructive dialogue and dialectical understanding. Theoretical method is thereby linked explicitly to the practical concept of therapeutic relating, openness and engagement transcending a singular view, in method as well as content (Peplau, 1952; Todres, 2007; Buber, 2010). In other words, reflexivity in the research relationship helps to inform other experiences of therapeutic relating, so that the methods employed in the study mirror the issues under examination.

Gadamer (1975) refers to dialogue as a conversation in which two persons agree to open themselves up to understandings of each other. Within the *I-thou* philosophy of Buber (2010) the dialogue is a precondition for an I to exist; an I constituted in a conversation between an I and a Thou. Reflectively, the dialogic interview, are intentional mechanisms to enter into an *I–thou* dialogue, defining and representing the situation form the both perspectives, empathically and holistically. Concealment of power is both ethically questionable and practically unhelpful for thoughtful change. What I hope to demonstrate, is the presence rather than the absence of shifting power dynamics in nurse-patient relationships.

Van Manen (2014) has developed a phenomenology of practice specifically for the study of everyday professional practices. Recovery-orientated mental health replaces

disease language with service user storytelling (Repper & Perkins, 2003; Barker, 2005). The starting point, in both cases, is the exploration of the enigmatic nature of lived experience. The foundation of meaning in phenomenological practice and study is the lived experience of and within the world, in order to present 'plausible insights' that connect diverse world views (van Manen, 1990: 9). In this context, knowledge gained through phenomenological inquiry has the potential to develop thoughtful action. In a mental health context this means that an alternative version of events is found in the lived experience of mental distress emphasising the uniqueness of each recovery journey, at once hopeful and empowering (Anthony, 1993: Deegan 1998; Repper & Perkins, 2004; Slade, 2009).

The findings of the study will facilitate new ways of seeing to enrich understandings and galvanise action. The experience of seeing and hearing women living with BPD in ways which diverge from expectations, might elicit changes in attitudes and practice. Complex practice concerns are addressed by developing a praxis and ethics of best interest, forming a bridge with direct participant experience of the things themselves in such a way as to question the status quo and catalyse change.

3.2.3 Gendered Being-in-the-world

Observer intention goes to the heart of making sense of what is being observed, described and interpreted. Intentions, however are necessarily restrained by the experience of being-in-the-world, which are in turn, defined and constrained by cultural subjectivities and constructions. Feminist phenomenology critically holds that being-in-the-world is conditioned by experiences of gendered embodiment and its impact on subjectivity. For the researcher, the challenge is to balance the location of criticality somewhere between existing concepts of say, mental health, education or spirituality, able to reflect on personal and professional influences, yet also being open to fresh perspectives. This means ethically balancing wariness of existing discourse with affirmation of, and for, individual experiences of a situated, gendered life (Ryman & Fulfe, 2013). A gendered emphasis on voice as a powerful metaphor for the empowerment of women's voices also facilitates attentiveness to the difference and otherness experienced by these particular women (Fisher, 2010). A feminist phenomenological stance informs considerations of the related issues of power,

subjectivity, objectivity, otherness and voice in the study. A perspective of feminist praxis has been adapted to engender critical interactions with existing discourses—by unsettling and dialoguing in order to both amplify and clarify voices hitherto distorted or unheard (Fisher 2010). Gendered approaches can also inform issues of spiritual embodied being and the complex relationships between the body and the self. Embodied suffering and embodied spirituality intertwine as psychological and spiritual formations of embodied selves, giving meaning to lives hindered by social, cultural, psychological and bodily restraints. The art of living such lives is a survivor's mission as bodies and spirits damaged by early trauma are reconstructed and regained (Levine, 2010; van Manen, 2014).

Reminiscently, mystical embodiment is fuelled by mythologies and religions embedded in cultural heritage and are long-lasting (Paglia, 1990; Pinkola Estés, 1993). Such objectification and the attendant internalising of the gaze of the other (de Beauvoir, 1972), has been influential in contemporary thinking about other oppressed or marginalised groups. It is suggested, by Bordo (2010) and others that the person identifying as 'object' experiences an uncomfortable dialectic, a 'disconjunction and connection', of body at the same time, *not-me* while, *inescapably-me*. The perspective of lived experience as objectified, inhibited, restrained, lacking full authenticity and power, deepens understanding of the positioning of the study participants. Bordo (2003: 230) likens storied female lives to 'life-enhancing fiction', with the potential to transform and empower in much the same way as the deep truths found in novels and poetry. Such storied perspectives, Irigaray (1985; 1993) suggests, have the ability to destabilise dominant discourse, prompting re-imaginings for being different.

Irigaray (1985) is critical of the kind of philosophy and psychoanalysis, which traditionally favours principles of identity and determinate individuation at the expense of the maternal-feminine, and more ambiguous, fluid forms. While Irigaray's work can be criticised for being founded on a western absolute of sexual difference, her work is also located within a multitude of symbolic and imaginary meanings (Whitford, 1991; Fisher, 2010). Such meanings provide new choices for women no longer satisfied with developing in the existing social world. In Irigaray's worldview,

women are enabled through fantasy, to create new subjectivities, where the symbolic and the imaginary are interconnected (Whitford 1991). Irigaray's innovative maternal-feminine concept is part of a wider re-working of new feminine mythologies (Pinkola Estés, 1993), new feminist theologies (Raphael, 1996; Radford Ruether, 1990; 1998; 2002; Coakley, 2002; Coakley, 2014;) and new feminist spiritualities (Jantzen, 1998) emergent at the close of the C20th. A symbolic *natality*, or re-birth is celebrated which challenges fixed conceptions, showing that self and non-self are not in opposition, but essential parts in a flexible and mutable identity. Natality in this sense, is not just taken to mean individual re-birth but also the opening of new social and political opportunities (Jantzen, 1998; Irigaray, 1993). Arendt's (1958) philosophical natality focusses on birth and beginnings. That we are all born links us in a shared humanity as *natals,* embodied, connected and capable of fresh starts, she proposes. The essence of the human condition is in the sameness of our shared uniqueness, from relational beginnings in a shared world (Arendt, 1958).

The birthing of new self (or selves) is a powerful element in mental health recovery. This study embraces understandings of lived experience as embodied, intersubjective, and woven into personal and cultural webs of significance. Participant experiences are interpreted from a critical perspective, noting, reflexively, what is said as well as uncovering what is not, or cannot, be said. In this way, intersubjectivity becomes a tool for hearing the voice of the other more genuinely, respecting their position as experts of their own experience.

3.2.4 Narratives for Distorted Voices

The study seeks buried wisdom through new powerful listening. Narrative methods provide researcher and researched, nurse and patient, with unique opportunities for a distinctly hermeneutic collaboration (Sandelowski, 1991). Narrative inquiry is a means by which stories are gathered and represented in order to reveal multi-layered individual truths and contextual realities (Clandinin & Connelly, 2000).

Myths and stories are used in psychological writing, illustrative of the predicament of the disenfranchised and unheard (Deegan, 1998; Casey, 2013; Maule *et.al*, 2008; Trivedi, 2008; Van Gelder, 2010). Indeed, narrative is popular in mental health

recovery, fulfilling educative and restorative functions. Narrative is also an effective way of presenting rhythm, pacing, time and place, both content and expression providing a fuller experience for reader and teller. Narrative accounts offer dramatic insight into the lives of the other, presenting the unique and unusual in a lived context (Sandelowski, 1991). In this study, taking on the role of narrative researcher has meant intentionally negotiating selfhood and identity with the other in an unfolding and reconstruction of stories through listening.

The voice of women living with BPD is powerful and articulate, a 'silent screaming', largely unheard in normative discourse (Serrant-Green, 2010). Issues of agency, identity and narrative incoherence, might make these voices unsuitable for story-telling (Adler *et al.,* 2012), yet an authoritative presence on social media and the poetic and compelling testimonies of borderline authors, Van Gelder (2010) and Kaysen (2000) belies this. Once a person is able to present themselves as the initiator of their own experiences … we need only listen. Pinkola Estés, (1993: 16) as a re-worker of myths points out, stories both heal and contain deep wisdom:

> Stories are medicine. I have been taken with stories since I heard my first. They have such power; they do not require that we do, be, act anything - we need only listen. The remedies for repair or reclamation of any lost psychic drive are contained in stories. Stories engender the excitement, sadness, questions, longings and understandings that spontaneously bring the archetype, in this case the wise woman, back to the surface.

For Bathmaker (2010) stories make more of a real life noise than other types of research in capturing alternative human experience. In real time, the stories told in the study may be unbearable, but in recollection, told as part of lived recovery, they have healing potential. They are not just revelations of past suffering but also tales of past and present successes. Through re-readings and analysis, the story is (re)created as a processual 'thinking with', rather than about, the stories to develop conceptual synthesis, bringing different worlds closer together (Bleakley, 2005). The study technique is both thematic and interactional, focussing on a dialogic process between storyteller/participant and listener/researcher engaged in finding meanings

collaboratively and discursively. The next section will explain the intentional process for carrying out this task through the research design.

3:3 Research Design

3.3.1 Introduction

The study design emerged throughout the research process, in response to the revelation of data and phenomena (Creswell, 2007). This section will present the detail in the process. The design is informed by studies of disciplines that inform the subject matter and debates about mental health, service user participation, changing roles of nurses and the dynamic nature of therapeutic relating are reflected in this study alongside the participant data and the personal and professional experiences of the researcher. Significant themes, statements and meanings have been used to illuminate multi-layered descriptions of the phenomena, thoughtfully applied to the practice of mental health nurse education. The methodology seeks to enable the deconstruction of existing preconceptions and prejudices inherent in the material, what van Manen (1996; 1999) referred to as the process of un-naming before naming, so that fresh caring perspectives may be developed (Heron, 2006).

The research process is summarised in figure 3.2 below:

The Research Process	
Ethical Approval (ongoing)	Preparation of RDA forms
Preparation and Sample	Making Connections Researching options Designing Advert Advertising
Dialogic Interviews	Resources and Equipment Digitally Recorded Interviews Transcription of Interviews
Data Analysis (1)	Immersion in the texts - listening and re-reading Moving **between** individual words, phrases and the entire text and context (Swinton, 2001) Moving **in and out** of the lived narrative, personal and professional perspectives (Johns, 2004)
Data Analysis (2)	Construction of codes from the chunks of narrative Construction of themes from codes
Data Analysis (3)	Return to the individual narrative (Re)telling of the story Identification of emergence and epiphany
Reconsidering Methodology	Exploration of Narrative Methods
Review and Revalidation	Discussion with critical friends Exploration of additional sources Participant Involvement
Writing the Research	Dialectical Thematic Analysis (DTA) Narrative Emergence
Re-writing the Research	Narrative (re)construction
Reflective Analysis	Feedback to participants and co-production Final re-write and Study completion

Figure 3:2 The Research Process after Creswell (2007) and van Manen (2014)

3.3.2 Sample Selection and Advertising

The aim was to interview women who had been given a diagnosis of BPD at some time and who were in recovery, meaning that they would not be currently in crisis or undergoing NHS treatment. The hope was to capture experiences from women who

would not be operating solely from the perspective of sickness or patient-hood, providing a destigmatised opportunity for them to engage in reflexive conversations, where they could look back into experiences with a degree of distance and autonomy.

Initially, I had decided to interview women who were 19-40, or early adulthood, a stage of life which Erikson (1964) refers to as 'Intimacy vs. Isolation', a time of questioning purpose, loneliness and isolation. The women that came forward, however, were all over 30 and one was 42. Psychosocial developmental stages are critically contested. In Jungian maturation terms, thirties and forties can represent a time of alignment with the authentic life path and the reconstruction of self-image within expanding structures of the unconscious (Johnson, 2013). Pinkola Estés (1993) proffers a feminist fluidity of development over the life span. Her model identifies the years 28-35 as the age of the mother, tasked with learning to mother the other and the self and the years 35-42 as the age of the seeker, seeking the self and giving courage to others. Additionally, Irigaray (1985) proposes a more ambiguous notion of individuation with developmental fluidity and a less compelling notion of fixed ages for life tasks. Even if psychosocial developmental consistency is accepted, women with BPD experience considerable interruption and disruption with spiritual stages are uniquely individual and enhanced spiritual maturity has been associated with suffering and difficulty (Moody & Carroll 1998). Indeed, some claim deepening spirituality at both ends of the life spectrum (Hay 2007; Manning, 2012). In summary, limiting the age range has provided the sample some homogeneity of adulthood and shared societal expectations and illness history, but is less significant than originally thought.

I advertised, through local networks for women volunteers, who had been given a label of borderline personality disorder, but were not currently undergoing treatment for the disorder. The advert was ethically approved and was sent out electronically via local networks (APPENDIX 4). The literature does not indicate an authoritative number of participants for research of this kind. There have been phenomenological studies of one individual, Swinton (2001) interviewed six people for his study of spirituality and depression, and Creswell (2007) recommends 3-10 participants in phenomenological studies. Using this as a guide, I had aimed to recruit six women but

as it turned out, five were recruited within the timescale and the fullness of the data has proven adequate for the study.

3.3.3 The Serendipitous Sample

The purposive sample was determined by advertising with a specific aim to find individuals interested and willing to engage in discussion of these sensitive and personal issues (Creswell, 2007). It has not been the intention to focus on any particular cultural or religious experience and heritage but all participants were required to have an interest in, and willingness to discuss, their experiences and their spirituality. This turned out to be an opportunistic or serendipitous process, in that participants came forward after hearing about the research in conversation with others; one participant volunteered through a mutual contact, and another was recommended by a participant. All participants made initial contact by phone and during this conversation, verbal information was given about the nature of the study and what the expectations of them would be and also what they could expect from me. Rapport was established by the researcher through the use of conversational cues and the adoption of an easy, open manner. An information sheet outlining the aims of the research, ethical and safety considerations, read out over the phone (APPENDIX 5), presented to the participant at interview and discussed prior to commencement. It was made clear that the participant could withdraw her consent or data at any stage of the process.

The sample was self-selected, including five women of diverse backgrounds and experiences; a brief background of each is included below as an illustration.

Participant Sample
K is a white British woman who is thirty years old at the time of the interview. She reports having no religion. She was given a formal diagnosis of BPD in 2006 but says that these difficulties, in particular overdosing had been going on for a long time before that, at least six years and probably as far back as her early teens. She has heard about this project through a nursing colleague and has come forward because she wants to tell her story and hopes that speaking out might do some good for others with 'the condition'. She is training to be an adult nurse.
S is a white British woman, thirty-three years old at the time of the interview. She answered an on-line advert through a local mental health trust. She describes her religion and spirituality as Christian, coming from a Catholic background, but having experienced religious renewal following recent crises in her mental health. She is planning to train to be an Occupational Therapist. She wants to tell her story and hopes her recovery might inspire others in similar circumstances.
T is thirty-three and white British. She is not religious and describes herself as an atheist. She answered an advert on a local NHS Mental Health website. T is very interested in science and studies of the brain. She hopes that participating in this study will extend the knowledge of this condition and help provide better help and support for self and others. She is currently working as a volunteer in a charity shop.
M is a British Indian woman in her mid-thirties. She was born in India. She is not currently religious and has come from a Sikh family heritage. Recently she has started practicing mindfulness as a spiritual practice and psychological support for the work she does as mental health peer-support worker for people with mental health problems. She wants to find ways of making sense of her life experiences and help vulnerable others to overcome oppressive and restrictive situations.
A is forty-two and British Asian/ Indian. She gives her religion as Muslim. She has had a faith journey, coming from a 'different faith group' where religion wasn't really practiced, through 'not having faith at all', to' being brought to faith, a different faith totally' which is Islam. She wants to bring others to Islam through forgiveness to an experience of directional belief that will mitigate the confusion caused by overwhelming life choices.

Figure 3:3 Participant Details

3.3.4 Respect and Authenticity - Beyond Ethics

Ethical approval was sought and gained prior to advertising and the ethical approval letter is included (APPENDIX 5). Every reasonable step was taken to protect privacy, gain informed consent and ensure confidentiality in keeping with University of Greenwich ethics policy requirements of me, and following British Educational Research Guidance (BERA, 2011). The unequivocal celebration of a diversity of approaches in educational research and respect for participants was felt to be particularly significant to this study. The researcher is additionally bound by professional code of conduct which promotes privacy, dignity, confidentiality and non-maleficence (NMC, 2008; 2015). Informed consent has been taken to mean an on-going agreement by a person to participate in research after risks, benefits and alternatives have been adequately explained to them (RCN, 2009). Additional care has been needed in the recruitment of people from potentially vulnerable populations. The research of people with mental illness raises additional concerns about issues of comprehension and risk, in particular risk of deterioration and negative impact of the research process to mental health. Indeed, research of people receiving treatment in NHS settings requires an additional ethical process. This study, however, set out to engage participants who are recovered or recovering, actively and collaboratively in a project which provides an opportunity to speak, both on the behalf on the individual and potentially on behalf of others. It was important to the research that individuals were provided with the opportunity to see themselves as active participants, with some autonomy in the process and the subsequent access to future work that might emanate from our discoveries.

There are particular concerns in a group whose mental health issues are characterised by self-harm and attachment issues. The researcher has demonstrated awareness that these participants will not always act in a way that maximizes benefit and minimizes harm to themselves (Dew, 2007). It is just necessary to exercise additional attentiveness to questions of motivation and voluntariness and the gaining of informed consent from people with BPD. Most importantly, participation in the research is voluntary and there is no coercion or incentive to participate, other than the wish to be part of the project. Participants are free to withdraw their consent at

any point in the process. Since personal sensitive information is being collected, all reasonable care and consideration will be exercised in dealings with the participants. A single initial delineates each of the participants, which corresponds to a part of their actual name. The reason for doing this is two-fold. It ensures that the participant is able to clearly identify herself in the narrative should she wish to, and reminds the researcher of the humanity and individuality of each participant. These individuals are not primarily research participants; they are, of course, primarily themselves.

The researcher is a Registered Mental Health Nurse (RMN) bound by a professional code, which requires that the registrant is up to date with current evidence-based practice (NMC, 2008; 2015). Additionally, the researcher maintains awareness of the potential impact of interpersonal relating on self / nurse / researcher, and other / patient / participant (Peplau, 1952). From this perspective, each interaction with the other has the potential to become a 'caring moment' loaded with expectation and possibility of change, healing or resolution (Watson, 2005). The potential to do harm is matched by an equal opportunity for existential growth and human connection. The establishment of a good level of rapport and empathy is critical to gaining depth of information, particularly where investigating issues where the participant has a strong personal stake. This approach develops a kind of ethical pragmatism. The phenomenology of practice speaks ethically to the values, principles and practice of professional lives. The intention is to integrate theoretical concerns with a values-based practice, enabling effective decision-making even where complex and conflicting values are in play (Woodbridge & Fulford, 2006).

This study of an under-researched group intends to give voice to those less heard, but not at the expense of the health and safety needs of those individuals. Before each interview, each participant has been required to identify reasonable coping strategies and support networks. In addition, each was provided with a list of on-line resources, local peer support networks and mental health services (APPENDIX 5). Participant autonomy and choice were a priority and an understanding of the process was explored prior to commencement of the interview and re-visited within the research process. In compliance with the University Ethics Policy, none of the participants are current patients of the NHS. Interactions took place in a room agreed to by the

researcher and the participant and booked by the researcher where necessary. The room was a safe, private environment, ensuring participant confidentiality.

3.3.5 Dialogic Interviews

The selected method for gathering shared experiences of the phenomena of relational spirituality is a dialogic interview. The interpersonal experiences between researcher and participant are intentionally designed to be akin to conversation than interview, enabling the participant to guide and control the interaction. While, there is no requirement to set questions in this method, a loose question schedule was developed in order to provide clear guidance to the participants on the purpose of the study and to facilitate the researcher in meeting the thesis aims, providing some homogeneity to the interviews. It is hoped that a real dialogue would take place allowing time and space for reflective mutuality within fluid power relationships, facilitating researcher-participant reflexivity. The result is collaborative perspective-taking and, what Way *et al.* (2015) have termed *flickers of transformation.*

Participants have been encouraged to talk about what is centrally significant to them, within a loose structure, which covers the area of interest to the study. A set of broad questions was developed and provided, as part of the participant informant (APPENDIX 6) and the interviews followed this structure addressing similar themes however, each participant will be encouraged to discuss these as they wish (or not, if they don't) in their own time and their own way. The participants will all be asked about their mental health, recovery, spirituality and the quality of their relationships. The interviews are conversational or dialogic, responsive to the interests and concerns of the individual participant. In this way, the current conversation becomes part of the lived experience, being both a lived experience of that present, and a reflection of the past, linking the here and now to the there and then.

The interviews were conducted in a manner complementary to the researcher's existing skill set as an experienced MHN incorporating non-verbal and verbal techniques of active listening. Core conditions of warmth, empathy and unconditional positive regard were present and a boundaried, psychologically safe space for

sensitive exploration was created (Rogers, 2004). Clarity of intent and the limitations and expectations of this process were transparent throughout the conversations. Engaging in a sensitive dialogue with the participant about the painful past also draws both into relationship with the lived present. Therefore, the data are not just the words 'collected' on tape in the interview but include the reflective recollections of the researcher both in and on the experience (Schön 1987). All interviews were taped as a feasible method of capturing all the data, carried out by use of a small digital recorder, which once checked and started was easily forgotten about. All interviews lasted one hour for purposes of equity and consistency establishing professional boundary setting, respectfully avoiding over-tiredness and maintaining well-being. In every case, due to engagement and interest, both parties would have liked to discuss the issues raised for longer. The digital clock on the recorder was an excellent method for enabling the researcher to maintain this important time boundary. All tapes have been transcribed. The interviews took place over one year from September 2013 to September 2014. They took place in various healthcare and university settings, ensuring privacy and confidentiality, negotiated to be geographically accessible and sensitive to participant needs.

The fast flow and loose connections of speech often made for a heady journey, requiring a quality of grounding in mindful, compassionate intention to enable the researcher to hold the other in calm attention. Metaphors and meaning emerged at the time and further meanings have been uncovered since. The narrative structure communicated a different kind of meaning, revealing possible disunity of self but providing a felt inner coherence. As Wirth- Cauchon (2001: 20) observed,

> Incoherence can be made meaningful by viewing it as an outward expression of inner structural disturbance, the narrative of pathology giving it fictional coherence – the structured meaning of the disordered, disunified, fragmented self.

3.3.6 Capturing the Stars: Writing the Study

The qualitative researcher is also author, not just reporting research findings, but through writing, expressing reflective inquiry. In this sense, to research is to write, and the insights achieved depend in part on finding the right words and phrases as well as analysis and interpretation. The challenge has been to write the study from the focus of those who produced the experience, and to communicate it faithfully alongside the researcher's own thinking about the phenomena. A key difficulty is finding a way of showing something which is elusive at best, almost a vibration. The process has been uncomfortably exposing, a Heideggerian self-showing (Heidegger, 2010), personally and professionally challenging to boundaries, self-disclosure and research confidence. These concerns connect researcher and participant to some extent, in the fundamental positioning of revelation and a parallel process of meaning and experience. In addition, the gushing flow of speech and somewhat chaotic nature of the narrative, have a strongly embedded, 'poetic, ambiguous or elusive' quality which van Manen (2014: 45) refers to as fragile, such that any alterations to the words or structure can drastically alter the meaning. Sometimes lengthy passages are included to provide the reader with some feel of the flow of the narrative and the impact of that flow on the researcher. Alternatively, short, powerful, vibrant phrases and images break out of the narrative, demanding their place in the text. Their inclusion, it is hoped will not cause a dramatic turn of phrase to overturn the meaning of the whole. Some expressions, considered weakly embedded and repetitive have produced compelling motifs, which are illustrative of powerful themes and emergences throughout the piece (van Manen, 2014).

A critical, yet simple and respectful approach has been applied to the meanings and significance of the data, both objectively and subjectively. Denzin and Lincoln (2003a) have identified a *post*-postmodern sensibility, looking past fragmentation towards future landscapes of moral and sacred discourse, new ways of embarking on and expressing sacred and spiritual inquiry. Approaches to the study of spirituality and mental health identify shared themes but often struggle to find unifying definitions and language (Wilding *et al.,* 2006; Clarke, 2009). Phenomenological text evokes forms of meaning that are ambiguous and individual, making generalisation difficult, yet van

Manen (2014) argues that such writing can also communicate existential meanings and a sense of universal wonder. The aim of such phenomenology is not just to develop meaning but to demonstrate *how* meaning reveals itself; thus, the writing of this study demonstrates the way in which the thing shows itself.

The writing begun as a step into the dark and has become like treading lightly along pathways illuminated by guiding lights of thought and meaning, intellectual, spiritual, emotional and practical (van Manen, 2002; Wilding *et al.,* 2006). The way chosen, however, is not the final way, but rather the now way, suggested in the experience, relationship and reflection of the study. The writing is at once craft-like and creative, rather like sculpting the raw data into a finished piece, or bricoleur-like, making a complex wonderful pattern out of the varied and beautiful individual pieces (Braun &Clarke, 2013; Denzin & Lincoln 2003a). As van Manen (1990: 90) movingly expresses it, I have been guided by:

> … the stars that make up the universe of meaning we live through. By the lights of these themes, we can navigate and explore the universe …

In the following section, these lights, or the ways in which the data was analysed to reveal themes and meanings will be discussed.

3:4 Data Analysis – Plausible Insights

3.4.1 Introduction

The interviews have been analysed using a constant comparative approach through multiple readings, to construct sets of themes across the individual interviews and then across participants (Creswell, 2007). Initial themes were clarified and then added to in subsequent interviews to search for confirmation or contradiction and used to construct a thematic framework using an iterative approach. The process was repeated several times until the coherent themes of all five narratives emerged. Awareness of the dangers of contamination with the researcher’s own material has prompted constant vigilance and revalidation of material. Viewed this way, the stories of lived experience (the data) are co-constructed and negotiated between researcher and participant both, in the text, and between texts. This has proved effective in capturing complexity and nuanced understandings (van Manen, 2014).

The transcribed data were then arranged in a table an example of which is shown below, with each line of script enumerated in order to track significant words, phrases and meanings. Codes were then applied to chunks of data as a shorthand for something of significance noted in the text which is either repeated often or expressed particularly strongly. This coding appears in the second column. The first concept that struck me, for example, was the phrase *'I got my'* in the first interview. At the initial hearing in the interview, and in later hearings and re-readings, the phrase became significant as a representation of the participant's experiential passivity in response to external *loci* of control. The theme repeated in this transcript gave it additional significance for this individual and the appearance of something similar in other transcripts gave it significance for the group. The coding process was primarily descriptive but inevitably interpretive as data immersion linked concepts found in individual data sets with each other and with other sources of experience and knowledge (Braun & Clarke, 2013). As the process continued the colour coding provided visual clarity as themes began to take on an increasingly complex and interpretative flavour. The codes are numbered in the order that they came to light. In the featured sample, below, it is possible to see that "I got my", has been coded after, "but when I spoke" denoting agency, even though it appears at an earlier point in the text, demonstrating the organic, reflexive nature of the process. A third column was included to document reflective comments from notes taken immediately after the session. The first reflection represents close cognitive and emotional memory, recollecting responses of immediacy, almost *in* action. A fourth column was added later to capture changing meanings and understandings gained through multiple contacts with the data, representing reflection *on* action.

Qualitative research often makes reference to themes emerging from the data, but in this study an active process has been undertaken, with meanings generated and constructed through reflexive interpretative engagement in the context of praxis, literature and positioning (Braun & Clarke, 2013).

Interview Transcription and Coding: K			
Data	Coding	Reflection ‘in’	Reflection ‘on’
Q: Can we start by asking you to tell me something about what led to your diagnosis? **1. As I say, I was diagnosed in 2006, that’s when I got my formal diagnosis.** **2. The events that led up to it were I was self-harming a lot,** **3. I was overdosing and I mean, that had been going on for a long time,** **4. probably 6 years prior to that but I sort of fell through the net as they like** **5. to say. They never gave me a firm diagnosis. They just put me on anti-** **6. depressants, but when I spoke to one of the psychiatrists in one of the hospitals** **7. after an overdose, that’s when they gave me the diagnosis of borderline** **8. personality disorder. Because of the episodes, the blank episodes that I was** **9. having, that’s when they gave the diagnosis and I’d never hear of it before.** **10. I’d never heard of it.**	‘I got my’ Falling The ‘They’ Self-harm - ‘it had been going on for a long time’ When I spoke something happened/ changed – emergent agency Something unknown	I am struck by the casual almost dismissive attitude to self-harm Speaking- finding voice – changes things	K - currently training to be a nurse and so distances herself from past experiences as a patient Later Reflection: We possibly share mutual language/ terms of reference as we are both nurses?
Colour Coding **1. Internal locus of control - Agency** **2. Dense internal world – vulnerability. Blankness and existential despair** **3. External locus of control –positive and negative ‘he’ and ‘they’**			

Figure 3: 4 Example of Initial Coding

The typical inductive approach to phenomenological analysis was combined with an “eiductive reduction” (van Manen, 2014: 228). Inductive analysis is driven by what is in the data, the codes and themes derived from the content of the data themselves, while an eiductive approach consists of entering into the world of the other, grasping at insights from the internal meaning and structures of lived experience. By combining both approaches themes are constantly expanded and clarified in connection with the researcher’s experience of the data, developing internal and external validity. Van Manen (2002) likens this to traversing into a world of endless alternative possibilities, such as the immersion of self in a novel or a film, stepping into worlds yet, unknown, yet evocative of unique meaningfulness. Constant refreshment was required so that each interpretation remained fresh, new and imbued with ‘questioning wonder’ (van Manen, 2002: 5).

After these initial readings and processes, fourteen themes emerged, and these (see figure below) formed the basis for taking the step into deeper data analysis.

Thematic Analysis from Initial Coding

1. Internal locus of control - agency
2. Dense internal world – vulnerability. Blankness and existential despair
3. External locus of control –positive and negative 'he' and 'they'
4. Connection- positive relating to self, world and other (things and people)
5. Struggle, difficulty- seeking voice, regaining through struggle, healing through knowing. Becoming through learning
6. Disconnection- detachment, rejection, abandonment SPLIT self/ others
7. Movement and Space
8. Internal spirituality- core self, inner strength, the 'inside yourself'
9. Emergence of phenomenon
10. Embodied and disembodied- harm to the physical self (cutting, poisoning) denying physical existence
11. Dark inner self or dark spirituality
12. Serendipity, turning points, luck
13. External spirituality - God and/ or other
14. Meaning making and finding purpose

Figure 3:5 Thematic Analysis from Initial Coding

3.4.2 Data Analysis – Dialectical Emergence

In order to expand and clarify the initial coding, significant statements from each of the narratives were identified then clustered to formulated meanings and coded as themes (Creswell, 2007). Formulated meanings open up the text in order to uncover inherent ideas and meanings, and the themes assign categories to them by identifying a central characteristic around which similarities and differences can be identified. The data were then reassembled to denote relationships between and within categories (Creswell, 2007); in essence a process of opening up meanings followed by a constriction of meanings and then a further expansion. From the five data sets, tables were constructed with significant statements, constructed meanings and themes. An example is included in the figure below, demonstrating similarities between emergent themes of other participant data and to meanings uncovered in the initial (colour) coding.

Constructed Meaning and Themes : T		
Theme	**Constructed Meaning**	**Examples (Significant Statements)**
Locus of Control Agency	Hidden, external, impersonal forces Doing her best to die Formal complaint to get something done	**T: 1** Unfortunately nobody said them. I was in hospital at the time, a psychiatric hospital and somebody slipped a bit of paper under my door with a summary of me, **T: 82** because I've done the best I can do, nobody else would have had access to any of that stuff. **T: 290** No I had to make a formal complaint afterwards **T: 9** bit of a rant and I was really upset and you know got action done
Constantly Moving	Going up and down No sense of normal 'tip back' 'bubbling away'	**T: 303** All that happens is I will wake up one day and I feel fine, that's all, I can sometimes identify triggers that will make me go down again that nothing that makes me go up again. So I wonder if that, when I feel ok that what I would be like if I was a normal person, but no there's nothing that would make me go up, … I just go tip back to that. but inside I'm bubbling away

Figure 3:6 Constructed Meanings and Themes for T

The same process was repeated with all five data sets, demonstrating that the constructed themes supported the initial colour coding and that there were similarities in each of the narratives, as demonstrated in this second sample.

Constructed Meaning and Themes: S		
Theme	**Constructed Meaning**	**Examples (Significant Statements)**
Being passive (controlled?)	I just remember Keep walking, keep walking Waking up Auto-pilot Wallow away	**S: 25.** I remember going off the ward on my own and I climbed these stairs and **S: 31** and I was thinking just keep walking just keep walking just keep walking **S: 82** going on around me and didn't notice and like a funny wake up that feeling of waking up … I haven't been able to get up, I haven't had no energy just completely and utterly just wallow away
Being in Motion	On pause In a bubble Get on a train In and out Revolving Spiralled - Griffith's' web?	**S: 51** on my way to work and I didn't get off at the stop I was supposed to get off I just kept going and I got to xxx and I got off the bus and it was just like I was in this big bubble and everybody was just speeding up around me and I was on a pause and I couldn't, all that was on my mind was get on a train get on a train get on a train I was I was in and out I was revolving **S: 41** things just sort of spiralled out of control from there

Figure 3:7 Constructed Meanings and Themes for S

Both samples demonstrate that where one participant, identifies themes of control and agency, the other has identified being passive or controlled, themes which are related and representative of opposing elements of a dialectical continuum.

Finally, the codes were re-gathered into one table, shown below, so that they could easily be compared and contrasted; shared commonalities were identified, as were issues of uniqueness and difference. Using a process of thematic analysis, themes relating to each individual narrative were counted to identify the most common to be shared for exposition in the findings (Creswell, 2007). This method, while somewhat reductive, clearly demonstrates what the over-riding issues were for each of the women both individually and as a group.

Emergent Constructs Collated from Thematic Analysis

K	S	T	M	A
Different selves	Locus of Control	Being (labelled)	Becoming	Being borderline
Emergent darkness	Moving	borderline	borderline	Movement
Locus of control	Harming self	Locus of control	Harming self	Different worlds
Divine: within and	Void	Voice	Movement	Hope
without	Root	Moving	Sleeping	Forgiveness
Place	Struggle to be	Harming Self	Rootless	Heart and voice
Safe and unsafe	Wanting to be safe	Being Abandoned	Locus of control	Harming self
Voice	Restorying	Being unsafe	Places and spaces	Faith Journey
Related	Emergent	Oppositional selves	Neglect vs nurture	Recovery Journey
Being labelled	spirituality	Science	Connection	Meaning
borderline	Inner strength	Being angry	Meaning and	Relating
Transition	Extreme	Relating	purpose	Structure
Transformation	vulnerability	Futures	Spiritual Practice	Directional belief
	Meaning and	Against god (s)		Divine relations
	purpose	Transforming		
	Relationships	Being evil		

Figure 3:8 Emergent Constructs from Thematic Analysis

Supportive of findings in the initial coding, this approach has also produced a fresh revelation. Each thematic construct contained the seeds of a similar alternative or oppositional viewpoint, the identification of emergent dialectical themes. Van Gelder (2010; 2012) provides an example of this in her exposition of experiences of passivity and powerlessness alongside an equal sense of considerable powerfulness, which she refers to as ‘ambivalent empowerment’. Contained in the data, for every meaning pointing one way was a meaning which pointed the other, demonstrating that, at the borders of meaning, direction varies and possibilities are many. As these dialectics emerged from the data, new constructs for *borderline* spirituality began to take shape.

Finally, in a reflexive review of thematic clusters, a conceptual meeting with the relational spirituality described in the literature was identified (Reed, 1992; Swinton, 2001; McSherry, 2006; Cook, 2009; Cook, Powell & Sims, 2013). The human spiritual dimensions of intra-, inter- and trans-personal relating are present as well as the sacredness of space and place and all are conceptually linked theoretically and practically through mental health recovery. These reflections are included as part of the findings which are presented in Chapter Four: Part Three. The researcher's journey of analysis, however, is not complete at this point and on turning back, in reflection, to each of the individual stories, an additional uncovering, more layers and fresh horizons were revealed. This additional analysis is presented in the next section.

3.4.3 Data Analysis – Restorative Tales

Reflectively, this was the researcher's turning point, where the study process turned back to (re)identify the narrative analysis layer. The unique collected experiences of events, epiphanies and chronologies seemed to have been getting lost in a complexity of analytic frameworks. The story of each individual was still waiting to be told, with unique intrapersonal patterns, individual voices and personal stories of struggle, coping and recovery. Data were therefore re-interrogated from a narrative perspective, enabling each to speak as author of her own story, survivor of her own suffering and architect of her own overcoming. This was unproblematic inasmuch as the interviews were conducted in such a way as to prompt storytelling and the collected data were characterised by long, attention-holding passages of variable content and flow. Narrative is pertinent to mental health recovery and to phenomenology. In recovery, people often recount significant life events, as protagonist of a singular story or drama (Holloway & Freshwater, 2007). The culture of storytelling as a way of sharing great truths is significant to the disempowered and marginalised, providing an opportunity to voice and share experience. While this project, had not intended to be a narrative study, the researcher participant relationship and the experience of immersion in passages of compelling rhythmic prose and powerful testimony, had incontrovertibly made it so.

Stories can liberate by developing fantasy worlds through which adversity can be overcome by harnessing 'the powerful energies of the unconscious' (Bryant 1993: 39). In a wider political-cultural context, feminist commentators use dramatic re-visionings of myths, legends and fairy tales to engender new meanings in the service of the vulnerable and dispossessed. The healing power of such stories is in the ability for protagonist and listener to identify both with the victim and the rescuer in a deep unconscious reconstruction (Pinkola Estés, 1993; Warner, 1994; Radford Ruether, 2002). Stories told and heard in this way can abreact pain long endured, giving shape to things outside persons and breaking the hold they have over them. In each of the narratives, a push and pull between contradictory impulses is present and the narrative analysis seeks to encapsulate this dialectic mutability. These are no straight tales and it is in the spirals, twists and turns of these stories that we are most informed, each depicting transformative and enlightening potential.

Barusch (2012) proposes a principled approach to narrative research, with two key perspectives, pertinent to this study. The first is that of sensitivity to vulnerable voice. Voicing is particularly important in relation to the power dynamics which Irigaray (1985) alerts us to, so that potential challenges are implicit in the recognition of multiple voices which destabilise the authoritative or dominant narrative. Using narrative in this way brings forth the voices of the vulnerable. Explicit connections are made to the motivation of the storyteller, as the why it is being told will inform and shape what is being told (Riessman, 2008; Barusch, 2012). The second is that human narratives are marked by intention, a sense of purpose and can be interpreted as a dialogic performance (Riessman, 2008). The study seeks to capture the dialogic performance through awareness of conflicts between narrator intention and the coherence and integrity in each narrative.

Finally, it is important to present the stories with some spontaneity, mindful of their natural emergence and creativity. In this study, the participants tell their stories, not just to work out their own lived journey but also to create life maps which act as a guide to others who might follow (Frank, 2013). The stories in this study are relationally produced in conversation and, as such they reveal the relational identity story told, in the first place to this one other, the researcher, in the present but also

to the multitude of others who are part of the story in the past and through re-telling in the future (Carlson & Erickson, 2000; Murray, 2008). Such tellings and re-tellings explore how each relationship influences the relational identity of the person. Figure 3:9 presents a brief summary the rich complexity of individual narrative themes, which are presented more comprehensively in the findings in Chapter Four. The restorative power of these stories represents the revelation of dynamic change in the teller and a transformative synchronicity in the hearer.

Individual Narratives
K's Story: Strong for Others, Strong for Self
The beginning is one of powerlessness and passivity, followed by a growing inner strength. On dialogic reflection this strength was present in early protection of her brother, but lost in blankness and self-annihilation associated with 'the condition'. Confronting past pain have led to a reattribution of control, developing life purpose and restored sense of self.
S's Story: God brought me to this place
This story uses literary, poetic language with alliteration, metaphor and language of irrevocable movement reinforced by repetition, such as 'get on a train, get on a train'. Feeling herself to be both God and the anti-Christ, emerging from an elemental darkness, within and without and transformed by reaching upwards – going higher, until, angel-like she is transformed and re-born into new faith.
T's Story: A Heart of Darkness
A story of darkness associated with alienation and existential disconnection. An experience of emptiness engenders thoughts of self-harm and annihilation. Ambivalence and contradiction characterise a story of inner battle between two sides of T's brain, revealing a dark heart at the core of being. Yearning for a new self with new neural connections and an organic god in the brain.
M's Story: Being kept in mind
Overwhelmed by suffering, neglect, abuse, deceit and betrayal at the beginning, there is no safe place to be. M has been dropped into a world of fairy tale like darkness, and visceral danger. Some solace is found amongst temple lights and music and healing comes through consistent, mindful relationships, self-growth and self-compassion until 'united with all' Ultimately, M is transformed and by being kept in mind by others, able to keep herself in mind.
A's Story: North Star and the Clouded Way
Emerging from a directionless dark place, lost in mind, a clouded way through the experience of forgiveness, family love and directional belief, finding the 'balanced' path, 'a way of life'. This is a story of seeking and finding. Looking upwards for 'god' or the North Star, a path of faith and discipline opens up an experience of changed patterns of thought and a sense of peace.

Figure 3: 9 Individual Narrative Themes

3.4.4 Data Analysis: Dialogic Reflexivity

My reflexive process both formal and informal, are integral to data processing. This includes my experience of the participants along with the intersubjective reflections that unfolded during the interviews and in the analysis of data. These are representative of the transformative potential of reflexive material, showing how the research-participant relationships contextualise the narratives within a shared, lived experience. Like Goldstein (2016), I propose that reflexive processes support the findings and mirror inter-relational experiences between women with BPD and MHNs. The reflexive processes have been characterised as introspective, discursive and collaborative. Two particular examples are illustrative of changes in participant acting which in turn may represent changes in being. One participant (K) reflecting during the interview, identified an inner strength which she had not previously identified, while another (S) found that being respectfully accepted in an academic study with an academic, encouraged her to embark on graduate study and a new career.

3.4.4.1 Introspective Reflection

During the initial coding exercise, researcher reflections were recorded immediately after the interview and later following supervisory discussion, in an attempt to follow Schön (1987) by reflecting *in* and *on* the experience (Figure 3: 4.). A representation of this process is presented below. In the first example (Figure 3:10), the reflective notes demonstrate some of the emergent themes including darkness and light, vulnerability and strength, indicating where these elements were identified in other data as, *like M* and *like K.* Underlining represented particular researcher sensitivity to the transcript. The second sample (Figure 3:11), shows how the some of the strongest themes emerged, through repetition by the women and strong reflexive resonance with researcher. Spirituality is identifiable in living through experiences of breaking *with* and *from* the past. In later reflections, the researcher's own voice is emergent, though personal engagement with hopeful recovering spaces and spiritual sensitivities located in the 'other' and inter-relationally mirrored in the self.

Refection in (then)	Reflection on (now)
Stark contrast between the dark and the light - feels like a dark external force rolling in like a moor mist Vulnerability vs. strength (to get up and break hospital conventions & patient role compared with weakness and passivity? This section reads like/ feels like almost stream of consciousness Like M – found a refuge Compare danger inside/ danger outside 'in and out'. Like K she suddenly breaks out of control 'I just kept going'	I am being swept along and barely interjecting - is it the nature of compelling storytelling or something else? It's like waves- is this like the borderline experience? Being UNSTABLE - desperate search for anchor Being in ambivalence – desperate desire to escape vs desperate need for holding?? Being out of self – I feel 'out of myself' There are 2 distinct tones- being in (like waves) the moment and being on (becalmed) the moment Fits with an idea of spirituality - a means of seeking balance & integration WITHOUT denying poles which have benefit and value (dialectically)

Figure 3: 10 Dialogic Reflexivity in Response to Participant S

Refection in (then)	Reflection on (now)
A is warm, welcoming, bright and makes good eye contact throughout. She is confident and kind and likeable, in control of her thinking and beliefs She chooses a religion that represents a historical battleground with her family (during partition) – spirituality as break with the past Emergence of faith and emergent self VOICE 'the way I understand life' and 'how do I put that word in my head' Emerging with uncertainty and struggling for the language to express this 'new' concept HOPE and inner strength (like K) Spirituality/ religion as break with the past like K, S, T, M, - A STRONG THEME Past Self (then) has 'fizzled away'. K, S, T, M, A distinguish a then self from a new self	In the end, if not the beginning, I form strong liking and affection for all these women – represented by an empathetic affiliation with their struggle and journey Emergence of my VOICE Note - developing Selfhood (as commentator) Spiritual world – a sense of inter-relational SPACE which is closely aligned to a sense of geographical, cultural and religious space New emergent language being developed to express these 'new' concepts HOPE and inner journey - recovery

Figure 3: 11 Dialogic Reflexivity in Response to Participant A

Experiencing connection and detachment directly in the research has sometimes led to viewing familiar aspects of myself as strange in order to disrupt self-assumptions and to move closer to the way the world is perceived by these others (Bolton, 2005). A reflective diary was kept tracing some of the twists and turns of the personal journey. The diary records the identification of critical pauses or *waypoints* in my own intellectual and spiritual journey. The emergence identified in Figure 3.11 was not without personal struggle recorded at the time in my reflective diary:

> *It is stressful conducting such personal research, trying to work out my own thoughts as I am going along as well as developing new skills, managing anxieties and listening to such horrific stories.*

Excerpt from Reflective Diary June 2013

This entry was made at the start of the data collection process, however later entries identify joy at apparent synchronicity in data analysis and the ongoing challenge of maintaining hopefulness and energy required during writing. At times my spiritual and intellectual journey chimed with that of the women.

> *The challenge is to keep looking into the data and keep loving it and trying to understand it – this is what motivates me. When it gets tedious and dull, I lose so much motivation. I must keep dancing my way along through it or I get down and start to feel quite physically and mentally unwell. If I hadn't promised someone – the women, my teachers, my parents, my sons, my better self? - that I would finish this, I would have given up time and time again. I start each session with prayer. I light the Hope Candle and I dig deep into myself to try and make work of value with kindness and love …*
>
> *I have learnt that I am* ***so*** *here and now that it is almost impossible for me to take a larger view - the horizons I fuse tend to be the ones that are most closely in my immediate orbit. I am learning apartness and strangeness from myself and others so that I can identify what's in-between!*
>
> *There is a confidence in my nursing and teaching practice that sometime spills into the difficult parts of this process and like van Manen I am struck with the wonder of the everyday and the immense privilege of being allowed to do this work …*

Excerpts from Reflective Diary February 2014 to April 2015

3.4.4.2 Discursive and Collaborative Reflections

Formal and informal opportunities for critical discussion and dissemination included doctoral classes, writing retreats, supervisory sessions and bi-annual presentations to students and teachers. Members of the mental health teaching team acted as critical friends and expert peers, proffering innovative approaches to data analysis and support.

> *Talking through S's narrative with PA, sharing experiences of nursing people with BPD. The water motif, safe harbor and anchoring, suddenly strikes her as similar in the story telling, the movements and turn of the tale with sailing, which is her passion. The turn of the story is like the turn of the tide, the mistaken relationships akin to 'foul anchor' and critical pauses like 'waypoints'. Ideas tumble out of a giggling joyful conversation. A wonderful, collaborative serendipitous moment!*

Excerpts from reflective diary July 2014

Reflexive dialogues mirror research processes with serendipitous moments, epiphanies and the development of courage and creativity. Each experience supported the positioning of the study from diverse positions in nursing, theology, politics, feminisms and psychology, as indicated here:

> *Finding it difficult to encapsulate embodied spiritualities in the narrative. DE advises that spirit in Hebrew is 'ru-ach' meaning breath or life-giving force, thus fundamental to WHOLE human existence. He says read Paglia and Bordo – revelatory! We coin the phase ''Pagliesque icon' and I gain critical understanding that some concepts of woman's body as sacred are fragile where bodies have been violated and damaged. How lucky to have a supervisor who is an ex-priest and a sexual health expert.*

Excerpts from reflective diary February to April 2015

The critical supervisory relationship between student and supervisor often modelled the complexity and dynamic nature of the participant/ researcher relationship. Intuitive mirroring and the reflective growth of new, deeper understandings within the supervisory relationship informed and checked the findings providing experiential face validity.

Sent reflective analysis to FK yesterday, using the amended constructive model she sent me. It works much better in terms of structure and meaning, than the way I was doing it. We meet up and I make some suggestions that are a bit fanciful - I'm not sure I always get the balance between creativity and fiction! FK is calm and thoughtful, never negative. She reminds me to keep mining the material, not adding too much in or taking too much away from the voices of the participants - genuinely interpersonal and co-productive working – finding the participant voice collaboratively through the development of the researcher voice. In this way she models the process, neither taking too much away from my thinking nor adding too much to it.

Excerpts from reflective diary February to April 2015

Reflexive fusion is presented diagrammatically in Figure 3:12, with each reflective experience informing and deepening the other. Each process aimed to develop a consistent position in relation to each individual and each shared emergence. The findings are audited against each other and validated through a constant reflexive interplay. While the analysis is limited to a singular relational experience, the phenomena studied had an intentional participant focus, and, in this way, the research design contributes to truth seeking (Groenewald, 2004). For reasons of possible harm, a judgment was made not to provide complete transcripts to participants.

Dialogic Reflexive Processes

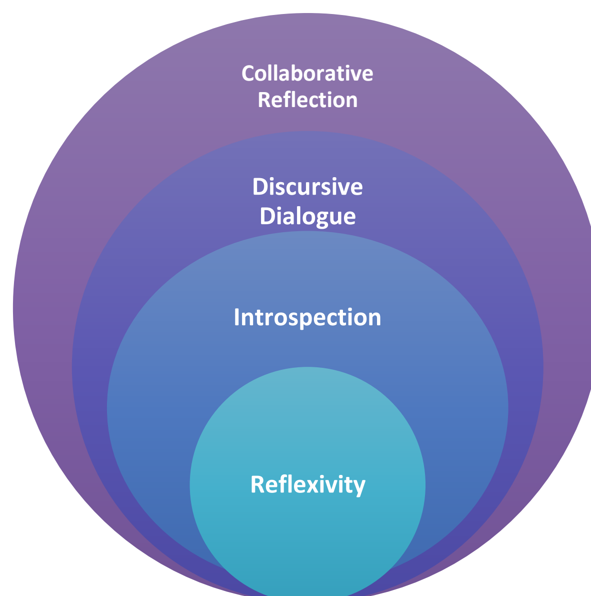

Figure 3:12 Dialogic Reflexive Processes

3:5 Conclusion

The aim of the study has been to uncover and understand particular relational phenomena through an investigative process of entering into the world of the other contrasting and classifying perspectives in ongoing interaction with them (Creswell, 2007). Such persistent observation and engagement has required the researcher to identify the most relevant and pertinent elements and pursue them in detail. The study has been designed to enable thematic coding and narrative processes to lead to deep engagement with phenomenological uncovering, continuing until no new themes or issues arise.

Chapter 4: Findings

The following chapter explicates the lived spiritual experience of the participants, showing through narrative tales and thematic explanations, illustrated with data extracts and researcher reflections. Each participant captured the phenomenon of spirituality differently, in relation to individual shaping experiences, motivation, belief and choices made about modes of expression. I endeavor to use unique voices to, ideologically and pragmatically, represent personal experiences and histories. As explained in Chapter Three there is one data source, but there are two presentations of the findings; the first, in the form of individual narrative analysis and the second in the form of a shared dialectical thematic analysis. Lastly, both processes have been synthesized as shared voices and subtheme clusters, es or what van Manen (1997b: 90) referred to as “knots in the web”.

There is no single over-arching emergent theme, but the experience of being-in-the-world derives meaning through two key catalysts of intention, those of voice and quest. These elements mirror the study’s ontological orientation of transformation through voicing and questing. Thematic links with the practice and principles of recovery orientated mental health approaches conceptualised in participatory and inclusive worldviews are maintained. A framework for application is explored from the lifeworld dimensions of temporality, spatiality, corporeality and relationality as a reflective context (van Manen, 2014). The multi-layered approach to the synthesis of complex data themes has benefitted analysis in the following ways. Firstly, it has facilitated the development of a coherent theoretical structure orientated to lived experience. Secondly, it has opened up domains of literature and thought which have broadened the scope for interpretation, thus widening the hermeneutic circle.

4.1 Narrative Analysis - Restorative Tales

4.1.1 Introduction

The following section intentionally provides an open discursive space for the authentic representation of the women, as agents acting in complex life worlds through narrative (Riessman, 2008). Each narrative is inter-woven, first separately and then

collectively, into a web of interrelated motifs that meaningfully speak to the initial research question. The stories are gathered and represented in such a way as to reveal individual truths and realities of content and expression. Every effort is made to represent the narrator fairly and accurately, acknowledging that each presentation is repeatedly filtered through processes of transcription, analysis and re-telling. Each story element is illustrated with the participants own words, directly from interview transcripts, identified by the initial code representing the participant and the text line number. Lived narrative is explored in a way that is inclusive of metaphor, imagery and symbolic meaning (Clandinin and Connelly, 2000). The stories are therefore more than descriptive accounts and always about something located in personal and public places where identities might be constructed or reconstructed (Holloway & Freshwater, 2007). While the women are *wounded storytellers*, in Frank's sense (2013), the intention is not to manipulate the teller or deepen the wound but rather to enhance recovery and restoration, highlighting meaningful progress and human connection (Tenore, 2014). Mindful of the context of the story being told, each is encouraged to uncover or rediscover the unique and energising in themselves experiencing what I believe Swinton (2001: 20) to mean by the "outward expression of the inner workings of the human spirit".

Narrative representations include significant rhythm, pacing, time and place along with epiphanies, turning points and transitions (Sandelowski, 1991; Clandinin & Connelly, 2000). The style of speech as well as the content of speech is of importance. Experiential darkness, emergence and seeking are powerful narrative elements of stories that are driven by a compelling rhythmic quality, combining long prose passages with short powerful phrases. The effect on the listener is that of a linguistic and symbolic motion of flow, stop, start and flow again. In each *borderline* tale a push and pull between contradictory impulses is present. It is challenging for the researcher to resist applying an order that does not reflect the lived experience of each woman. Seeking unity and harmony that is not present, alters meaning, from an *Irigarayn* perspective, so the chosen thematic framework intends to encapsulate dialectic mutability and make sense of instability, rather than exclude or misrepresent it (Harrington, 2008).

The content and style of speech of the first interviewee has had a primary influence on what follows. As processes of data collection and analysis have continued, however, a fusion of histories and interaction of experiences, styles and influences has taken place (Gadamer, 2013). The issues of significance in the stories are voicing self or different aspects of self, experiencing darkness, emergence of knowing and seeking to make change. Each story is presented in turn, with an introductory and concluding summary bookending the key themes. Finally, a reflective conclusion of all five narratives is presented with an explanatory framework.

4.1.2 K's Story - Strong for Others: Strong for Self

4.1.2.1 Introduction

The story begins with felt powerlessness and passivity which is transformed through awareness of inner strength into a self-confident narrative of recovery and agency. Dialogically, K identifies a core strength which has always been part of her, present in early protectiveness towards her brother and diminished by feelings of blankness and inner deadness. Being able to confront the past has enabled a reattribution of suffering, restoring to K her sense of self. K has taken this opportunity to talk about her years of struggle and difficulties in accessing the right help. She is motivated by her recovery and the desire to inform and support others. At the time of the interview, she is training to be a nurse, living a "happy" life filled with meaning and purpose.

4.1.2.2 Like a different person

As the story changes from one of despair to hope, K's narrative style and tone change. She reveals the experience of different aspects of self in distinctively different modes of expression. The voice which denotes sickness and difficulty has a higher pitch, repetitive and uncertain while the voice of recovery is deeper, sounding confident and calm. Two passages, one from very early in the interview, and one from near the end illustrate this, particularly well. In the first K is describing the most potent trigger of her "condition".

> **K: 54** *Oh! Rejection! Rejection was a massive trigger! I mean during that time I had a couple of relationships break down and that triggered something chronic*

I mean that was my worse trigger. Even in my relationship that I'm still in now if, you know, if he rejected me for any reason I was really, really sensitive to it and I think that was the main, my therapist recognised that that was my main trigger I mean not everyone has the same trigger. That was my main ... I was so sensitive to rejection due to the condition and I think that that was the worse one for me …

There are elements of dramatic intensity to this first sample, with repetitions of the words rejection, really and trigger emphasising significance. The transcribed exclamation marks are used to illustrate force. In the second sample there is a more ordinary way of speaking. As K conversationally re-lives her recovery journey, there is a distinctive transformation of tone and persona. Her voice and demeanour become relaxed and good-humoured, as purposeful life goals are identified.

K: 377 *As soon as I got the all clear from the mental health team, I enrolled in the access course. That was the first thing I did. I'd got better but I still had this void in my life but I think now that void's gone because I'm stable, I'm happy. I mean I'm stressed out about exams but you know it's a happy stress (laughs). I'm doing a job I always wanted to do and I think that's why I've got that distance now. Even though I try not to think of who I was then, it's still part of who I am now, I have to distance myself from who I was then because there was a lot of shame, I felt a lot of shame about what I put people through. Even though I knew I was ill I sometimes think 'Oh my God' (laughs) you know I laugh about it now but when I look back, it just feels like a different person.*

K experiences a distancing in this passage between a past and present way of being and the past way "just feels like a different person" to her. K does not describe a disconnection from the past but rather maintains her connection through acknowledging an ever-present fear of rejection and remembered shame. Reflective knowing thus enables some integration of past and present selves.

4.1.2.3 Something inside

Spirituality emerges in this narrative as a developing core inner strength linked to treatment, healing and recovery. In a faltering way, quite unlike the flow of previous speech, K begins to understand her spirituality as “something inside”. Hesitation is present in repeated phrases such as “sort of” and “something like”, as K begins to feel her way through new language and concepts, almost as though she is trying it on to see if it fits with her experience. Reflectively and conversationally, K is able to locate the roots of her spiritual essence, her inner core in the present and the past, experienced both inter- and intra- personally. Positive and negative relational experiences are significant to this emergence; she refers to her protective nurturing of her brother and the furious rage against a “they” who have persecuted her as evidence of inner resilience, a hidden strength at her core. Strength emerges from both known and unknown aspects of self, initially coming to the fore in bad times. She describes it like this:

> **K: 139** *… its inside yourself. It … sort of helps you through the … it’s something inside you that gets you through the bad days. Something like that, even now, there’s something inside me that gets me through them bad days …*

The ability for self-healing has inception in a resilient practical and symbolic response to early trauma, linked to the emergence of a uniquely strong voice. The intrinsic “something inside” (intrapersonal) is matched extrinsically through the relational presence of kind others (interpersonal) and benign protective forces represented by angel imagery (transpersonal). Positive ways of thinking about other people are generated through the trust relationship developed between K and her therapist, initiating inner healing, symbolically sustained by external presence. K says of this:

> **K: 153** *So it is something that I’ve learnt, even though in treatment you don’t really talk about spirituality and things like that but it is there because you just feel that there is something there helping you. It’s like an angel sitting on your shoulder really saying, ‘no you can’t give up!’*

A new understanding of her own core essence is brought into awareness both conversationally and relationally, harnessed as her mind clears and her spirits soar. K's sense of self develops as her experience of her mental health recovery deepens, life goals are realised and a life of meaning and purpose becomes available to her.

4.1.2.4 They gave: I spoke

K's relationship with professional helpers has not always been so positive. She had been given her diagnosis of BPD from a disempowering "they", who did not provide her with terms of reference or a full explanation. She says:

> **K: 7** *… that's when they gave me the diagnosis of borderline personality disorder. Because of the episodes, the blank episodes that I was having, that's when they gave the diagnosis and I'd never heard of it before. I'd never heard of it.*

The locus of control is experienced as wholly external and threatening, a "they" able to restrict knowing and being, withholding information and restricting freedom. The pejorative diagnosis is followed with treatments which are characterised by attempts to destabilise and impose external physical and psychological control. Ks linguistic and experiential passivity is in contrast to the "they", who "put", "gave" and "say", evidenced in active verbs and outcomes. The experience of profound otherness and exclusion, increases K's experience of intrinsic dissonance or self-otherness and isolates her further from present solutions and future choices. It is in the deepening isolation, however, that K embarks on her unique recovery journey. Eventually her voice emerges, an "I" who speaks, finds out, knows and manages. K's healing is linked to growing confidence in managing the subtle interplay between intrinsic and extrinsic control. Engagement in therapy identifies a "root cause" for K's suffering and it is a resurgent I who finally faces past trauma in a supportive, guiding therapeutic relationship. From this turning point, K seeks therapeutic reparation and brokers the necessary truce between a traumatised chaotic past self, and a now self, 'happy' and set on a purposeful future. With the uprooting of the cause, core inner strength (re)emerges, and with it a new way of conceptualising self. As she voices it, conversationally, K reflectively names and owns a process of inner questing towards a

new experience of core self. The *rag doll* persona in the early narrative, as K is pulled and pushed in all directions, now recedes. Therapeutic techniques have taught K to push back, able to steady and ground herself, so that the *to and fro* becomes a *to and to.* Recovery is driven forward as inner strength grows and conflicts recede.

Through reflective vocalisation, K recalls earlier experiences of this core strength. As a child she was able to be strong for her brother, in order for them both to survive early threats. This phenomenon had been lost, hidden by the dark shadow of the mental illness, an experience she describes as, being "killed inside". The emergent agency has solidity and cohesion, holding her through adult trauma and advanced by realising her ambition to become a nurse. The kindness and attention of others - one good community psychiatric nurse, an effective therapist and a "rock"-like boyfriend provide the scaffolding for fundamental change. Within that safe structure, K has been able to nourish 'the "something inside" and with external support re-integrate past and present, to experience authentic happiness.

4.1.2.5 Reflective Summary

One interpretation of Ks increased confidence and calm as the interview progressed is that of a naturally developing comfort between the two parties. Repeated hearings and readings, however, confirm that the changes in K were related to her reflective re-evaluation of core strength. The impact on myself, as researcher was one of experiential mutuality in knowing and understanding between us. Sometimes, the researcher's interest in learning about the treatment was more present than the relational connection, more knowing about, than being with. At other times, however, over-identification resulted in intense emotional researcher responses, such as anger at K's poor treatment or the terror of vulnerability. Keeping balance was difficult, but what really helped was the adoption of the researcher role, implying curiosity and wisdom. The stumble K experiences when she starts to talk about her personal spirituality, is mutually revelatory (K: 134). In order not to interrupt her external expression or birthing of something deeply internal the challenge was to remain still and quiet, not disrupting the energy flow. This moment is the turning point in the interview, mirroring the turning point in K's life where she understands that her

repeated asking, her tenacity and commitment had eventually got her good help and recovery could begin in earnest. A shift in the balance of power in K's life is brought about through knowing and acting. From this point, as K takes the lead in the interview, setting the mood and path, the researcher is able to step back further. Finally, the space between us feels safe and connected; in that moment we both laugh, authentically and playfully celebrating her strength and success.

4.1.3 S's Story – God brought me to this place

4.1.3.1 Introduction

S is motivated to tell her story in the hope that it might inspire others. She describes herself as a Christian, originally from a Catholic background. S is currently experiencing spiritual, psychological and relational renewal, emerging from repeated mental health crises and recoveries. She uses literary, poetic language with alliteration and metaphor, evoking a sensation of irrevocable movement through repetition of word and phrase, such as "get on a train, get on a train". She has experienced the terror of the demonic and sacred within herself, as being God-like and being the anti-Christ, emerging from terrible elemental darkness. Her mental health recovery has been accompanied by spiritual transformations, the experience of reaching upwards, culminating in being "re-born" into new faith and new life.

4.1.3.2 I just felt darkness

S captures an atmosphere of ambient threat, early in her interview. In this evocative passage, an insidious darkness overcomes a seemingly ordinary spring day, the darkness springing out of the light.

> **S: 11** *I remember sitting on the sofa one day and it was in the spring time and normally in the spring time I feel fairly bouncy and I feel fairly happy and this particular day the sun was shining through the window and all around me I just felt darkness and I felt suffocated so I was thinking should I go to should I go and see my doctor and I was having this argument with myself for a good say two*

months em … and in the end I didn't go to my doctor because I felt quite embarrassed about how I was feeling and I thought they would say oh its nothing you know it's just hormonal or something like that so em … I dealt with my emotions in different ways. I self-harmed but one day I went too far with my self-harm and I had to go back into hospital to have surgery on my leg again …

Darkness and threat are located within as well as without, indicating a complex interplay between internal and external threat. S does not really trust such powerful feelings. On the one hand she says, "it's just hormonal" and yet later describes the disturbance of having this unknown "overwhelming feeling … this feeling I'm feeling, … "like a pain inside my head that I wanted to get rid of". Cutting provides an opportunity for release, connecting her viscerally to a body damaged by surgery and escalating self-harm. External threats are equally powerful. S was "horrifically bullied" at school, abused and abandoned at home. Of her family, she says:

> **S: 127** *… my family had left, had abandoned me apart from my Dad but it was very hard on my Dad, my Dad had had two heart attacks, his health went downhill and I feel so much to blame for that and my Mum she didn't want anything to do with me em things that I had spoken about what came but my mum called me a liar, em I was abused as a child by my brother and my mum's an alcoholic as well so and when I was 14 she left the family home she em got she em had numerous affairs and she never bothered with me she didn't want to see me or anything she only see me when it suited her so and then when I was 15 my brother raped me it was very hard to come to terms with …*

The inner darkness gains power and S recalls disturbing experiences of "being the anti-Christ" and believing she has "magical powers". She once thought she could fly. During one admission, S finds refuge in the hospital chapel and safe support in the person of the hospital chaplain. Through such occurrences, she finds a connection with God and experiences unconditional never-ending Divine love. Feeling forgiven and re-parented, S is able to forgive others and ultimately forgive herself. This love fills her emotionally, physically and elementally with light. God is experienced externally as a "breeze" and internally as a "glow", which she refers to as "God with me". When she

describes the glow, she appears to physically glow exhibiting a compelling lightness in her features and demeanour.

4.1.3.3 Just keep walking

The particular speaking style of this narrator is characterised by long, rambling passages with a quality of dream-like reverie or stream of consciousness, events seeming to float and merge without the boundaries of time or space. As in the previous narrative, two verbal forces or alternating forms and flow of speech can be distinguished, one, being in the moment, like waves rising and falling and the other, being on the moment or becalmed. The former can be experienced in this long passage, early in our conversation (see sample S:11 above). The water imagery seems indicative of inner and outer mobility. Early experiences of trauma, abandonment and threat have diminished any sense of safe place. Bullied at school but unable to return to her abusive home, S has taken to wandering, finding herself untethered, rootless and occasionally homeless. Once, in crisis, S begs to stay in hospital, which has become a safe haven for her. In a desperate, sad echo of her childhood, she begs the nurses not to let her go home, however, she is sent home.

S struggles to exist in the spaces in-between darkness and danger, relentlessly restless, physically and psychologically transitioning between levels and elements. She depicts herself as caught in transitional places, on stairs, bridges and trains in search of safe destinations, which take on sacred significance – a cathedral, a hospital, a chapel, a women's refuge. Constant emotional and geographic motion is illustrated by frequent speech repetition, such as, "just keep walking just keep walking just keep walking" and "get on a train get on a train get on a train"; she is, "in and out", "revolving" and "spiralling out of control". Sometimes she seems to be getting close to something. The most serious self-harming takes place, sitting under the Millennium Bridge in the shadow of St Paul's Cathedral and in another critical state, S "decided to climb up to the helipad on top of the hospital up the metal staircase". Going under, going over or going up, S is surely going somewhere. In contrast, is utter stillness in the midst of frenetic movement, being "on a pause" or "in a bubble", as though experiencing an

interruption in normal space and time. In this sample, voiced in the on-the moment way of talking, the visual image is like time stop animation.

> **S: 51** *… on my way to work and I didn't get off at the stop I was supposed to get off I just kept going and I got to xxx … and I got off the bus and it was just like I was in this big bubble and everybody was just speeding up around me and I was on a pause and I couldn't, all that was on my mind was get on a train get on a train get on a train …*

On occasion, disorientation and exhaustion remove any sense of internal agency and a powerful "they" controls S. Of her BPD diagnosis, she says, "they thought, then they thought, then they thought … and I had so many, I had so many diagnoses thought at me". She describes being held, contained and controlled in both internal and external spaces as she is, "sectioned", "dragged to the ground" and "carried down".

4.1.3.4 Slowly rebuild you back

Once, serendipitously, S experiences being saved by an unknown doctor who stops her from throwing herself down some hospital stairs. Experienced as rescue, the event becomes a significant turning point in the beginning of her trusting and developing different ways of being with others. In therapy, S experiences relational and psychological stability, probably for the first time and therein a safe place for healing and change.

> **S: 142** *… and em … yeah I remember sitting down opposite my therapist once the very first time and I looked at him and I said I don't like you I'm not going to speak to you, you know this next 18 months is just going to be like this, we're going to be sitting in silence every single week and he got me talking he got me opening up about things that I had stored away from when I was a child and I never, never like looked at before em … so not only that I learnt how to keep a relationship and, not that sort of relationship but a trusting relationship because I couldn't trust anybody I still find trust very, very hard sometimes …*

Initial resistance gives way to an authentic desire for healing. One kindness has opened a door to other possibilities for S and, once in therapy, she finds a consistent

safe haven. In this setting, S is able to regrow in relationship with herself and others. The experience of her therapy is profound, described as a complete reconstruction. S uses her therapist's terminology, in this sample to illustrate the impact of the new relational presence, linguistically and symbolically in her life.

> **S: 150** *… they helped me literally unpick everything … they literally knocked me down and then they built me back up again one thing that my therapist always used to say to me and what he said to me at the beginning of my therapy is just like imagine yourself as a crumbling building, what I am going to do is I am going to put, I am going to build up scaffolding around you and I am gonna like stable you whilst I take all the bricks down, clear it all out and then slowly rebuild you back and it was then that actually I thought do you know what …*

S begins to consider a different future for herself. She says: "it's like I come in there not knowing who I was, disliking myself I come out of there a new person it was like I'd been reborn". She wonders with a mixture of fear and anticipation, "what am I going to do now?" The new person is reborn in faith as well as personhood, and S re-negotiates her relationship with God, identifying her new-found beliefs in a relational Christianity of the Holy Trinity, characterised by love, trust and forgiveness. These steps are supported by a new husband described as her "rock" and "a devouted Christian", in a wonderful verbal mix of devout and devoted. Less governed by powerful emotions and powerful others, but by what "Jesus says is right", S has begun to live the life of "a good disciple", held within thought and behaviour boundaries which provide structure, safety and purpose. When she reminisces about what brought her to this moment of connection, she ponders on divine presence in her healing journey:

> **S: 306** *… so it's just the fact that that doctor was there when I wanted to chuck myself down the stairs and the police or whatever was there when I was going to fly off the building em … so I think it's a bit like God sends his angels down, I mean I used to watch a programme called 'Touched by an Angel' but I know that it was God that brought me to this place where I am now sitting here talking to you about this.*

S conveys journeying from a dark place into a light one, transitioning through relational and spiritual renewal towards deeper connectedness and inner fullness.

4.1.3.5 Reflective Summary

The story dialogically unfolds in ambivalence and darkness. The desire for escape is counteracted by the desire to be held; instability opposes safe haven and a dream-like reverie permeates the narrative such that events seemed to float and merge in time and space. The poetic sensibility and textual flow is like being swept along by and in, the narrative. This means that the hearer/ reader has a direct connection to the experiences of ambivalence, darkness and movement. S demonstrates, in literary form, struggles for balance and integration between the poles of her existence, the darkness and the light. In recovery, S has a keen insight into the damage wrought by herself in seeking constant attention and the "wrong sort of love". Developing trust, she finds herself being loved for the first time, by friends, by her husband and finally, unconditionally, by God. Spiritually, by giving up part of self, S is able to transition into the safer internal and external spaces and new life. She movingly recounts an analogy of crumbling self-hoods needing scaffolding, tearing down and built anew. She appears to relish the opportunity and the challenge. To quote from Linkin Park (2014), the band she loves:

> *Now is not the time to look back to see if anyone is following. Now is the time to charge forward into the unknown!*

As she charges forward into the unknown, the dialogic experience is transformational, also filling the researcher with a sense of new life and new energy. The connection is marked by shared laughter and genuine affection. For S, this moment now is the most important, pregnant with meaning, looking towards a future with the potential to repair the past. When she texts later to tell me she got a job she had applied for, the forward momentum is celebrated in mutuality and genuine joy.

4.1.4 T's Story - A Heart of Darkness

4.1.4.1 Introduction

T participates in this study to extend knowledge and help provide better help and support for herself and others. She is a proof-seeking scientific person, particularly interested in studies of the brain. She is not religious and identifies herself as an atheist, antagonistic towards spirituality, which posits as a "cheesy … American" concept. She relates a lived, felt, inner darkness, associated with alienation, existential disconnection, emptiness and persistent thoughts of self-harm and annihilation. An inner battle rages between the two sides of her brain, represented by ambivalence and contradiction. T is at a less advanced stage in her recovery journey than the other participants and her fragility during the interview is apparent. My experience with her is largely negative, except for the passages where she a yearning for changed self with a new brain and new neural connections.

4.1.4.2 Two Brains

T has a slow, faltering considered way of speaking, most of the time as though taking time to find the right word or phrase to express meaning. She has two distinctive speech tones, adopting a much deeper, almost masculine voice when discussing issues of special difficulty. Her intrapersonal relations are often contradictory and ambivalent, sometimes, for example she regrets being too stupid sometimes, too intelligent. T experiences herself both as not fitting in with others and, fundamentally, not fitting well with herself. An oppositional selfhood is described, the experience of having 'two brains', constantly at war with each other. Her grasp on existence is equally ambivalent. Of her most serious suicide attempt she says, "… about 50% was yes I want to die and 50% was … it was a call for help". T's mood is often incongruent and mercurial and in the midst of periods of bleakness, she can begin to feel unaccountably fine, unaccountably "going up and down" with "no sense of normality".

T is able to mask her vulnerability explaining, 'I put on my face', yet this belies deep vulnerability, sensitivity, intense anger and a sense of betrayal. When asked about

receiving her BPD diagnosis, T's description reveals shame and a sense of unfairness at the hands of powerful, impersonal forces. She says:

> **T: 2** *I was in hospital at the time, a psychiatric hospital and somebody slipped a bit of paper under my door with a summary of me, XXX, age 33, diagnosis depression and borderline personality disorder. It sounded absolutely horrendous to start off and obviously I know more about it now and it covers all the spectrums of different people and different types of behaviour and ways of thinking so it's not all, it doesn't necessarily mean something very, very offensive but it just sounds horrific and I think the title is horrific it makes me think well there is something wrong with my personality, you are disordered. I don't think it's, I don't know I mean when I read it into more detail and what it, that title is supposed to represent I think you could call it something much better than that, it puts people off the mental health thing anyway and people are already ashamed of having a mental illness.*

Depersonalisation accompanies anger, illustrated by being provided with, "a summary of me" which indicates "you are disordered". Fear and anguish are also present in this "absolutely horrendous" situation, implying that there is something so wrong, it cannot be brought out into the open. T demonstrates a strong sense of injustice about the world and her place in it. When she speaks in defence of others, she adopts a more capable, cohesive tone. In this sample she describes making a formal complaint about poor hospital hygiene and safety.

> **T: 290** *No I had to make a formal complaint afterwards …. but in so many ways it was dreadful and what I really, really feel for the other patients, especially the ones who are inarticulate or they are always going there so they just think it's normal, and it's really wasn't normal and it was not ok, these are human beings and just because they're unwell it doesn't mean that it is sufficient to live in circumstances such as that it was really not ok.*

Externalising and expressing the anger, reveals a different character and a more reasoned, competent, active voice. T feels separate and disconnected even here, with a clear distinction made between herself and 'the other patients'. Similarly, T responds

to attempts to care for her with derision and bewilderment. The following notes her view of endeavours to save her life following a serious overdose.

> **T: 81** *… em… that's what it means they tried to save some homo sapiens and that somebody being myself cos they think she was worth saving I guess or it's a natural instinct isn't it, you find some half-dead body and you think oh God yes sort that out. … the amount of money that would have been spent on me, the thousands and thousands that's been spent on me by the NHS it's just so awful I just wish they could find somebody worth saving, you know?*

Even allowing for the potential for dramatic re-enactment in the interview setting, the experience of hearing such a depersonalised account is shocking. The most potent alienation that T experiences is from herself. Looking down on the "half-dead body", she describes hopelessness on the one hand and ambivalent undirected fury, on the other.

4.1.4.3 Something evil coming over me

T's explanation for her difficulties in her early experiences of abandonment by a father who was not really interested in her, and having to grow up fast to care for an emotionally dependent mother. She continues to find relationship endings difficult, regressing back into the period of growing up that she feels she missed out on. Her self-image is relentlessly negative. Her pejorative descriptions of herself include, "attention seeker", "pathetic", "immature", "not worthy of friendship"', and "a bitch". She often compares herself unfavourably to others, like her "really clever" cousins who are doctors and teachers. Her own career dreams of becoming a pilot, engineer or doctor have been diminished by ill health. T struggles with closeness. When asked to identify what others might value in her she says "they must be looking at things through rose tinted glasses". T's primary relationships are with her friends, who are "funny", "clever" and "supportive". She notes their loyalty and care, but is unable to deeply experience their support. Her only helpful professional relationship to date has been with a hospital counsellor who was "very good at listening", practical, solution-focussed and able to engage in "normal, intelligent" conversation. T is positive about

student nurses in hospital who, in stark contrast to more experienced staff, are “really fun”, “positive” and, she finds “still really wanted to be there”.

T makes sense of inner and outer worlds through scientific, physical evidence, not believing in things that cannot be observed, or evidenced describing the New Scientist as her ‘bible’. T identifies herself as an atheist, with no belief in any “God, superior being, any fairies at the bottom of the garden”. T likens religious experience to brain chemistry playing up, like an experience of aura in epilepsy. She extrapolates from this the possibility that inexplicable happiness might also be the result of faulty brain wiring. The warning signs that precede her own epileptic seizures feel “evil …, like something coming over me”, described in this sample:

> T: 35 *… like something coming over me but for me it was something, it felt like evil, it sounded like a religious thing that I’m saying but that’s the only way I can describe it but then I’ve also like read a paper on how sometimes when people do have some kind of epileptic, not necessarily fit, but some kind of seizure and they feel so happy they don’t want to feel anything else and I just thinks it’s so much to do with brains that we don’t understand and I reckon that loads of folks and that could be affected and just haven’t been diagnosed.*

4.1.4.4. Controlled through Fear

T began to question and fear the controlling God she meets at Sunday school attendances, confessing, “I was very afraid of this God”. She notes, “I just perceived religion to be a control and that, in a way that people are controlled through fear”. When asked about what gives life meaning, T is adamant that there is no meaning and that existence, “doesn’t mean anything”. Existential bleakness and nothingness dominate this sample:

> **T: 368** *Nothing. It’s one of the, sort of big questions I’ve had of late, in the past couple of years. What’s the point of being here anyway? I don’t understand and also in the whole great scheme of things if you go back to well 13.6 billion years ago the existence of us lot is just a fraction of a second and doesn’t mean anything and just like that I’m going to die and what is one in seven billion*

people, nothing, and so then part of me gets angry, why do people get all like funny about oh you must do this and you must do that your existence is so important, well why is it so important I don't understand?

While T uses scientific knowledge to understand human existence in a way which might keep individual problems in perspective, her tone of speech and demeanour is, however, angry and hopeless. T acknowledges that every person is in possession of unique neurones, neural connections and brain chemistry, but finds no comfort from this, perceiving her own brain connections and chemistry, faulty. She proposes that she can only be fixed by a process of being broken down and built back up, given "new neural connections" to transform her from experiencing herself as being "forever alone … an empty shell". Given the stark delivery of this passage, it is still the most hopeful comment of the interview. She pleads:

> **T: 519** *Something has to just, I feel possibly somebody has to break me down into pieces for me to get better, so possibly get me down to, really get me down and build me back up again cos like I'm just fucked.*

The experience of relentless inner conflict intrinsic emptiness is visualised as having a "black heart" at her core. She most fears that which is within. Responding to being asked to draw what is on her mind, by an occupational therapist, she shows this side of herself:

> **T: 510** *… so I drew of a heart with all the arteries coming out and it was red on the outside and then black in the middle and I just felt like there was some sort of, if there was such a thing, evil darkness inside of me that needs to be scooped out, that's how I feel.*

The image is visceral, red and vital on the outside, dark and evil on the inside, something needing to be scooped out. T yearns for self-reconstruction. At the interview's end, however, there is little sense of forward motion or resolution. T appears to be fixed in a place of dark over-shadowing. She is ambivalently stuck though, with a light shining from the faint possibility of becoming a longed for new self, with a different brain.

4.1.4.5 Reflective Summary

The lasting impression of this interview is the experience of Ts struggle to connect authentically with herself or others. She is constantly masking and disguising, even at her most vulnerable. Knowing and meaning in this story are in constant flux and often contradictory. For the researcher, this is difficult for, as soon as any concept might be grasped it has become elusive, and not grasped, thinking and feeling is in a constant state of reinterpretation. T locates her beliefs exclusively and categorically in the scientific material world yet provides a powerful image of darkness at her core, at once visceral yet strangely evil, unknown and non-material. The dialogic experience would have been grim were it not for a self-depreciating humour, characteristic of an underlying warmth and care for others. On the one hand, T still wants to die, then apologises for bringing me down; while appearing to dissociate from herself, she entreats me to "keep digging", for answers demonstrating curiosity and hope that there is a more hopeful attribution for her experiences. T is thoughtfully aware of the impact of what she says on others. She wants the interview to "keep going" for the sake of the study and the possibility of improving services for others. Her closing comments are hopeful and redeeming. The researcher responds by commending T for being "exceptionally courageous", hopeful that her words can make a difference.

4.1.5 M's Story - Being kept in mind

4.1.5.1 Introduction

M has chosen to take part in the study as part of her mission to find ways of making sense of her own experiences and help vulnerable others in "oppressive and restrictive situations". She has experienced Hinduism and Sikhism in her familial and cultural heritage and, growing up, found solace amongst temple lights and music. At the time of the interview, M is not religious. She practices the mindfulness which she learnt in her peer support worker training as an ongoing spiritual meditation. M travelled to the UK from India at the age of nine, dropped into a world of almost fairy-tale like darkness and danger. Her early experiences are dominated by neglect, deceit and betrayal. Positive adult experiences of being kept in mind by others have ultimately

helped her to keep herself in mind. The voice of this narrative is gentle and quiet with long thinly connected passages, joined by conjunctives into a constant flow. The listening experience is such that the thoughts, like the words feel as though they are constantly on the run.

4.1.5.2 I was really on my own

M relays a formative story of extreme emotional neglect, profound loss and the betrayal of trust. Her early life is cloaked in confusion and secrecy. Growing up in India with her mother and grandmother, she often feared for her life. She believed her grandmother to be her mother. In actuality, her mother was mentally ill, unable to look after her and "very, very frightening, quite violent". M remembers:

> **M: 177** *… when I was growing up I believed my grandmother was my mum, I didn't know that lady was my mum and we all slept on the same bed, so when my grandmother would always sleep in the middle and I would sleep on one side and my mum would sleep on the other side …*

There are pre-natal threats to M, with her mother receiving invasive treatments for her mental illness, including electroconvulsive therapy while pregnant. When her grandmother can no longer look after her, M is then passed on to her father's family, and is moved all over India for three years until she is transported to the UK at age nine. This is for M "the worst thing that could happen". She is left amongst strangers in an alien culture, denied contact with anything or anyone from her past. Years later, her mother becomes lost at a festival in India and, with that, any chance for reparation of that relationship is lost. M experiences a rift between different remembered pasts and sometimes yearns to retrieve her time line and rescue her small, lost self. Her circumstances continue to get worse as she spirals downwards through abandonment and loss into violence, terror and abuse. Without stability in relationships or place, India turns into a fantasy escape destination and, M tries to run away, to her place of origin. When the plan fails, she returns to a deteriorating situation with curtailed freedom. At this point, fearing death yet longing to escape, she takes her first overdose. M feels isolated and let down by those meant to protect her. She weeps when she recounts being given away by her grandmother, reminiscing, "I was really

on my own". In reflective dialogue she re-experiences her total isolation, a childhood of neglect experienced and her journey through acceptance to peace.

4.1.5.3 Therapy cycles

Despite her fragmented start, M has developed a sound sense of self, an "I" who decides and reflects on her own potential for agency and questions, reflecting, "can I do, can I do anything?" Indeed, M is help seeking and makes best use of any help offered to her. She coins the phrase "therapy cycles" to describe three approaches, which have facilitated her healing - counselling, psychotherapy and a therapeutic community. Over time, therapy reveals fundamental disconnections inside and outside herself. With intelligence and fortitude, M sets herself to work within the therapeutic modalities, learning and adapting to new circumstances, reconciling her past. She views her recovery as cyclical rather than linear, understanding that she has to go through certain things repeatedly, negotiating acceptance and resolution. The first therapeutic encounter is with an Indian-born counsellor in an Asian women's refuge who is enabling and culturally coherent. She says that the counsellor, "went beyond her role" providing low-key, consistent relational support through periods of struggle. A relational allegiance develops which is pivotal in making sense of the past. As M feels authentically heard and valued for the first time, her recovery begins.

The work is continued later in a therapeutic community, which provides a social setting and a safe base for M to experience new ways of relating and make sense of past hurts. She develops understanding of the dilemma faced by her "adored" grandmother, such that, when they meet again, many years later, both are able to express sadness and regret. Trust established with the counsellor impacts on other relationships, ameliorating the impact of early trauma, mitigating against anger and building resilience. Eventually, individual psychotherapy provides M with a psychologically "safe space" which over time she learns to use restoratively. It is her own kind perspective applied initially to herself and then to others however, which is the catalyst for profound and lasting change, an internal turning point. M begins to develop a future vision for the empowerment of vulnerable people, training them to

gain their voice. Significantly, M recognises the need for constant journeying and renewal in her recovery and her becoming.

4.1.5.4 Creating a reflective space

M gained an early eclectic spirituality, represented as soothing and beautiful, stories and sounds that continue to evoke strong physical and emotional responses in her. While no longer religious, she recalls a magical spiritual ambience in this passage.

> **M: 544** *… music from the Sikh temples, and I find that soothing, I don't understand it but it's beautiful, it physically does something for me. I don't listen to it that often but it's something that when I hear it now and again it just, I don't know I just find a sense of calm and also I think. So that was my early kind of thing and the early experience were also, she wasn't very discriminating so she would also go, she was a Sikh, a practicing Sikh and she would also go to Hindu Temple. I remember her taking me to this Hindu Festival in a temple, I was very young, there were lots of strong lights, and I think it was the first time I had seen small manikins, or kind of figures, figurines of story kind of acted out from an Indian Holy text and that's so magical for me because it was the first time I'd seen figures which looked life like and I almost thought they moved …*

She regretfully contrasts growing up India where religion forms a cultural backdrop to everyday life, to the UK where religion is separate and ignored by many. The fluid, eclectic approach she experienced in India is contrasted with her paternal English family where a more rigid, ritualistic practice is observed. She notes that they seem to be, "trying to hold on to something". When M becomes responsible for cleaning the household shrine, a dangerous pathological regime of ritualised prayer, diet and exercise is invoked, as she starts to psychologically unravel. Her mental anguish is expressed in restrictive physical extremes for some years and even now she can experience the polarising pull towards frenetic activity on the one hand and complete inertia on the other. Her peer support training included mindfulness practice as a means of self-support and, through it, M develops a new self-experience of reflective present space, freed from the sadness of the past and worries about the future.

Through mindfulness, M is able to balance oppositional restrictions and control and (re)locates a fluid, connected, soothing spirituality.

> **M: 600** *I think so now it's more the spirituality is more from like my meditation and mindfulness because it's a different way of me experiencing myself which is not psychological which is not emotional its more kind of, have a different experience of myself when I'm meditating, I am, its creating a reflective space that's what it feels like for me where I can just be at peace with myself and be more able to be in the present without the sadness of the past, or any worries about the future, and that probably is what I think I'm starting to experience was spirituality is for me probably…*

Meditation develops an inner unified safety where she is constantly "revitalised". M fundamentally changed though therapy cycles and mindfulness, experiences peace, wisdom and new ways of relating. Able to transfer the peace, wisdom and relationality back onto the environment she completes the cycle and is energised. She identifies having been transformed by 'being kept in mind' by kindly thoughtful others, enabling her, at last to keep herself in mind.

> **M: 719** *Yeah, I think what has been my issue and what has helped me a lot is being kept in mind by these people and that never happened throughout my whole life and because I hadn't been kept in mind it meant I didn't know how to keep myself in mind and these interactions with these interactions in these new settings I learned how to do that by then doing that for me, definitely.*

Early spiritualities founded in a beautiful sensory religious heritage of temples, lights and music have developed into a mindful, meditative path. A *borderline* polarisation of entrapment and escape has given way a physical and spiritual holding place, attaining anchorage and peace. Being "kept in mind" through relational consistency has enabled self–nurturing and a way of doing good things and helping others.

4.1.5.5 Reflective Summary

Repeated therapy cycle and mindfulness have grown deeply felt connections, internal and external experienced reflectively in the dialogue. These mutual, collaborative

experiences stand in stark contrast to early experiences of loss, abandonment and the imposition of ritualistic spirituality. M has developed and embraced a spirituality of body and mind. A peaceful, grounded demeanour permeates the interview. Her quietly spoken voice flows gently between us so that, even where her train of thought is running, there is a sense of coherence rather than chaos. M appears to be experiencing her life and herself non-judgementally, transformed rather than broken through vulnerability. Her turning point is a gradual opening to being - physically, emotionally and spiritually restored. She is calmed by music, ceremony and space and is relationally repaired through therapy cycles and revitalised through learning. M finds a place of equilibrium, between the supernatural and the rational, a cultural consistency that is a significant bridge to recovery. While set apart and disadvantaged through early trauma and cultural dissonance, M pursues a culturally coherent spiritual path, leading towards integration, unity and wholeness. Having experienced genuine help, she is exhibits gratitude and a progressive desire to help others. In spite of fragmentary reminiscence and the presence of constantly running thoughts, the relational experience of being with M is one of peaceful stillness and deep, inner calm.

4.1.6 A's Story – North star along the clouded way

4.1.6.1 Introduction

A is specifically motivated by the desire to share with others the potential impact of directional belief in balancing the confusion caused through having overwhelming life choices. She has been brought to Islam from a non-practicing "different faith group", which links her faith and recovery journeys. A describes coming from a directionless "clouded way", through forgiveness, family love and new beliefs, onto a "balanced path". She tells a story of seeking and looking upwards for "God or the North Star" and, in that moment being led towards self-discipline and an opportunity to change patterns of thinking. At times A adopts an authoritative, confident tone in keeping with her mission to educate and inform. At other times a somewhat meandering monologue, characterised by difficulty in finding the right words or descriptors, is adopted. She uses the phrase, "how do I put that word in my head", indicating

expressive difficulty at the point of thinking as well as speaking. She also completes sentences with "this and that", in a tone of lilting uncertainty, swaying between one concept and another. Her key narrative elements are seeking, letting go of the past and the development of new beliefs in a journey towards inner peace.

4.1.6.2 Letting go

The past in this narrative is recounted in a detached unemotional way. Unlike the other women, A does not allude explicitly to early experience, stating that "most of it has kind of like fizzled away". In fact, she rarely gives voice to anything painful or negative, intentionally focussing on the hopeful and the positive. She obliquely refers to the need for forgiveness, so that the past does not affect the present:

> **A: 92** *I do believe that your past affects you unless you deal with it and people have different ways of dealing with it, it can affect you to such a degree that you can continue with it and you keep that information as clear as it was when it's already gone … so when you forgive, forgiving something or letting go, in other words your letting it go so that it doesn't bother, harm you, if you are continually remembering it, remembering it, remembering you are reinstalling into your mind and it won't go.*

A believes that, while "forgetting is very hard", forgiveness is eminently possible. She has resolved not to "fuel" negative experiences by attributing too much importance to them. Her belief in a merciful Deity, guides her, supporting hopeful internal processes. A is focussed on finding the "correct, balanced" path for her life. She had experienced being lost in a maze, perpetually going "high and low", "up and down", "back and forth", "a see saw thing", "all over the place" with "nothing to hold on to". She posits that finding balance is the task of living, not just for her, but for everyone:

> **A: 502** *Well, but, what we've got a job to do during our life time to correct it onto the path which will keep us balanced you know and we see things for what they are and not to, it's not that we're going to be perfect human beings, we all go up and down this balance.*

Using her own recovery as a template, A links deepening spirituality with experiences of fragmentation and suffering, quoting a religious verse which says:

> **A: 683** *… when you have lost something that you cannot bear to have lost, you will gain something that you wouldn't imagine you would gain. Many people who are, if you speak to people who reverted into faith they come from broken families, they got hurt, they left, they lost things, their hearts been stripped from everything of this physical world, money, things they got some really low moments and that heart is then open to whatever is reality and when that happens that is when I think spirituality can start...*

A believes that those who have been hurt are more heart-open than others, reflecting on the human heart as "crooked", "aching" and capable of being "changed". She states that letting go of the past and coming to terms with loss, opens the human heart to spirituality and new starts.

4.1.6.3 Nothing around me, nothing behind me

There are many descriptors for being lost in this narrative, including, "go off somewhere", "lost in your mind", ending up "nowhere" on the "clouded way" with "no light" and "nothing to hold on to". For A, the human experience of existence is both fundamentally physical and profoundly spiritual but remaining solely in the former is to live a meaningless "robotic life" with the inner self-unfulfilled. She extrapolates from her own life and shares with other seekers through writing poetry, holding home groups and on social media. The physical world, she suggests is illusory and monetary and people are indoctrinated into believing that a particular way of relating to this experience is the correct one. She refers to this perspective, as a "Hollywood fairy tale" which entraps people into thinking that all they want is to find the man of their dreams, doing "this or that". A finds that the confusion created by overwhelming choices is ameliorated by directional belief.

When hospitalised, for example, the structured day and family-like environment counter feelings of pervasive nothingness proving significant in her recovery.

A: 120 *I was happy that I was there because it was like, because I had come from a family, I don't feel like I had that closeness with, so many things went wrong, I'm not really, I don't have family relationships like a father or mother, I didn't have my mother around me ever, and the fact that I was in a situation there was other people around and we were all in the same boat we were having a laugh, or just being around people made me, it makes you stronger and that, I think that, apart from other things obviously you know your being looked after and this and that …*

Boundaries are needed to contain uncontrolled internal energies awakened in sexual relationships which unbalance hormones which can go "right, left and centre", in A's worldview. The resulting "constant energy" merges individuals until each one is "as if it was nothing". She believes it is the woman who will be forced to synchronise her energies with that of the man, so chooses caution and avoidance.

4.1.6.4 "I need a direction; I need a way"

A has experienced intense aloneness in her childhood and as a single mother. At her lowest ebb, depressed and overdosing, yet "burning to know" she finds herself "brought" to a new family. Seeking something different is a turning point, which opens her to the three revelatory experiences culminating in her being brought her to Islam. The first is an invocation. She "looked into the sky" and asks, "God I need a direction, I need a way". The second is serendipitously relational. She meets a Muslim family who impress her with their qualities of kindness and disciplined lifestyle. The third is intentional and directional. Coming to know and understand through study and prayer, she develops her individual faith. She says, "when I became Muslim I just felt that was the right thing to do". Her three-part journey is undertaken with hope and belief in "God's mercy and forgiveness", her starting out on the journey at all is a sign of hope. The "wonderful" family are kind and responsive, providing her with new experiences of being nurtured, and accepted. She recalls:

A: 595 *… so they just took me in for who I am, I used to smoke then as well, they didn't have any qualms on that, typical Asian-style family, they wouldn't think of my gosh she's smoking, they didn't have anything, the mother was that*

kind of person that if one day she'd hear me say "I haven't had rice pudding for ages" the next day I would go there she would have it prepared for me …

These relationships are paralleled in her relationship with God, who she finds to be unconditionally benign and loving, not requiring anything in return. God is also completely other, impersonal and transcendent, not conceivable in human terms. She experiences a God so vast, that in her smallness, she cannot know God. Direction and guidance is neither intimate nor personal, but beyond comprehension.

A: 264 *… there's also things that we cannot understand but they're still there it's to do with quantum physics and other things and time and this and that, we're only around because time and space is around because that's what developed that what made, you know, the big bang and all this, but behind that we don't even, we will never understand that because it doesn't exist in our understanding of physical nature, so that side is what the faith side is trying to level you up with …*

The prose in this section becomes a little fragmented as A struggles to encapsulate her experience of unknowing and its significant place in her self-containment and recovery. A embraces the external structure provided by directional belief and accepts the enormity of those things "we will never understand", developing an internal structure through prayer and study. Like a leaf, A is becoming who she is meant to be, fulfilling her core potential, free, at last, to live. She has sought and attained the strength to quiet the "buzzing" in her mind and keep it "straight on one thing". Currently, she lives with God's "fair guidance" maintaining her inner balance and outer boundary, "cutting out" extraneous thought and focussing on God. Experiencing a family's goodness has facilitated relationship with benign Transcendence and ultimately to the experience of goodness and loveliness in herself. Love and pain in equal measure have brought her to know God, "by any beautiful name".

4.1.6.5 Reflective Summary

On one level, this interview is an exposition of an individual belief system. Through personal experience and religious study, A identifies holistic natural process whereby

the worship of God makes all things well. The dialogic experience sometimes feels like being preached to, a doctrine disconnecting the two parties from engaging with each other. In the re-readings, however, a deeply personal spiritual journey consistently emerges, supplemented and enriched by religious thinking and teaching. A feels the need to fight against a dominant societal discourse which muddles and clouds her thinking, that of rampant individualism and overwhelming choices. She seeks simplicity, clarity and balance. She looks to the sky for her North Star and embraces a new religious-cultural system which is more consistent with her own needs and life goals. Rather than seeking to diffuse or confuse, A constantly struggles to find satisfactory meanings and explanations, often worrying that “I think I am going off of the mark again”. Dialogically, the voice is quietly reflective, creating an exploratory learning space. Indeed, when A’s phone chimes the call to prayer, it invokes a mutually compelling call to spiritual connection revealed in a shared smiled apology. Eventually, by pushing herself to express her deepest beliefs a clarity of vision and purpose emerges, direction and balance are achieved. Her celebration of the loveliness and goodness in others is finally reflected back towards herself.

4.1.7 Reflective Restoration - Summary of the Five Stories

The use of narrative invites participants to give performances of a preferred self, selected from the potential plurality of selves that individuals normally switch between (Reissman, 2008; Holloway & Freshwater, 2007). The researcher had therefore not expected revelations of essential core selves. Narratives of ambivalence and mutability, such as these, however reveal more potential essential selfhood than others might. Indeed, the study identifies a strong narrative voice, which finds meaning in distress and chooses pathways of progression from amongst many potential shifting alternatives (Bryant 1993; Swartz-Salant, 1989; Nelson, 1994: Wirth-Cauchon, 2001; Van Gelder, 2012; Kaysen, 2000). Each story has liberating revelatory potential on its own. Taken together, however, the stories provide a thematic testimony to the transformative power of the human spirit engaged in the struggle to make sense of traumatic and troubling histories. The five stories demonstrate self-

reflexivity in looking backwards and forwards, within and without, reworking the bleakest of circumstances and creating alternative futures with improved outcomes. Adler *et al.* (2012) suggest that people with features of BPD show unique disruptions in the themes of agency, fulfilment and overall coherence, which hinder the construction of comprehensive narratives. While it is true that experiencing the content, rhythm and flow of these stories is challenging, it is in disruptions of movement that earnest truths for each individual have been revealed. Shifts in vocal tone, rhythm and water imagery reflectively and dialogically experienced by the listener, uncover deeply experienced motion and flow. The thread of seemingly disconnected speech was often picked up later on, indicating an internal structure to the narratives, not immediately obvious, but entirely consistent with the flow of the evolving story. Indeed**,** creative writers use such techniques purposely. Novelists, like Wolf (1994; 1996) use stream of consciousness as a literary device to externalise the inner life and repetitions are reminiscent of Plath, describing her mental descent (1963: 167) in the Bell Jar, 'I am, I am, I am', the fundamental impulse to name, capture and hold on to existence. Reflectively, as a student of English literature, rhythm, pace, imagery and metaphor, added to the richness and depth of expression, rather than detracting from it.

Frank (2013) reminds us that messy recounted illness stories do not necessarily fall neatly into categories. Storied ways of coping with illness include chaos, or feeling overwhelmed, and seeing illness as an opportunity for change or quest. Frank's work represents ways of dealing with physical, often terminal illness, yet similar features are present in these narratives with a different tone and pace adopted for disturbance (chaos) and recovery (quest). Clandinin & Connelly (2000) emphasise the importance of epiphanies, metaphors and transitions in illness narrative, all elements in this stories. Gadamer (2013) notes the fluidity of any interpretation, dependent on the motivation for the interrogation, the nature of the audience being addressed and constant changes to the interpreter's horizons. Similarly, Denzin (1989:81) views all stories as "open-ended, inconclusive and ambiguous subject to multiple interpretations". Josselson (2004) makes a helpful distinction between hermeneutics of faith, in which the interpreter seeks to give voice to the participants, and

hermeneutics of suspicion in which the researcher seeks explanation beyond the text. While accepting both the fluidity of interpretation and the potential for bias, the researcher has intended to enable each narrator to make sense of her own reconstructed past, rather than assimilate it in preconceived patterns or theories. It is certainly true, that the researcher experienced deepening curiosity and profound challenge to previously accepted ways of thinking. Ultimately cohesive tales of restoration tumble out from the blend of messy interpretations and fused horizons.

The stories can be said to function politically and critically, prompting the development of new ways of talking about *borderline* selves for the participant in potential tension with societal and medical discourse (Charon, 2006; Reissman, 2008; Squire 2008). Significantly, each story has told an individual story of struggle, facing overwhelming adversity with courage and hope. These women are consistently help seeking, even where the help on offer is inadequate or harmful. The darkest story is not without a vision of a better self. Each participant identifies serendipitous events or turning point, echoing a potent element of recovery found elsewhere (Deegan, 1998; Repper and Perkins, 2003). Contextually, while the women are met at diverse life points, they are invited to formulate narratives based on reflective accounts of their mental health, relationality, spirituality and recovery. This means that the stories are guided by questions about their illness, their spirituality and their recovery. Like everyone, the women journey through their own narrative, in continuous cycles of being-becoming-being. The research interview acts as a *waypoint*, a critical juncture to pause, reflect and revaluate the direction and speed of travel.

At this waypoint, a certain mode of travel can be divined, suggested by similarities in motivation and way of speaking. Revelation of different voices tell powerfully of the recovery of self. Representative of psychological fragmentation, the motif of different voices is also illustrative of the search for an authentic voice distanced from external threat and internal self-alienation. Potent dual drivers of wanting to know and wanting to care demonstrate shared curiosity and generosity of spirit. The following diagram encapsulates the dynamic interplay between lived experiences a journey of *wayfaring,* encapsulating the drifting, fluid nature of such nebulous beginnings. Questing, the first waypoint does not refer to the start of the journey but rather the point at which

awareness and application of meaning are experienced, because, of course the journey is already underway. The next waypoint is denoted as progressing, open to serendipitous turning points, towards an emergent, restored and re-storeyed self.

Wayfaring towards Restoration

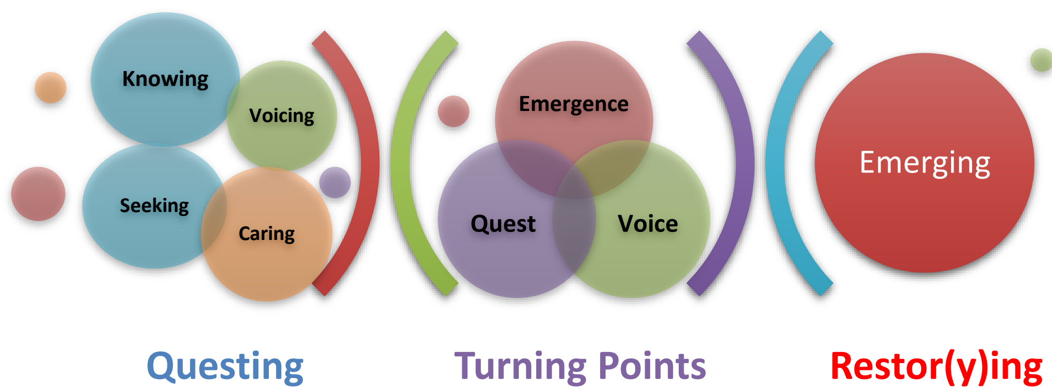

Figure 4:1 Findings from the Narrative Analysis

A restorative narrative is a story that represents the rebuilding and recovering of people after experiencing difficult times. These women also experience restoration occurring in the midst of experiential chaos and felt darkness. Reflectively, these are moments where the woman is feeling herself out of numbness into lived potency. As such, these are critical points, which illuminate professional opportunities to tap into the strength and power that the women are capable of, and to understand the ways in which this might be enhanced to build resilience and coping. Spiritual questing is identified in the interconnected elements of knowing, voicing, caring and seeking, not linear or fixed but mystically emergent in constant mutable motion. The participants are journeying away from the perils of the past and towards self through acceptance and integration of different voices rather than their exclusion. Each narrative

demonstrates meaning-making in the darkest of places in intelligent, articulate, courageous and inspiring ways, revealing a potential for self–healing and the motivation to help others; a journey from felt nothingness to felt *numinosity*[5] (Jung, 1964; Corbett, 2012).

Depicted in Figure 4:1, smaller untagged circles represent any number of elements which are present and mysterious, or unknown. Key, known elements are represented both nouns, thus naming and verbs, thus acting. *Voicing* is therefore an element of awareness required for questing, and *voice* represents a turning point, or uncovering of a different way of being. Significant turning points are uncovered through naming and restoration emerges as acting, through the process of re-storying, being and becoming. Each spiritual element reveals possibilities for enablement and facilitation, spaces where MHNs might fruitfully and therapeutically engage, partners in emergence, questing, voicing and conclusively, restorying.

The next section is a representation of the thematic analysis of the findings.

4.2 Thematic Analysis - Dialectical Convergence

4.2.1 Introduction

Theme clusters were identified through cyclical processes of syntheses of data similarities and comparisons, combined with reflective field notes and additional processes of vigilance and interpretation. The selected clusters represent the themes which are most consistent with participant lived experience. This section will explicate the meaning of spirituality in the lived experience of *borderline* recovery through phenomenological description and data extracts. The following eleven clusters are present in all transcripts with enough material to be deemed significant to the research question and study aims. Each is dialectically and discursively considered,

[5] *Numinosity is a combination of numen and numinous. Numen being a spiritual force or influence identified with a natural place, phenomenon, or object. Numinous is supernatural and mysterious; filled with a sense of the presence of the Holy, appealing to the spiritual. Once something or someone has acquired spiritual force they have obtained numinosity toward the individual or people, in this case towards the self.*

presenting, where possible, a conceptual convergence of shared truths (Creswell, 2007; Swinton, 2001). It is these shared thematic truths which are now discursively presented.

The theme clusters are:

1. Root cause
2. Empty shell
3. Cut deeper
4. Winning the battle
5. Hear me
6. A vicious circle
7. Safe haven
8. Making a connection
9. Life is a journey
10. Higher being
11. Right foundation

4.2.2 Convergent Themes

The following is a discussion of theme clusters, presented with examples from the interview transcripts and reflective notes.

4.2.2.1 Theme 1: Root cause

Identity, agency and autonomy are significant to the lived experience of being-in-the-world for these women. An intrapersonal dissonance is present in each data set as though something is fundamentally disordered at the centre of being. Characterised by the phrase, *"something's wrong with me"* (M), the same participant goes on to explain, *"that fact that there is something going on inside me, a complete disconnection with everything and being made aware of having, making a connection with myself…"* Another (K) is made aware of the therapeutic necessity of "*trying to get to the root of the problem"*, because, "*the main thing was dealing with the root cause and that, once that was dealt with, I did feel like the condition started to ease off".*

Alongside felt wrong-being is an additional trauma of BPD diagnosis, a seemingly pejorative and distressing naming of wrongness. Naming is accompanied by a sense of unknowing and disempowerment. For one of the women (T), unknowing is intensified with unseeing, as diagnostic information is given in a short simple note pushed under a door. This participant finds herself labelled, discounted from discussion, without meaningful understanding. She recalls the shame and distress of reading, *"you are disordered",* causing her to wonder what it would be like if she were a *"a normal person*".

Significantly, the women do not, and have not, stopped asking for help. Even at fatalistic moments, the women demonstrate a forward–looking perspective towards change. The perception of "*something not being right"* can also be buried deep, almost demonic, viscerally described as *"an evil darkness inside of me that needs to be scooped out"* (T) or a suffocating *"darkness"* emanating from external forces whilst simultaneously linked to inner worlds as "*this feeling, I'm feeling''* (S). In crisis, one woman has believed herself to be the "*anti-Christ"* - such deeply buried root causes demand analogous responses. *Borderline* functioning is associated with a self concept which is inconsistent and unstable, permeable and shifting. The data reveal diverse interpretations and inter-relationships between inner worlds of deep vulnerability, which hold core strengths and inner power. Selves are experienced dialectically as vulnerable, damaged and oppositional while, at the same time powerful, reflective and strong.

4.2.2.2 Theme 2: An empty shell

A lack of sensed rootedness and extreme inner emptiness, combine in a pervasive feeling that something is missing. The experience is described variously as "*nothingness", "this void", "go blank", and* represented in two modes. The first is an ever-present, ambient emptiness, the second an acute crisis-induced emptiness, which generates violent disruptive action, in attempts to (re)create feeling and build an emotional centre. Participants note a tendency to dissociate, one would "*blank out and do stupid things"*, and even in recovery understands "*I'd got better but I still had this void"* (K). Another, (T), notes, *"I feel I will be forever alone. I just feel like an empty*

shell". Diverse aspects of emptiness do not exist independently of each other and often merge, externalised in lengthy periods of inactivity punctuated by desperate impulsive action. The emptiness leaves gaps that the women may seek to fill with other things, leading to addictions, ritualistic behaviours and repeated high risk actions and self-harm. One or more of these behaviours are present in each of the transcripts. Where feelings of emptiness become critical, repetitive cycles of high risk or self-harming behaviour are counteracted by periods of detachment. Behavioural extremes of excessive sleep and hiding away from the world coexist with frenetic activity such as extreme exercise, dietary restrictions, excessive alcohol use or overeating. Experiential, intentional, emptiness also has positive connotations. The casting off of "*overwhelming emotion"*, for example, referred to by one woman (A) as she becomes able to let go of the past is creative and healing, heralding the emergence of new self. Inner emptiness is a complex, permeable and changeable. Sometimes, the women are paradoxically, overwhelmingly full of emotion, demanding release. They express fullness of spirit in the poetry of their narrative, sensitivity to others and stoicism in responses to early trauma and hurt. Their extreme sensitivity and volatile expressivity also facilitate a visual and visceral depiction of lived abandonment and aloneness, found in these dialogues.

4.2.2.3 Theme 3: Cut deeper

Self-harm is associated contrarily with responses to overwhelming feelings (too much) as well as blankness (too little), and extremes of sensed imbalance. Cutting and overdosing are attempts, paradoxically, both feel pain and to numb it, containing the final ultimate threat of self-annihilation in acts of completed suicide. The women report that self is repeatedly under attack from self, demonstrating clarity of thinking about self-harm aimed at getting help and self-harm which seeks to end life, sometimes experiencing the latter as possible response to the failure of the former. Each serious attempt is marked with fury, sometimes directed at having been allowed by to get this far and sometimes directed at having survived at all. An anger with existence, raw and unquenchable acts as a potential agent of mitigation for experiential emptiness. Self-harm can have a catalytic effect on support, with more serious acts gaining hospitalisation and therapy referrals. For example, "*the events*

that led up to it (hospital admission) *were I was self harming a lot"* (K); and, "*I was sitting in the hallway which I didn't know what I was doing because I had taken so many tablets, she then did call the ambulance and I went into hospital"* (M). Self-harm is described as both a way of coping, and a means of escape. One says, she went "*straight for the razors or the tablets and I was drinking a lot of alcohol as well"* (K) while another says, *"I didn't want to face what would happen if I went back home, so I took an overdose"* (M).

There is a tenuous grip on existence, described as 50:50 by one of the women (T), "*I did all my research so I knew how much I should take of this codeine which I had … and so I did about 50% was yes I want to die and 50% it was, it was a call for help".* There is the contradiction of careful planning in opposition to a sense of daring and not caring in these day to day struggles for survival. Some self-harm is denoted serious as in: "*I mean the last overdose that I took was quite a serious one. It was one to die, it wasn't just … I wanted to die"* (K). Even here it is only the "quite" serious and ambivalent almost accidental quality that is present in all participants. One says "*I self harmed but one day I went too far with my self-harm … and I remember just sort of slicing away and I just could not, what's the word, em … the confidence to cut deeper"* and, *"I have tried so many times in my life … It wasn't my intention to cause pain, I just didn't want to exist anymore"* (S). Counterintuitively, these women fear death and pain while desiring the cessation of experiencing life. One just yearns to sleep, saying: "*I just kind of took lots of types of tablets and didn't want to wake up …"* (M).

A longer passage exemplifies cognitive ambivalence, emotional bitterness and a calm, fatalistic vocal delivery (T):

> *… granted that was possibly a pathetic cry for help, one of many by the way, I have tried so many times in my life, and then I just couldn't deal with anything any further. It was in the first or second week of October, I took so much I should not be here, like because I'm on multiple medications for epilepsy as well and then I had lots of codeine left too and all of these things should have made me die and then, but I was found about two hours later, and yeah I was on life support for a few days and em … all my organs were fine, I'm still angry about*

> *it, I'm really angry. I've had big problems with my hand, you can see all the scars over my hand, but I've almost got full usage back its still pins and needley*

There is also a slightly incongruous concern shown for the listener, "*if this is too much".* The event in the past is thus reattached in the present. One part, the cutting part, is detached from other parts, in this case, the flesh being cut. Dialogically and reflectively, the parts are reconnected. Acts resulting in physical pain may neutralise felt deadness; flesh cutting, damaging the physical boundary between internal and external reality can provide delineation and intactness. Yet there is no suggestion of pleasure or satisfaction in such events and two participants (S and T) express dislike and fear of the pain associated with self-harm. Even in high risk suicide attempts, such as large overdoses in quiet places, there is an absence of certainty about wanting to die. Harm chiefly enacted in the body alleviates embodied pain in a physicality already experienced as the site of danger, exploitation and entrapment. The body is mutilated, damaged and potentially annihilated by the will, or other parts of self. It is difficult to hear stories at once painfully casual yet graphic and visceral, requiring a quality of listening quite different to that of being with someone at the point of self-harm.

4.2.2.4 Theme 4: Winning the battle

Alongside the battle for life, war is constantly being waged between parts of self. In recovery, a battle between a past self, traumatised, chaotic and an emergent self, healing, taking control is apparent. Expressions of inner struggle are evident as in, *"I think half the battle was knowing what I was doing … once the condition became more manageable, my strength did come back and … I don't have the conflict now"* (K) and, *"I feel I have two sides to my brain and they are fighting against each other and that's so frustrating"* (T). The past is filled with shameful reminiscence and hurt. Forgiveness and letting go, function as a way moving forward, acting as a means of re-establishing strength and control. Struggling can function as a way of masking core self from the outside world but also hiding vulnerabilities within self, as one (K) puts it, *"I have to fight with it, because there are times when I feel like giving up".* Masking techniques such as, *"I put on my face"* and "*I have this hard cover on"* (T), shield other truths. Shifting, alternative selves are not just set apart from one another but set in

opposition to one another, described as battling and split. One participant, (T) experiences having two sides to her brain, constantly fighting against each other; another, (K) describes ongoing conflict between different parts of herself, and marks her recovery as the ability to progress from a psychological battlefield to a gentle inner chiding. The women experience, at their lowest points, feeling beyond repair or not worth fixing; in spite of shame and low self-esteem each woman recognises a need for change at a deep level.

4.2.2.5 Theme 5: Hear me

Diminution of agency is linked closely to experiential external loci of control in these dialogues. The presence of a powerful other, a *"they"* responsible for abuse and abandonment in childhood and an active, influential force in adulthood. When asking for help, the women feel unheard and unacknowledged, a re-enactment of early problematic trust issues. All the women describe experiences of, and intense reactions to, rejection and abandonment. Rejection is identified as *"a massive trigger"*, and each participant can recall being left alone, helpless against potential harm. The women are repeatedly turned away from hospital, their only identified source of support. Even when, "*I was begging the nurse … to hear me"*, there is no respite, "*so I felt no one was listening to me",* and, in the end, "*I could barely talk anyway"* (S). This exemplar (K) sums up the sadness and resignation:

> *Then they discharged me and, like I said, I didn't feel ready. I was still feeling ill and obviously within a week or two I was back in another psychiatric hospital because I'd overdosed and that happened three times, so I felt like no one was listening to me … I don't think they took me very seriously.*

Internal agency develops through processes of knowing and naming; learning about the diagnosis and transforming it into an owned identity. Reattribution of responsibility as to the root cause and deepening understandings about mental health are achieved through personal research. Initial responses of disengagement and disconnection can give way to relief and understanding which shift power imbalance and develop internal agency. So, *"I didn't really engage with it in anyway … it didn't have any meaning for me'* (M) becomes*, "I felt relieved that they'd actually diagnosed*

me with something" (S). Meaning and develop reflective, voiced agency represented effectively in the phrase (K), "*when I spoke … I could manage".*

4.2.2.6 Theme 6: Spiralling

There is an amount of rootless wandering, emotionally, psychologically and geographically in the described lives of the women and all have had periods of homelessness. The instability of place and person is described variously throughout the interviews as being, "*up and down", "in and out"', "revolving", "in a vicious circle"* and *"spiralling out of control … without any sense of being able to stop".* The women reveal in the content and manner of their speech, a state of being in constant motion, shifting and ungrounded. Sometimes they are moved by others, or placed in unfriendly, harmful environments where their requests to go or stay frequently ignored. If they do move themselves, it can be to situations that are more dangerous than whatever they are moving away from. Movement is apparent in the flow as well as the content of speech in passages of relentless flow without a prose structure. The effect is of a dizzying momentum and apparent lack of an end point, as though each concept goes on and on, uncontained. Another significant movement is that between the then and now. Even though the women seek to strictly delineate past and present, reflections on recent events trigger the past, effectively hurtling the participant back in a merging of time and place. The past is shown to have a powerful impact on current states, returning the women to experiences of previous distress. Balance develops with recovery, but state fluidity means that the internal and emotional motion is often present. The following sample shows how one (A) continues to experience life, losing direction at times:

> *I still go low and high and things like that, I think the experiences of life sometimes there are too many negatives that happen regarding marriages or just moving or these kind of things have happened quite a bit in my life that's I just I think you lose yourself through this maze sometimes, … then you get the strength back again until that flops and you go back down again or something, it's just a seesaw thing.*

The women seek to steady the motion through physical, cognitive, emotional and spiritual balancing using exercise, music, prayer, meditation and the comfort of containing and sustaining relationships. Spiralling out of control is dangerous, yet a spiral is a pattern of continuous winding movement around a central axis point or core. Without forward motion, there is stuckness; without fluidity, there is rigidity. Setting out on journeys of discovery and recovery would be impossible without motion.

4.2.2.7 Theme 7: Safe haven

While journeying, the women need places for respite, away from external spaces which are experienced as hostile and risky. There are numerous examples of early threat. M is required to sleep in the same bed as a mother who is very mentally ill, then transferred to an abusive home in a foreign country. S experiences sexual threat at home and bullying at school and feeling unsafe everywhere begins to wander. When admitted to a women's refuge, she begins to feel safe and begs not to leave, but is forced to. Later psychiatric hospital, becomes for her "*like my safe haven"*. Such havens might, it seems be found at the intersections of hope and despair. Hospital can be that place, a place of care and containment, such that one remembers "*I was safe. You were in a safe place. You couldn't harm yourself"* (K). Relational safety is identified in group therapy, activity and community. Such therapeutic milieus satisfy yearnings for belonging, respite from isolation and protection from liaisons. One of the women (T) does not feel safe in hospital, described as dirty, dangerous and life threatening and gets herself discharged, vowing not to return. These relayed experiences suggest that the women are safety-seeking, struggling to make safe places for themselves. For one, moving to a new area presents an opportunity for her to *"… hang out at this sweet shop, where people used to talk about life, the world, these things really interested me"*. The relief in finding somewhere that she can be herself, connected without expectation is palpable.

Retreating to bed to shut the world out is one solution, but there are pitfalls of self-enforced isolation and rumination, potentiating periods of passivity, despair and darkness. Alternatively, one (M) is ambitiously embarking on a silent meditative retreat in the near future. While expressing trepidation about this, she acknowledged

that such an enterprise would have been impossible prior to therapy and recovery. Two of the women (S and A) experience their sense of safety in new religious beliefs, through an enabling, safe Divine presence in their lives. On reflection, S identifies inner and outer spaces where she is able to redefine her relationships with self and the Divine, experiencing "never ending love" and renewed relational being. Through such processes, the women define external safe havens as places of temporary respite, transitionally safe until inner safe spaces can be constructed and inhabited; a metanoia of about-ward face from the struggles of illness towards safety / God / home. Frantic attempts are made to negotiate external safety and develop inner sancta for to recover balance and restore peace. While previous experience offers little in the way of safe models, the concept hoped for. One proposes an imagined place of calm in her brain were the right connections to be made, another has learnt therapeutic visualisation techniques for seascapes of beauty and calm, and one has developed safe inner space, through the discipline and practice of mindfulness.

4.2.2.8 Theme 8: Making a connection

Relational safety is just as important as place safety, and alongside hostile and fearful relational experiences, are ways of relating which are supportive and therapeutic. The women demonstrate caring and protectiveness towards others and value people who are safe without being emotionally suffocating, who listen, and are kind and accepting. In these transcripts, an ambivalent relationship between self-control and other-control is in constant interplay with power often located in others. The women report feeling constantly let down; isolated and helpless. Experience of early trauma have diminished trust and the lack of effective help adds to a sense of hopeless loss: One (K) expresses this sadness:

> *There was no one helping me there was just nothing I don't know I just know I had known for a few years something wasn't right but I just wasn't getting any help even like I think it started when I was about 14. That's when I started noticing it with the self-harming and it was just, I sort of I think I'm not angry now but at the time I was angry cos I was just why is no-one helping me.*

Desperation can result in attachments that re-enact betrayal and misunderstanding, reinforcing experiences of the external world as fearful and unstable. Indeed, professional helpers can harm by repeating patterns of faulty or inadequate parenting. There are numerous accounts of feeling ignored and not helped. One participant (K) assumes that one nurse who didn't help her didn't like her. Significant to recovery is the opportunity to know and to understand the past. Lack of clarity about diagnosis, prognosis and treatment, paradoxically keeps these women in positions of dependence, ill-equipped for meaningful engagement in conversations about themselves and their future. Each indicates that the right professional helper can make a world of difference. Some have benefitted from specialist interventions and all identify individuals with particular attributes and approaches which have helped, indicating that the person and their positioning can be as important as therapeutic technique. One participant (T) describes her sessions with a hospital counsellor who provides welcome normality as, "*just nice normal conversation … an intelligent level and looking at things from logical perspective and what can you when you feel like this and this and this".* She also values the student nurses who make time to listen to her, and are "*fun*". Another, (M) has had extensive treatments in her recovery pathway, and still values the first counselling relationship with someone who shared her cultural heritage and was kind and responsive. She reflected on this hopeful potential of establishing one trusting link as a template for inner connection, saying, *"I think the counselling really helped me to … have some kind of idea, that some kind of future is possible, or some different experience is possible … being made aware of having making a connection with myself".*

Intimate relating is especially difficult and sexual and romantic relationships are fraught with desperate fear of rejection. Periods of sexual voracity which later become sources of embarrassment are common. Experiences of hostility and abandonment create a toxic relational mix with lasting implications for relational development and trust. One powerfully good relationship or a number of small positive interactions, however, can begin to over-turn accepted, even deep-seated patterns. Therapeutic relationships, formal and informal rebuild trusting potential as one (S) explains, *"I learnt how to keep a relationship… a trusting relationship".* Both women who have

partners describe them as a "rock", and all the women boast friendships which are characterised by firm support and loyal acceptance. In the main, the women do not like being alone for too long but trust takes time to build. Being with people who are understanding, is therapeutically positive. One (K) comments, *"group therapy really helped … I think sometimes hearing them talk you think that's exactly how I feel. So you didn't feel alone with it"*. Another (A) gains strength from others acknowledging, "*being in somewhere that I had people around me and stuff like that and to work out anything or just to find out if things were ok or not, and making sense of things or, I think that helped".*

4.2.2.9 Theme 9: My journey to understand

The women talk about embarking on life journeys which require commitment, dedication and tenacity. One (A) looks to the North Star for guidance, others (K and S) engage in treatments, unconvinced of the outcome, yet working hard at it, never being late or missing a session, M undergoes years of "*therapy cycles" slowly* getting better, understanding that the depth of damage will take *a "long time to change".* Each experience of recovery, demonstrates understanding of a personal pathway, hewn through struggle, developing resilience by repeated engagement and connection. One (A) puts it this way, *"there was still my journey to understand".*

The women do not embrace or celebrate struggle and have no wish to return to places of difficulty, but they do respect its fundamental role in their becoming, inextricably linked to who they are. One (A) reflects, "*I think the heart is developed through experience"*. Another (S) goes further and states that it was her mental ill-health that brought her to the faith which sustains her, stating, "*because if I didn't fall unwell with mental illness I wouldn't have gone through xxx (treatment), I wouldn't have gone down to xxx (centre), I wouldn't have met my husband and it's my husband that literally introduced me back to the Church".* Spiritual meaning is gained through making mistakes and experiencing hurt and loss. None of the women end up where they started spiritually or psychologically. Good outcomes seem miraculous and yet come to be expected in the constant hopeful outreaching, as A reflects, *"I've seen so many miracles … there's no such thing as a coincidence, if something happens it has to*

be a miracle". Transformation, where it is experienced is deep at the core; K, for example finds *"it just feels like a different person"*. Exceptional ongoing life challenges in the context of early difficulties require creative coping strategies, resilience and balance. Participants demonstrate the ability to resolve past rejection and loss through letting go, to develop lives of meaning and purpose, emerging resolute and reconstructed. At the end of her interview, K describes how a combination of dealing with the past and starting out on her vocational pathway have brought happiness and healing. Life in recovery is seen as a journey. A concludes, *"you got a journey, you have to develop yourself, you have to its all about action and doing what you're saying … life is a journey and every little thing you say or do is accountable".*

4.2.2.10 Theme 10: Higher being

There is a cluster of themes expressing responses to questions of spirituality which refer directly to religion and to God. Theistic relationships include experiences of strangeness and unknowing, of heritage and cultural memory, of anger and fear, of close connection, or love. This mix of responses is not particularly informative in terms of the study, except to note the significance of familial and cultural heritage in the formation of spirituality and present beliefs. What is of interest is the meaning ascribed to the relationship with God and the guidance of respective religious teaching to recovery. One (S), who describes herself as a Christian reborn, sees the Divine hand in her recovery:

> *I don't think anybody else could have made that happen but God, ok I've got my own mind and things like that and you know some of my friends may think that I am a religious nut but do you know what, let them believe it because I know what I believe and what other people believe is what they believe everyone's entitled to their own opinion but I know that it was God that brought me to this place where I am now sitting here talking to you about this.*

The deep meaning implicit in recounting beliefs indicate experiences, not just of new meanings and purpose but of a new becoming. For A, who has been brought to Islam, the point of life has become not just the changing of self but world-changing, making it more equal and balanced, benefitting all. The (re)connection to God that these two

women experience in faith provides them with new experiences of themselves, others and the world, and equips them with ways of coping including prayer, worship, fellowship and a sense of perspective about suffering. The relationship with God is profound, containing opportunities for mercy, the power of supernatural forces and Divine love. As on (S) remarks, *"I just think it's pretty amazing and I think I mean God loves everybody, you know it doesn't matter what you've done in life there's always that love there".*

The three non-theists view this same process somewhat differently. K locates an inner spiritual centre and M a mindful way of being, each presenting sacred qualities in the relational experiences of self, others and the world, laden with deep meaning. As K says,

> *"…because there are times when I feel like giving up. It's like an angel sitting on your shoulder really saying, "No! You can't give up!", and you're sort of almost fighting with yourself."*

M is comforted by the religious music and imagery of childhood; metaphorical symbols connect inner and outer worlds, internalising hopeful reminiscence and externalising inner strength. Fear of God is expressed by T, now an atheist, with lingering concerns, saying, *"I was very afraid of this God … and I just perceived religion to be in control and that, in a way, people are controlled through fear and yeah I'm not really happy about it"*. For S, who had once fallen out with God, there is a new found joy in rediscovering sacred connections within and without, when she says, *"I mean I do things like this, I like to talk out about my mental illness, I love to talk about my spirituality, I don't get the chance often".* The women express connections with something completely other, some hostile or fearful, some grateful or loving. All, reflect experiential higher being in current or hoped for self.

4.2.2.11 Theme 11: The right foundation

Living with BPD has resulted in compromises of early ambitions, yet the authenticity of the hopes and dreams of these women remains a driving force in their lives. In fact, progress towards goals provides a useful marker of recovery and an increasing sense of well-being. On embarking on her nursing career, one (K) describes it as *"all I ever*

wanted to do". The women see themselves as contributing to the lives of others and have plans for even brighter futures. One (M) has a vision of returning to India and developing new models to enhance the health and happiness of vulnerable people there. The women, are all strongly motivated by the desire to help and support others who are facing distress. At the end of one interview, the happiness and delight in new life and opportunity is evident in the desire to, *"live in a responsible way and you do the right, you lay the right foundation"* (K). Indeed, the dizzying flow of dialogic experience is often slowed and replaced by a more confident and purposeful tone in moments when participants discuss successes and life goals with evident pride evident at overcoming challenges, pleasure in success and excitement about the future. There are glimpses of a shared ability to build meaning and sense of purpose through re-attribution in the reflective interview experience. In one case (S), engagement with the study has rebuilt and reinforced her previously thwarted plan to enter a profession and embark on a University education. The women study and endeavour to improve themselves in active engagement with the work of self. Recovery is an act of reconstruction which is ongoing in four of the women and longed for in the other.

The women use the terminology evocative of building, digging and pathing as ways of developing a purposeful life. One (S) describes having therapeutic scaffolding constructed around her, so that she can be completely reconstructed; another (T) believes that something or somebody will have to break her down into pieces and build her back up as someone different; K describes digging right down to the root of the problem to have it pulled up and expunged; M has put herself through repeated therapy cycles; and A has walked the clouded way towards the balanced path. These women are the warriors of their own struggle and the captains of their own forces, embarking on the mighty task at hand. The resulting success brings joy and self-recognition, as one (K) can finally proclaim, "*I'm stable, I'm happy"* and another (M) describes a "*different way of experiencing myself … without the sadness of the past or any worries about the future".* Recovery, is built by laying the foundation for a more coherent connected sense of self, leading towards the point where one (S) knows, "*I've got my own mind"* and another (A) feels, "*you are doing the best that you can and you're strengthening your human self".*

4.2.3 Converging Dialectics - Summary of Thematic Analysis

Multi-layered experiences of the data uncovered significant thematic experiences illuminating individual and shared worlds in the essential dimensions referenced by van Manen (2007; 2014) as lived body, lived space, lived time and lived other. Threads of meaning, purpose and identity are woven into the material, highlighted and developed through processes of knowing and voicing. Participants share through the interview a dialogical re-experiencing of being and a reflective experience of becoming. The study findings compliment the *borderline* functioning of psychiatric language of interpersonal difficulties, desperate efforts to avoid abandonment, self-damaging impulsivity, acts of self-harm and longstanding feelings of emptiness (APA, 2000; WHO, 2010). An alternative, spiritual perspective, shifts the underlying assumptions, the relational centre and the language. Relational functioning is found to be demonstrably with self or selves experienced as wrong, empty, unheard, having a tenuous grip on existence; yet rooted, winning, journeying, recovering and laying the foundations for transformation and higher, or at least, other, being. Connections are made within and without, developing extrinsic and intrinsic places of safety. The thematic cluster approach to the findings uncovered shared dialectical experiences of lived relational spirituality in the dimensions of intra-, inter- and trans- personal worlds of being and becoming (Reed, 1992).

Intrapersonal representations include thematic clusters of root cause, empty shell, cut deeper, winning the battle. Damage experienced at the core of being is inextricably linked to cycles of hurt, the abuse perpetuated by others and harm by self. The women relay painful early experiences of abandonment and loss and two refer to sexual abuse directly. Early trauma is reinforced by the frustration of not being believed or helped, diminishing trust and increasing threat. The root cause of childhood trauma and neglect permeates the data obliquely and explicitly. The physicality of the pain and the associated somatic location of wrongness demands physical and somatic solutions, generally self-harm. Viewed as integral to their psychological survival, the women effect plans, intentions and actions for hurting the self. Existential emptiness can be positively embraced in life, balancing and the pursuance of spiritual goals through prayer, meditation and visualisation, for example. Disconnection and

dissonance is described as a war being waged on self, or at least parts of self, psychologically and physically, presented as a battle which can be won.

Interpersonal representations include the thematic clusters hear me and making a connection, the experiencing of worlds of other persons and other communities characterised by being unheard and disconnected. The overwhelming motivation is, however, towards the desire to be heard and connected, and the many attempts and diverse methods employed in this endeavour are described. The women demonstrate deep concern for others and a relentless drive to find a voice that can be heard. Each has experienced relationality through openness to one, or more then one, safe nurturing connection, personal and therapeutic which develops a sense of acceptance, belonging and love.

Transpersonal representations include the thematic clusters safe haven, life is a journey, higher being and the right foundation insomuch as they refer to described experiences of engagement with worlds which go beyond the usual limitations of person and other, linking to the esoteric, the mystical, the sacred and the Divine. The women describe process of building, digging and pathing, laying the right foundations for a personal journey and a higher self-being.

These clusters present world views for developing life purpose and meaning, the movement away from experiences of alienation, darkness and negativity towards experiences of hope, joy and fulfillment. The theme of spiralling, which emerged fortuitously as the mid-point cluster, surrounds and embeds the others, representing experiential connections and disconnections with self, world and other, denoting constant movement in and out, on and off, healthily disrupting straight pathways of progress, maintaining the mutability and momentum essential for journeying. Corporeally, spatially, temporally and relationally, the lived experience thematically presented invokes worlds of fluidity and flow between I and I, here and there, then and now, I and you, or in *Buberian* terms, *I-Thou.* Thematic analysis has identified the major areas where the women could be said to be experiencing their spirituality, relationally to aspects of self, others, places and spaces in journeys and discovery and recovery, represented in Figure 4:2, below.

The thematic material presents ways of being-in-the-world, at once ambivalent and oppositional, yet at the same time balancing and strengthening. Participants describe intense coexisting experiences of alternatively giving up power, and grasping power, where subjected powerlessness coexists with an emotional, elemental instinctive powerfulness. Self-identity and a sense of agency is conceptualised through engagement with reflective, emergent voice and progress towards well-being, recovery and spiritual centre. In the processes of reflection and finding voice, relationships with self, others external worlds are re-negotiated, re-balanced and deep existential growth, transformation and recovery can begin. Messy and mutable journeying is initiated through the breaking of bonds of otherness, labelling and stigma and the reattribution of causes, connections and possible solutions. This process of unmaking and re-building is both deeply personal and essentially public and political, being undertaken in relation to the external world of relationships and perceived order. The figure below summarises these findings. Visually, the relational human dimensions are connected through the struggle or finding the courage to be towards a *becoming* of changed self. These growth stages are spiralled by the vicious circles, taking each individual on and off, up and down, in and out, maintaining momentum towards transformation. The spirals represent emotional, psychological and geographical rootlessness, a state of constant motion. Whether directed by others or by themselves the women can find themselves in situations which are more dangerous than whatever they are moving away from. The spiralling movement describes patterns of continuous winding movement around a central core or *anchor* point, potentiating the momentum for processual travel, discovery and recovery. Each space is loosely held by spiralling boundaries of motion, which are fluid, ephemeral and only apparent in motion. The spirals cross the dimensions of self-identity, interpersonal relations, spaces and places, as well as each other represented both by the colour and format (Figure 4:2). In those intersections and lightly enclosed spaces, relational spiritual essence is present.

Dialectical Convergence: Thematic Analysis

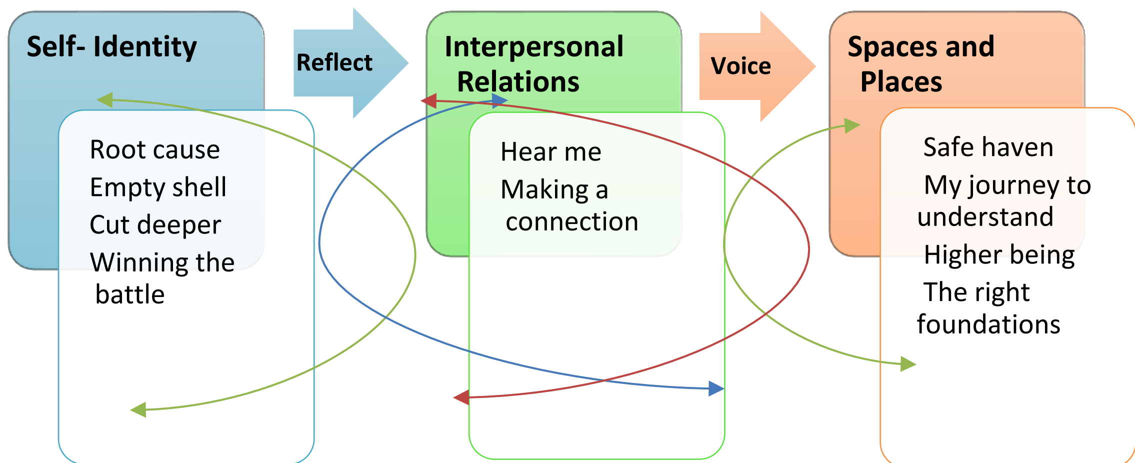

Figure 4:2 Thematic Analysis

Each of the theme clusters will be combined with the narrative themes in order to formulate dimensional spiritual themes for practical application.

4.3 Discussion of the Findings

The findings demonstrate the significant presence of spirituality in the lived experience of the women. Four of the women identify meaningful spiritual contexts for their recovery, while one woman at an earlier stage of recovery identifies spiritual components, which both hinder and enhance emergent selfhood. For all of them, lived spiritualty has meaning as a phenomenon of being (*borderline*-self), becoming (reflecting-voicing-questing) and being (recovering-self). These spiritualties offer new dynamic insights, unlikely to be attuned to through normative understandings, presenting opportunities to both view *borderline* functioning differently, presenting new with repercussions for the education, practice and development of MHNs. An analytical summary of the findings will now be presented and a hermeneutic spiritual

model conceived. In addition, dialogic reflexivity (3.4.4) reveals parallel experiential processes from the researcher's perspective, which are now summarised.

4.3.1 Parallel Reflections

In a recent publication, Goldstein (2016) demonstrated how reflexivity acts as an integral source of *meaningful* findings. Her PhD thesis about therapy relationship experiences of women with BPD argues, as I have done for the contextualising of narrative content in co-created relationships and shared lived experience. (Goldstein, 2014). Dialogic reflexivity (Figure 3:12) working throughout the data collection and analysis, introspectively, discursively and collaboratively meaningfully enrich the study findings. Experiences of challenge, growth, commitment, gratitude, anxiety and wonder resonate with the experiences of the women, with each process deepening understanding. The following specific reflections are included to inform and strengthen the study findings.

4.3.1.1 Reflective 1: Evoking Water

The relentless motion in the listening experience is elemental, evocative of water, present both in the speech patterns of the participants and the researcher's reflective reactions to them. One narrative seemed to gush and flow in torrents like a flood while another gurgled and trickled like a stream. The researcher often felt herself to be adrift or all at sea. In the context of the study, water imagery well represents the fluidity and flow of internal and external boundaries. In the tidal model for mental health, Barker & Buchanan-Barker (2015) use water as a metaphor for recovery, noting a rhythmic wave-like quality of life change, moving forwards and backwards, only showing over time. Water, like life, they say is a force to be lived with, rather than overcome; in recovery people learn to either swim or build a boat. The continual flow of talk might be interpreted as a wish to merge through constant contact, or the effect might be to keep the other at bay, unable to get close or involved. Such interpretations, however, are not supported by the engagement and enthusiasm of the women, keen to participate in the study. The flow appears to be unconscious and unstoppable, effecting disorientation on the listener. What was interesting was the many times that, even after a particularly long passage, some over five minutes long, the narrator

would return to the key themes or question being addressed. The thread had not been lost at all and the narrator was meandering circuitously towards the end point, verbalising fragile thought (dis)connections along the way. Narrative transcription and re-reading reveals a process which might, conversationally be lost. On reflection, each of these women seem to have an anchor point somewhere inside. While seemingly chaotic, there is something at the core to hold onto, tenacious and strong.

4.3.1.2 Reflective 2: In-between Spaces

Through the content and manner of their speech, the women also reveal transitioning states, betwixt and between, with parts of space experienced in a qualitatively different way from others (Eliade, 1957). Thematically reminiscent of the *thin places* identified between material and spiritual existences (Rickman, 1999), significant elements of the narrative occur in places of movement or crossing, such as stairways, bridges and hallways. These are often places where events are forced into play and change happens. For example, one sits on stairs following an overdose and climbs stairs when she believes she will fly. Three women self-harm in hallways. Most visually powerful is the presented image of sitting under the Millennium Bridge in the shadow of St Paul's Cathedral relentlessly cutting. Stairs are modes of getting to another level, hallways are ways of getting to other rooms, bridges are a means of traversing and crossing over; such places represent hermeneutical travel, geographically and spiritually to new places and spaces. Barker & Buchanan-Barker (2004a) denote *bridging* as a purposeful therapeutic connection, which enables continuation or joining, a means of reaching across a gap to something of importance. Fluidity, shift and in-between places suggest movement, flow and marginality. The women are located somewhere different and also moving towards something different.

4.3.1.3 Reflective 3: Birthing Voice

The women are empowered through processes of voicing. The telling of the story, changes the flow of the action, impacting outcome and something new emerges from multiple intrinsic and extrinsic interactions. In a parallel process the voice of the women, the I, heart and voice begging to be seen and heard' is revealed and reflected

through shared conversational experience. Desperation and struggle eventually thrust the voice into external worlds where it can be heard in direct expression. The phrase (K) *"but when I spoke"* is illustrative of the beginnings of a new communication mode, challenging to normative discourses, medical, social and cultural (Gilligan, 1982). The self-reflective thread running through each narrative, acts as the source of meaning-making and ultimately of change. Moments of clarity and understanding bring each individual to re-negotiations with self. In re-readings I can detect my own style of writing becoming more akin to the speaking style of that individual. Constantly, throughout this lengthy academic process, I have paused to reflect on the ways that the women have made me a researcher, as much as I have made them participants. In this endeavour we are all rebirthed. I am able to say, reflecting, with S, *"I think that's when it actually hit me".* To paraphrase Irigaray, when "one speaks the others are silent" (1985; 2008). Now I speak. Through repeated experiences of unaming, renaming, unknowing and knowing we are becoming

4.3.1.4 Reflective 4: The Compassionate Pluriverse

A sense of serendipity, the presence of fortuitous shaping events and unexpected turning points, threads through the lived experience. The women variously refer to experiences of being in the right place at the right time, getting the right treatment, meeting the right people and discovering a higher being in themselves and others, compassionate, redemptive and transformative. On reflection, the light shadow of serendipity permeated everything in the study experience from inception, choice of supervisors, selection of participants, reading, reflective analysis, outcomes and conclusions. All of the past, theirs and mine, seemingly coming together for one small yet significant moment of enlightenment. Ontologically, the study has become located in worlds of potential, something is always turning up, shapes and patterns form, and, in worlds of dark-being and struggle there are a million bright, mysterious and wonderful possibilities (Housten, 1997). All perspectives, narrative, thematic and reflective are threads woven into individual and shared lived experiences of meaning and hope. Where strong resistance has been experienced in people and circumstances, pulling away from the study, equally strong forces emanate from people and circumstances coming towards the study. Participants, supervisors,

colleagues, friends, family, spirit guides, and eventually, even the researcher's self become compassionate and enabling. In the end, or perhaps, in the beginning, *"maybe I just got lucky".* The meaning of things, shapes the things themselves, and for the women new selves and new lives emerge balanced with hopeful intentions.

4.3.2 Drawing Together the Threads

The final section of this chapter provides an amalgamation of the findings. A dimensional model representing *borderline* spiritualties is provided formulated in the dimensions of lived worlds, following van Manen (2007; 2014) of corporeal, temporal, relational and spatial dimensions, and referencing the relational spiritualities of intra- inter- and trans- personal dimensions suggested by Reed (1992) and Cook (2011).

The conceptual and research literature revealed *borderline* spiritualities that reflect mental health spiritualities in human relational dimensions, intra-, inter- and trans-personally, significantly aligned to recovery journeys. BPD-specific elements of somatic suffering, self-harm, desire for change and emergence are found in this study, as are the chaos and confusion around interpersonal relating and the elemental presence of water. In particular, the role of destructive elements in self and others, the significance of motion and in-dwelling found in the literature, are echoed in the study. These themes are expounded here, uncovering lived *borderline* spiritualties in the relational dimensions of self, others and of spaces, both immanent and transcendent. Recovery spiritualties, experienced intrinsically and extrinsically through lived journeying towards the complex task of being are presented in a way, which focusses on the inter-relationships between all these elements.

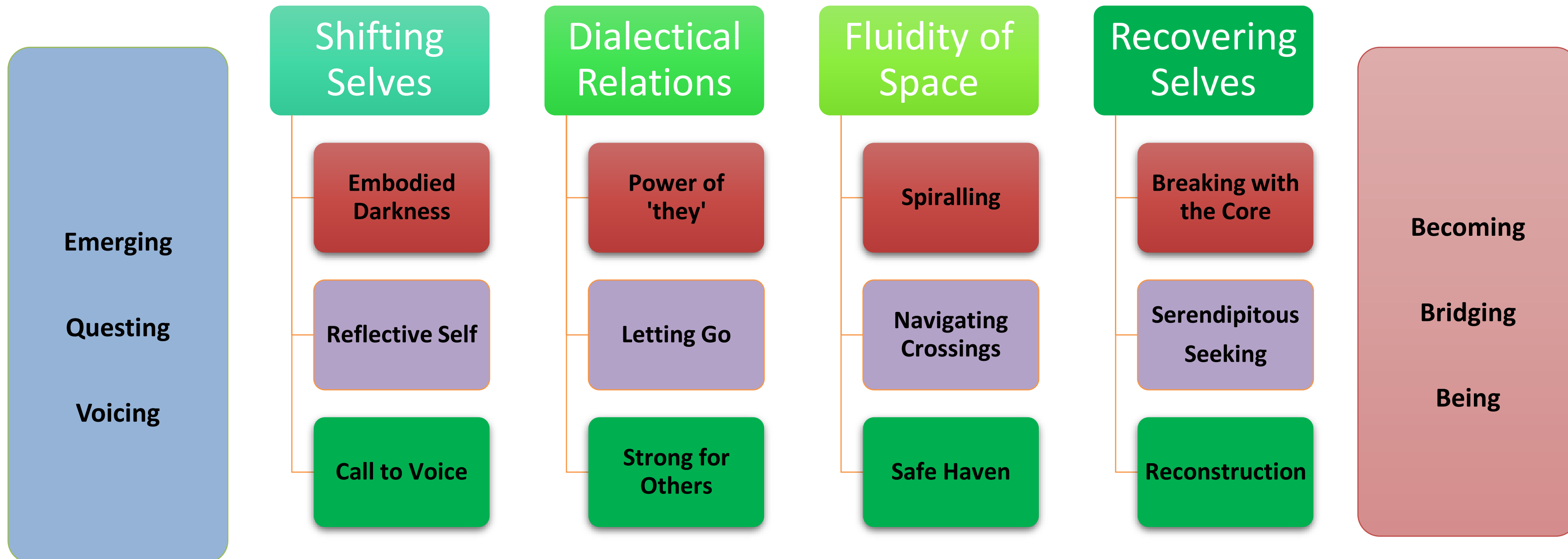

Figure 4:3 Relational Borderline Spiritualities

The model demonstrates the ways in which the women are empowered and liberated through relational experiences with self, others, external space and purpose. In each case, core difficulties and fragmenting elements of these relational spaces are mediated through connectedness, towards more hopeful outcomes, across corporeal, temporal, relational and spatial dimensions and developing understanding of the inter-relationships between these aspects (van Manen, 2007; 2014). The dimensions or experiential worlds are shifting, dialectical, fluid and recovering or recoverable, through emergence, questing and voicing, the inception of agency. The women travel from positions of difficulty intra-, inter- or trans- personally towards positions of relational recovery, from spiritual ill-being to enhanced spiritual well-being. The struggle of early trauma and present difficulty are not the means of travel, but can trigger the necessary fluidity and mutability, the spiralling precipitation. Rather it is understandings, negotiations and attributions from the perceptual relationship with struggle, which drive the journey, forming bridges between past and present selves, towards that something of importance (Barker & Buchannan Barker, 2004a; 2015). The elements suggest a growthful journeying in each of the dimensions of selves, relationships and spaces, going downwards into deeper understanding and connections, combined with momentous traversing of elements, crossing through shaping foundational lived experiences towards resolutions. The model structure initially suggested the state of being, shifting selves, and becoming recovered selves, with dialectical relations and fluidity of space as bridging processes.

Reflexive reconsiderations of the data, however, suggests something different. Firstly, that the spiritual journey undertaken by the women does not start from a position of *borderline* being, where the researcher and study question had located them, but from a position of *meaningful becoming*. The study has not uncovered movements from one way of being to another but has reflectively engaged with the women in the process of becoming, going towards a new way of being. Secondly, the structure revealed dynamic rows of meaning across the dimension. These rows do not represent distinct stages or levels of a journey but are rather conceived as identifiable pausing

places of meaning or [6]*waypoints* along the way. Beginning at the top row as awareness comes into consciousness, a waypoint of emergence towards becoming, is identified, dropping down into the transition waypoint of questing and bridging, towards the restorative waypoint of voicing and being. It has been difficult to represent such fluid processes in sealed boxes with straight lines; reality is messier. The boxes however, enable a representation, which can inform intervention and understanding, acting as hermeneutic signifiers for engagement. This is a suggested way of journeying only and like any map, the direction of travel will vary dependent on the place and manner of setting out, bends in the path, stops along the way and changes to the finish point. Temporal dimensions are not explicitly included because the study found little to evidence the importance of time in these lived experiences. Events from the past became so vivid as to have direct experiential reality in the present and present events send the individual hurtling back into the past, such that time lines often merge and collide. Reflexively, time and space, are experientially intersected to form a point of spiritual force a space where then and now have parity in the here and now.

4.3.2.1 Intrapersonal Dimension: Shifting Selves

Different experiences of self are consistently featured in the lived borderline experience in the study. Self is fluid and shifting, with problematic core-sensing and self-centering. Perceptions of wrong-being, emptiness and inner darkness are embodied recalling early trauma and current distress, carried in and by the body through body memory and activation (Levine, 2010). Darkness within and without merge through *thin* permeable physical and psychological membranes of skin and psyche, and are framed in bodily and spiritual inpourings and outpourings. Quintessential self, attempting to uncover herself through experiences of being-in-the-world is constantly disrupted by structural normative discourses, which label and stigmatise. Disruptions are negotiated through reflexive process, destabilising normative accounts and enabling the emergence of a fluid and mutable self (Archer, 2014). Different voices, inconsistent, oppositional, and negative scream out, and are often unheard in practice (Gilligan, 1982; Serrant-Green, 2010). New voice is called

[6] *A **waypoint** is a landmark or reference point in physical space used for purposes of navigation*

into being through processes of renaming and knowing by taking control of the discourse (van Manen, 2014). Symbiotically, agency is developed and emergent, reconstructed selves are brought into being thorough new voicing, a natality of emergence and voice (Irigaray, 1985).

4.3.2.2 Interpersonal Dimensions: Dialectical Relations

In a similar way, agency is negotiated in relation to others through reattribution of root causes of *borderline* functioning and a redeveloped sense of inner strength and power. Consistently, the women experience a power to either cast off, and condemn, or to rescue and save. Forgiveness, reconciliation and reparation are potent means of letting go, not just of the past but of the daily catalogue of hurts in the present (Baetz & Toews, 2009; MacDiarmid, 2013). In this way the women find ways to negotiate forgiveness of self. Relationships marked by overdependence and passivity can be developed therapeutically into supportive liaisons which inspire hope and promote lives of autonomy and independence (Repper and Perkins, 2003). The women identify therapeutic characteristics in people including knowledge, acceptance, loyalty, cultural competence, resourcefulness and presence. The renegotiation of relational boundaries develops significantly through and with emergent agency. Moreover, the care and concern for the well-being of others rebounds in positive relational experience. The women, not always able to galvanise themselves on their own behalf, can be strong, personally and professionally, on behalf of others. Renegotiated power relations and compassion are important in developing a healing self-compassion (Gilbert, 2010). The resulting sensitive, nuanced relational consciousness generates enhanced spiritual connectivity between self and other (Hay, 1987; James, 1982).

4.3.2.3 Spatial Dimensions: Fluidity of Space

With the expressed compelling movement in tone and topic, the study draws attention to the impact of language. Instability associated with BPD is the terminology of medicine and construction, while the term spiralling, indicates curving movement around a fixed point. Where spiralling effects a shaking off of constructed preconceptions, it is experienced as liberating, a positive precursor of challenge and change (Griffiths, 1995; Wirth-Cauchon, 2001). Spirals can be turns in the dance of

becoming, able to go down as well as up, forming unenclosed places for spiritual in-workings and out-workings, spiralling freely towards soft, safe landings and reintegration. Such a dance might well stir up psychic and spiritual essences, enabling an energetic free flow, hermeneutically linked with water imagery, the streams, waves and floods of lived emergence and re-birth (Wirth-Cauchon, 2001; Barker & Buchanan-Barker, 2015). Such waters, are navigated and crossed by means of geographical, psychological, relational and spiritual crossings to bridge intersecting places of hope and despair. Safe havens are sought from rest and growth, places where understanding and healing happen, through compassionate holding and emotional containment (Haigh, 2013). Safe haven is both destination and transition, a space for possible reintegration.

4.3.2.4 Recovery Dimensions: Recovering Selves

Selves are recovered through the depth of experiential meaning. A quintessential breaking with the core is variously depicted in the repeated traumas of self-harm, abandonment and loss, through a therapeutic process of being knocked down and broken apart and ongoing therapy cycles. Core trauma requires long deep work. Recovery approaches assume the therapeutic necessity of grieving for the losses experienced in having mental illness (Deegan, 1998; Repper and Perkins, 2003). Therapeutic holding provides scaffolding, for such processes, facilitating the courage needed to confront inner darkness and re-learn how to to be, act and speak. Yet it is in hopeful self-directed seeking and in serendipitous turns in each story that new pathways are found which are both life-saving and life-enhancing. Living with schizophrenia, Deegan (2008), posits that recovery cannot be built out of nothingness and develops her survivors mission. Through the visualising, owning and construction of a purposeful future, she experiences the power that begins to move her onward. The core belief that things can get better, leads the women towards paths of hope and happiness and the possibility of reconstructed, recovered futures and lived fulfilment.

4.3.2.5 Journeying Dimensions: Becoming-Bridging-Being

The women, can be said to be travelling downwards through the four identified dimensions of self, other, space and meaning towards deeper experiential knowing,

and along horizons of becoming and being. From this perspective, the invitation to participate in the study has acted as a call to tell, generating emergence from the shadows towards a shared revelation of quest and voice. Emergence does not represent a simple process of coming out from darkness, as voicing does not represent a simple act of telling that clears a pathway to open communication and understanding. These are not linear processes. Thus, emergence is dialectically, away from and back into embodied darkness, both challenging and accepting relations with the *they* of powerful otherness, positively and negatively spiralling to loosen the bonds and break with the core, at once liberating and terrifying. Similarly, the development of agency represented as voicing, emerges in response to the call to voice, being strong for others, finding safe havens for respite and potential reconstruction. All these processes are capable of engendering personal conflict, tension and probable pain, so the something of importance on the other side is not acquired without struggle. Bridging draws together the threads of each individual quest, forming an ever-present potential or axis point in-between the dimensions, therefore bridging represents the quintessential human journey *of being ~ becoming ~ being*. The self, becoming increasingly aware and reflective, begins the process of letting go of the past and the pain, navigates transitional crossings, seeking serendipitous alternatives and the travel itself is underway. The bridge is therefore, less of a fixed construction and more a growing towards (May, 1993; 2005). If the term spirituality represents the outworking of the inner yearning to be connected with something larger than personal ego, it is hope and purpose, which fuel the journey, a journey that would not be possible without such foundations (Palmer, 2000; Deegan, 2008; Swinton, 2011). Inner selves and outer travel are accessed and connected with through an emergent narrative, the re-authoring, re-telling and editing of lived experience. The women make themselves up as they talk, constructing and uncovering their capacity for everyday brilliance and soulfulness (Buchanan-Barker & Barker, 2004a; 2004b; Riessman, 2008).

4.3.3 Quintessential Dimensions: Reflective Conclusion to the Findings

These lived spiritualities offer possibilities and alternative perspectives for *borderline* being and becoming, enhancing understanding by specifically contextual viewing

(Chugani, 2016). Instability, for example is re-conceptualised as a fluidity of states represented thematically through lived worlds of *becoming-bridging-being.* Processes of dialogical re-telling and reflective showing give different perspectives on things that have already happened, primarily to the participants. In this way the key themes of relational spiritually are revealed through the women reflectively knowing, doing and telling, as meaningful acts of emerging, questing and voicing. The process of dialogic story-telling represents a transition between worlds of experience to realise relationships across dimensions of time, space and persons, dialectically formed and reformed. This transition represents the centrality of therapeutic bridging in both the study and the lives of the women, symbiotically linking method and meaning.

Narratives of reclamation and reattribution, through knowing and restoration, are uncovered, revealing interpretations of inner worlds characterised by elemental darkness and ambient threat. The stories are illustrative of seeking and voicing different selves, showing hidden accounts of emergent knowing and agency, the fundamental empowering inter-relationship between acting and knowing. Fluidity of narrative once attuned to, connects teller and listener to experiential rhythms, moving and pausing, ebbing and flowing, transitioning between states and spaces, seeking safe haven. The spaces are crossed and connected through the powerful encounters with relational forgiveness, acceptance and love, but also informed by deeply felt ambivalence, disconnection and depersonalisation.

A diagrammatic representation in answer to the key question of the nature and essences of a relational spirituality for women recovering with BPD has been presented. *Borderline* spiritualities as unfolding spiralling journeys of escape and engagement, present and embodied, connecting inner and outer chaos to experiences of inner and outer peace have been identified. The narrative is messy, the travel circuitous and open to multiple interpretations, yet relational, directional, intentional thematic elements represented in emergence, quest and voice have been identified. The adoption of the researcher role enhances therapeutic rapport through the imposition of curiosity as key motivator distancing the researcher from unhelpful temptations to rescue and take control. Relational bridging represents the nursing role, facilitating journeys of mental health recovery (Buchanan-Barker & Barker,

2004a; 2015). Spiritual questing, represents individual bridging, the crossing and entering into something and is seen as of new significance for the women in the study. The implications for an educational practice, which draws on this concept, will be considered in the final chapter.

Chapter 5: Summary and Implications

5:1 Overview and Introduction

The study has identified lived relational experiences of spirituality in women living with BPD, with the intention of creating symbiotic pathways of understanding to inform the spiritual and relational education of MHNs. For nurses in practice, *being*-in-the-world is inextricably linked with *doing*-in-the-world, developing, what Swinton (2001: 177) refers to as '*practical wisdom'*, 'knowing that guides being and doing.' Such wisdom is born out of the explicit merging of theory and practice; the interplay of critical praxis worked out in the life worlds of people with lived mental health experience. Nurses are called upon to both *see* and *act* differently in the world, developing, a particular kind of deeper knowing, both of self and of the potential and imagined other. This study is concerned with the development of such wisdom, applying the reflective insights of the study to spiritualities for nursing practice. The following proposals are a creative outpouring of ideas, using readily available capabilities and engaging genuinely with diverse, relational, linguistic and cultural, educational contexts. None are intended to be prescriptive or exclusive.

The final chapter considers the study from the perspective of the original aims and research questions, and the exploration of applications for the study findings to the principles, practice and education of MHNs. Limitations, contributions and future directions are presented and a framework for the spiritual education of MHNs is critically considered. The chapter closes with a conclusion and reflection.

5:2 Response to the Research Question

In order to summarise outcomes, it is apposite to recall the research question and ascertain the extent to which the study has addressed it. The initial question is critically considered throughout the final chapter. This being:

> How might an understanding of the lived experience of spirituality in women with borderline personality disorder inform and influence their therapeutic relationships with mental health nurses?

The literature explored in Chapter suggested that people with BPD and similar relational difficulties are less spiritual than others, in ambivalent and punitive

relationships with the Divine, are not supported by this study. Support has been found, however, for the findings in studies of trauma and abuse, which found recovery likened to spiritual awakening through searching, meaning-making, connection and epiphanies. A spiritual attribution for existential growth, including integration, maturity, well-being and *in-dwelling* are also supported by this study. The Findings Chapter (Chapter 4) provides a detailed analysis of the nature and essence of spirituality for the women in the dimensions of self, relationships, space and recovery (See Figure 4:3). A particular approach to being and becoming has been suggested by this study, proposing two elements of special spiritual significance. Firstly, transitional bridging experiences, also named questing, because this is where spirituality, and hopeful travel is experienced in reflective self, letting go, navigating crossings and serendipitous seeking. Secondly, turning points, or pauses in life's motion, where meaning and restoration can be established, also named waypoints. The interrelationships between these spiritualities, nursing practice and education is now considered.

5:3 Sensitive Attunement Revisited

The literature review found that people living with BPD value contact with mental health services, despite meeting with negative, judgmental attitudes, ambivalence and confusion. Relationships with others are seen as vital to recovery, and those which are consistent, long-term, trusting and participatory are most helpful. Turning points or serendipitous events are identified which promote recovery. Service users invite nurses to simply establish connections of genuine shared interest and values.

A primary aim for this study has been to regain the interpersonal relations approach to mental health nursing, through a spiritual re-visioning and adaption. By pursuing spiritual and relational concepts significant to the women, the study methodologies offer a lens through which to review understandings of interpersonal nursing, going beyond empathy towards, what McAndrew *et al.* (2014) refer to as *sensitive attunement*, to the other. Theoretical constructs that rely on deep human connectedness, therapeutic dialogues and the creation of safe healing environments are tempered, however by the everyday complexities of praxis, whether in research,

nursing or education (Griffiths & Leach, 1998). Similarly, the language constructed around otherness and disorder, is often at odds with messy reality and fails to voice the subtle adjustments nurses and patients are required to make in response to constructed worlds experienced as destructive and oppressive (Barker & Buchan-Barker, 2004b; Wilson Schaef, 1987; 1991). A key assumption of the study is re-stated, that mental health problems are part of the human experience and that mental health nursing is crafted and practiced within lived contexts of people who are physical, psychological, social and spiritual beings (Swinton, 2001; Barker 2003; 2004b). Interpersonal nursing is a human partnership between the one being nursed, in need of that service, and the one nursing, educated for that task (Griffiths & Leach, 1998). From these perspectives, MHN education is concerned with 'fitting' the novice nurse for deep and subtle inter-relating (Benner, 2000).

Clarke's (2013) proposal that spiritual care is woven into the fabric of caring, through authentic, ordinary, nursing relationships, is supported by the women's narratives. Intentional responding to the other with one's whole being, in *I-Thou* relationships, opens transcendent potential for the nurse (self) being-in-the-world, to become inter-connected with service user (other) being-in-the-world (Buber, 2010). The study suggests developing knowing and acting *with* other as ways of being which enhance the knowing, acting and becoming of the other. Spiritualities are uncovered in-between selves, others and spaces, through relational telling. Differences in spiritual awareness and maturity of nurse and patient might be thought to inhibit collaborative journeying; those with lived experience gaining through struggle and suffering (Barnum, 2011; Moody & Carroll, 1997). The study finds, however, that it is not suffering alone which develops spirituality but rather the meaning that is made of it. Nurse and patient can be seen to travel parallel roads; not to merge, but rather to move onwards together, learning with and from each other, relating inter-spiritually in genuine soulfulness.

Working with fluidity of self-concept, however, produces as many opportunities to harm as to help. MHNs are required to develop self-surveillance through deep inner work, ensuring clear pathways of intra-action and inter-action. Being able to draw from the whole (self) but not necessarily to fully engage with the whole (of self and

other) and developing compassionate self-care, facilitates a working presence which is both protected and protective (Neff & Germer; Gilbert, 2010). Boundaries need to be fluid and permeable, acknowledging and valuing vulnerability, while accessing wise guidance through supportive supervision, delivered in safe exploratory spaces (Heron, 1999).

5:4 Praxis in the Dimensions of Spiritualities

While a spiritual dimension in therapeutic relationships is both valued by, and of value to, clients, a biopsychosocial model predominates mental health nursing. Authentic facilitation of the becoming and being of the other demands subtle inter-relational developments. In this discussion, praxis is taken to be practical knowledge in action or "action saturated with meaning" as Swinton puts it (2001: 176) and it is this praxis, which is now considered in the identified dimensions of self, relationship, space and recovery.

5.4.1 Praxis as Shifting Self

The study women experience themselves as shifting, restless and transient, with fluidity of internal and external boundary relations. Nurses' offer of containment is often experienced as restrictive of physical, psychological and spiritual movement. Haigh (2013) proposes a less oppressive dialogic openness and compassionate holding, difficult to adopt without the development of communities of support and practice which are not currently the norm. The position of this study is that, while, women living with BPD, experience something very particular, fluidity and shift is part of all human experience. The point is to develop a practice of intersubjectivity of thought and practice which honours the meeting of equals, though fundamentally differentiated, has similarities of shared humaneness. Such intersubjectivity, understood as the meeting of two authentic selves (Husserl, 1960; Charon, 2006) goes deeper than the usual requirements of empathetic nursing to a deeper negotiation of co-constructed, co-represented meanings and values. The nurse is not required to engage in the other's internal battle waged against themselves but rather to care for that person in compassionate mutuality. The joint sense of being-in-the-world grants fellowship and a sense of communion, which ameliorates otherness and enhances

equality. In the study, once engaged in deep conversations, the women were able to identify a sense of self that was strong, reflective and progressive.

The narrative elements represented by *embodied darkness*, is critically illustrative of this point. Symptomatised expression of darkness, linked to psychodynamic responses to early trauma or bio-medical neurochemical imbalance represent perspectives from external knowledge paradigms. While valid and useful in directing treatment, such explanations are unlikely to soothe the fear, horror and fragility of inner brokenness. Intersubjective selves can meet darkness authentically and imaginatively, through story, poetry or art (Leech, 2004; Charon, 2006). Similarly, bodies harmed and mutilated in distress, are eased, in the study, by cultivating attunement to the body, through distraction and re-centering activities. The physicality and focussing of walking, dancing, mindfulness and visualisation techniques are shared ways to re-attune, internally and externally (Hinterkopf, 2004; Bateman & Krawitz, 2013; Kabat-Zinn, 2004). This is indicative of a mutuality of nursing practice which involves less doing, specifically, less talking, and more relational, being-with; the peace, stillness and absolute necessity of attentive, focussed silence (Anon, 2001; Maitland, 2009). The reflective ability to anchor self, which the women demonstrate, during periods of ambient and critical stress, points towards a potential intersubjective anchoring. The task of the nurse is to facilitate the discovery or recovery of this potential in the other, while, at the same time developing it in the self. Such developments would enhance tolerance of shifting in nurses, while enabling them to be steady at the core, attuning to cues offered by the other (Nouwen, 1999). Assisting with the birthing of emergent selves, in their new ways of being is akin to midwifery, offering comfort through metaphorical (or actual) skin-to-skin contact.

5.4.2 Praxis of Dialectical Relations

The women encountered professional helpers, lacking in the essential knowledge, skill and aptitude for working with them and were easily able to identify those nurses who were either disinterested or hostile. In previous work, (Watkins, 2002) I found that nurses who wanted to work with BPD, had developed a different quality of nursing presence. Certainly, working therapeutically with people who have compromised

agency, involves avoiding the re-enactment of early traumatic patterns to provide safer opportunities for re-nurturing and developing coping (Nelson, 1994; Haigh, 2013). The challenge is to develop the kind of dialectical relationality which values the person for being who they are, yet at the same time, promotes and supports them in therapeutic change.

The narrative elements represented by being *strong for others*, demonstrate how caring for others can become a critical catalyst for self-care. The women are often held in the sway of powerful others, seesawing between fantasies of the perfect rescue or brutal abandonment, caught in relational push and pull conundrums. Genuine connections have been witnessed, which are characterised by acceptance, consistency and humour. The women have reserves of strength, 'borderline powers' (Van Gelder, 2012), which can be positively exploited rather than crushed. Normalising relationality is a beneficial antidote to crisis relationality, yet the women, like everyone, wish to experience being unique and special. Trainee nurses are better able to realise the potential of others to shine if they themselves are encouraged to shine; enabled in letting their own light shine, liberates them in the liberation of others (Williamson, 1992; Irigaray, 2008). Working collaboratively with, and for, others is a pathway of mutual benefit and beneficence for the nurse and the patient, travelling towards goals of care and compassion. Care in the service of others, is key to the nursing vocation but also key to wholeness and well-being; the ability of the nurse to be both sensitively human and humane. Tapping into the natural goodness that these women have shown respecting rather than pathologising the wounded healer, will promote compassionate, intuitive self- healing (Nouwen, 1990; 1994).

5.4.3 Praxis in Fluid Spaces

Physical and emotional spiralling seems to call for holding, stilling and steadying. Attempts to interrupt momentum or cease the motion, generally prove unhelpful, and, in any case finding find the right point for interruption, the *up and down*, the *in* and *out or* the *on and off*, is tricky. Empathetic attunement or moving *with* provides opportunities for understanding and allows the journey to continue. The nurse needs to practice self-anchoring and self-control, developed through meditative breathing,

mantra or prayer so as not be swept up in spiralling motion. The study illustrates that there will be a number of opportunities for pause and transition, in any case. To identify these naturally occurring turning points or crossings, sound knowledge of the terrain and a feel for the motion are needed. The narrative element of navigating crossings is symbolic of these process. Students are best prepared for co-habiting fluid spaces through experientially traversing the crossing points in their own lives, embracing transitional opportunities to explore new things and develop different perspective in the relative safety of the classroom.

Individual safe spaces are sought and created by each of the women; focussing on the unique essence of safety for each is key to understanding that individual (Barker & Buchanan-Barker, 2015). Once safety is negotiated, lasting haven can be built inter-relationally through journeying work and deeply internalised. Developing practices which are visual and tactile as well as vocal, safety-seeking rather than conflictual, which are mindful, inquisitive and emancipating will help (Janner, 2007; Bowers, 2015). If nurses are to provide experiences of the kind of compassionate holding, proposed by Haigh (1999; 2013) then, they need to have such experiences in their own learning and support, developing foundations which are rooted and mutable, steady yet fluid.

5.4.4 Praxis for Recovering Selves

Recovering self**,** purposive and independent requires sensitive, inter-relational support, which values unique journeys of hope, adaption and acceptance. The narrative terminology of the study, suggests a recovering of self, which requires 'breaking with the core', potentially painful and damaging. Grief work and supportive counselling can help repair repeated cycles of loss, including loss of past or potential self and MHNs would be well served by being trained in this work. Serendipitous seeking requires an openness to the possibility of hopeful outcomes. Integrating positive psychology and compassionate mindfulness help develop attunement to positive potential, so that MHNs can intuitively prepare the spiritual groundwork for personal ambitions and future visions in the other (Deegan, 2005). Above all, being there with, and for, the other in intentional, embodied, anchored, kind attention is

significant in maintaining a hopeful journeying motif. In keeping with the numerous analogies to water in the study, a sailing metaphor seems apposite. With the patient steering, acting as helmswoman, the nurse might act as the navigator, suggesting the course in the light of predicted conditions, suggesting waypoints and stopping places for the journey to be re-evaluated. In this way, safe passage can be designed in tandem.

Reconstruction is the narrative element that completes the positioning for recovering selves. Deegan (2008) significantly recalled that it was not possible to build recovery from nothing. Restoring meaning and purpose in life is key in recovery-orientated nursing, sometimes requiring the gentle but firm push to the next place along the journey. While mindful of the need for rest and time for grieving, the nurse will not facilitate improvement by getting caught up in repeated patterns of stuckness. A recovery-orientated classroom likewise facilitates learners in the pursuance of ambitious goals for individuals and groups.

5:5 Bridging as Signifier of Student Experience

Spiritual education needs to be as subtle, complex and diverse as the spiritual care that it seeks to explore and inform. The literature review (Chapter Two) revealed tension between contemporary educational approaches seeking to apply certainty and evidence, and the need for pedagogies which value diversity, fluidity and flow. Clarke (2009; 2010) identified a dilemma at the heart of nursing in the omission of spirituality, postulating a three-way experience of the other, soul, spirit and body and a vision which includes spiritual care as fundamental to compassionate nursing care. In spite of the ambitions of some nurse educators to integrate spirituality into nurse programmes, learning strategies which satisfy theoretical and practice demands are not in evidence and current professional guidelines leave out spirituality altogether (McSherry, 2006; Barnum, 2011; O'Brien, 2011; NMC, 2015).

This study postulates that authentic engagement in spiritual work with others primarily requires spiritual work with, on, and for, self. As stated, processual becoming and being are identified by the women in the study as they adapt and adjust to lived and recovering *borderline* experience. The student nurse is also embarking on a

journey of discovery of self, others, place and meaning in their new vocational context. The development of 'genuine mental health nursing', invites fundamental renewal and change (Rolfe & Gardner, 2003; Freshwater, 2002). Current being (non-nurse self) is traded for future becoming (nurse-self) trading old ways of seeing and acting for new 'nurse' ways of seeing and doing (Swinton, 2001) through transitioning. In a reflected mirror image of the women living with BPD, nurse education forms a bridging process between the two, in the following way:

Figure: 5:1 Bridging for Recovery and Learning

In the same way, that bridging could be said to occur between states of *borderline* lived recovery bridging is a way of conceptualising educational and enculturation processes undergone by nurses in training. Service users and students may start in positions of different emphasis, but share experiences of disempowerment. While not seeking to underplay the distress and serious risks associated with BPD, nor to over-dramatize student stress, shared developmental essences and experiences of meaning are present. Both are in an unenviable situation of lived chaotic destabilisation, which is stressful and challenging; and, dialectically, both are in an enviable situation of lived chaotic destabilisation which is exciting and transforming. Shared understandings generate compassion, promoting safer relational experiences for patients and more supportive experiences for students. This is one reason why student nurses are so popular with patients. The bridging position is an opportunity for pause, taking stock and developing awareness of processual being-becoming-being. The perspectives and positioning of the women are educational bridging points for themselves and others.

Bridging has narratively been represented by questing, in part to capture the sense of seeking and pursuance and in part as reference to the holy grail, elusive, often sought and rarely found. Bridging is constructed as a foundational aspect of journeying towards something sacred and revered (Pargament & Mahoney, 2005). To explain, the bridge is built as the person experiences transition. For the women, this experience was represented by the narrative elements of Reflective Self, Letting Go, Navigating Crossings and Serendipitous Seeking. Students are required to undertake similar journeys of deep, contemplative, self-study, guided by teachers adopting a pedagogical stance, more akin to an adult andragogy of dialectic discovery and exploration, both valuing what the student already brings and facilitating their change (Knowles, 1984). Such learners require teachers able to provoke, challenge and illuminate, rather than confirm and settle; such teachers will first need to be able to engage with a processual bridging of their own (La Boskey, 2004).

5:6 Intersubjective Andragogy

By this, I mean a subtle, sophisticated, intersubjective andragogy of profound engagement with relational transformative learning cultures and genuinely co-productive partnerships. This section will describe the learning strategies, techniques and relationships that will make up the proposed andragogic stance, proposing a framework for use across curricula. Learning strategies will include the use of individual life experience as the starting point for processual reframing, in formulating "a dialectic of understanding and action" (Mezirow, 2000: xii). Assuming that we become through culture (Irigaray, 1985; 2008) healthy learning environments are those that exhibit meaningful diversity, becoming cultures of belonging (Haigh, 2013). Language is one site where cultural and perceptual differences can be located. The teacher is in a position to facilitate collaborative, creative, dialogues, which work with and through difference, developing citizenship of new worlds of knowing and acting (Irigaray, 2008). Genuine partnerships of educators, service users and students can engage intentionally co-productively to enable individual and communal change. Diverse perspectives of existence, paradigms of consciousness, learning and healing modes from other cultures, create new syntheses and common ground (Mezirow, 2000; Sunny, 2006; Zajonc, 2006).

Conducive educational environments, invite *learningful* relationships with students (Palmer, 2007). Spiritual teaching, practiced in the messy spaces in-between student and teacher, and students with each other, requires courageous teaching, mindful of a duty of care. Classrooms provide safe(r) learning spaces, protected from the realities of nursing practice, providing the teacher takes, what Watson (2005) referred to a carative approach, mindful of power dynamics which can make the students world smaller or larger, brighter or duller, safer or riskier. The spiritual teacher, like the spiritual nurse, needs support in developing their own spiritual pedagogy. Palmer (2000: 4), describing teaching with heart and soul, comments:

> A teacher has the power to compel students to spend many hours living in the light, or the shadow, of the teacher's inner life. Are we doing enough to help teachers-in-training understand their inner terrain in ways that will minimize the shadow and maximize the light?

Sometimes it is timely to let be and let learn, allowing threads and connections to form naturally. Sensitively taking opportunities for letting learn does not, however, preclude the equally important cultivation of internal and external spaces for learning (Fielding, 2008). The teacher's fine attunement enables the learner to cultivate *in-dwelling,* the inward spaces for transformation and letting them learn to form a phenomenological continuum between mutable leaning points of self-work and guided-work. Learning is enriched by fluidity of movement between roles and settings, places and spaces, cultivated amongst like-spirited people, sharing passion and interaction (Wenger, 2007). Community models, outside of the largely barren, resource-driven, existing paradigms for education and health, cross lines of geography, discipline and practice. On-line forums for supporting spiritual practice generate ideas and support. A community which challenges an increasingly competitive vocational training arena, can develop networks and cultures of learning and collaboration. Over time, this collective effort results in practices, which are the outward expression of developing human experience (Wenger 1998).

Finally, intersubjectivity occurs when two subjects or authentic selves meet. It is, as Charon (2006: 51) puts it, "in meeting with other selves that the self comes alive", with each being available for the other's consideration and regard (Husserl, 1960). As a

literature scholar I am attuned to the intersubjective relationships that are inherent in authorship, readership, interpretation and influence, catalysed by storytelling. Mutuality can be established from potentially life-enhancing meetings between teller and listener. In these acts, the women are both giving and receiving at the same time.

A learning framework is presented which informs the development of intersubjective andragogy, suited to spiritual education for MHNs that draws on these understandings.

Intersubjective Andragogy for Spiritualities in Nurse Education

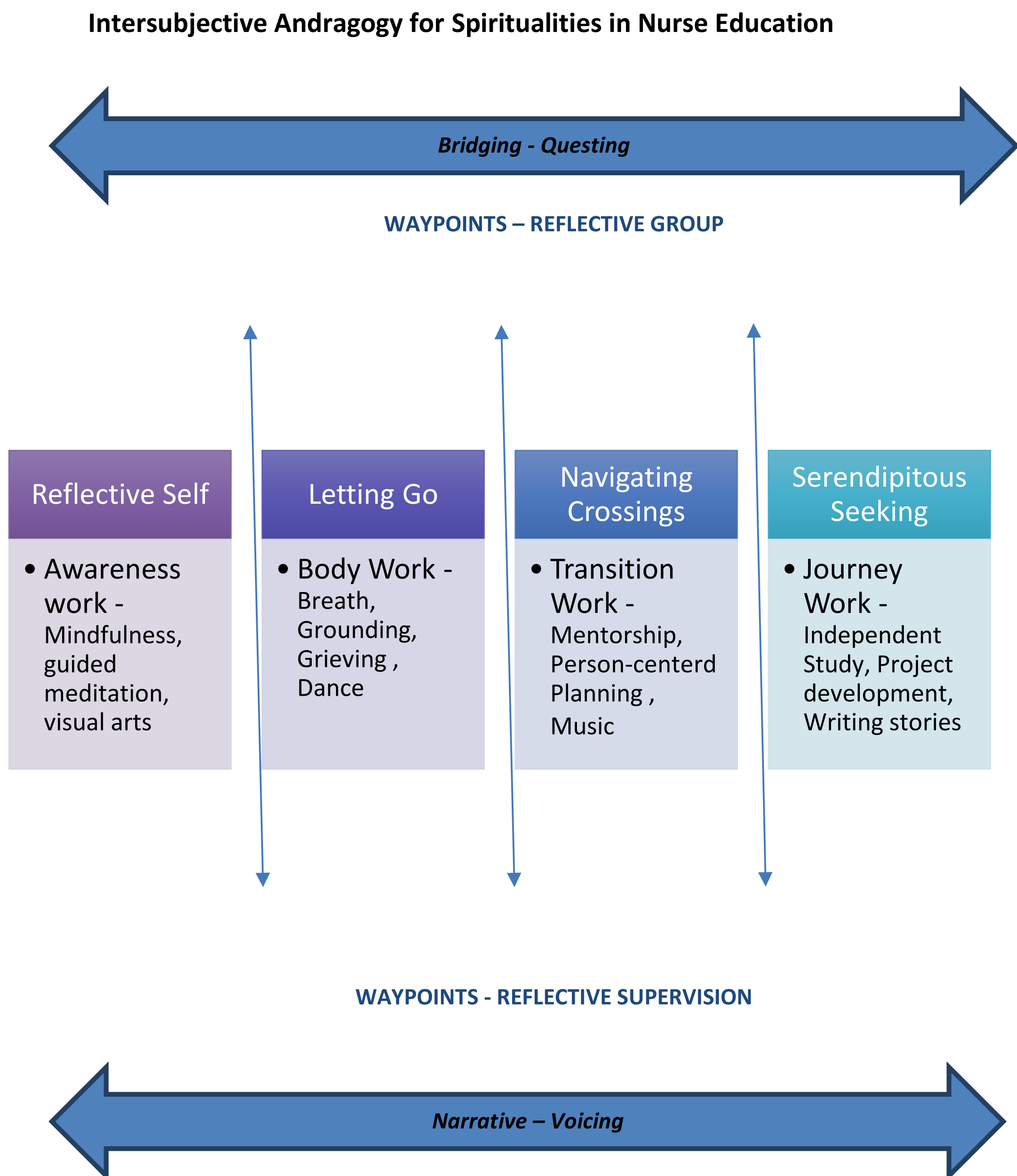

Figure 5:2 Developing an Intersubjective Andragogy

Each bridging element symbiotically links to a suggested learning strategy and an approach to vocational study and self-development. Each element includes work for self, with others, space and recovery. The waypoints in-between each section facilitate pause and contemplation through flexible, symbiotic concepts of bridging and voicing.

5:7 Limitations and Contribution of the Study

The necessary deep embedding in the women's narrative experience has had a profound impact on the researcher through the constant re-living of hurt and trauma, making the experience like insider research at times. Elements of the methodology were overly complex and unplanned, with multiple journeys around the same stumbling-blocks and along the same pathways, in service of emergent thinking in an inexperienced yet passionate researcher. On reflection, a more cohesive structure might have developed clearer insights and intellectual confidence to pursue a single method of data analysis, potentiating more time and energy for the end. Multi-various data analyses, however were suggested by the meandering and strongly embedded nature of the data, and have helped keep the thesis messy, in keeping with the lives and topic areas being explored. The analysis cycles became the way of entering into the worlds of confusion and, at the same time allowing for calm reflexivity and the deep understanding needed for researcher growth. As van Manen (2014: 45) advises

> A phenomenological text does not just communicate information, it also aims to address or evoke forms of meaning that are more poetic, elusive, or ambiguous, but that cannot be easily told in propositional discourse.

The above advice from van Manen also supports the inclusion of substantial contextual framing. On reflection, I wonder whether more of the literary, particularly poetic influences might have been included. The tension has been in balancing interest, subject and perceived doctoral demands.

The key achievement of this thesis has been to identify the essence of spirituality for women living with BPD and the possibilities this offers as a conceptual element in their self-knowing, self-adjusting and healing. Individual stories of richness and clarity and a shared conceptual narrative with thematic consistency have emerged. The study

reveals fluid, creative transformative spiritualities supported by relationships of forgiveness and love. Reflectively, this has proved a complex undertaking with difficulties following through on the diverse study aims. There seemed to me, however, to be points of commonality or waypoints in nursing conversational currency, the poor state of therapeutic relationships with patients diagnosed with BPD and the failure to incorporate spirituality in nursing curricula. The passion I share with many about the craft of mental health nursing, punitive discourses about the state of nursing and constant threats to mental health as a field of nursing, have been powerful drivers for the study (Francis, 2013; DH, 2015; 2016). Deepening the understanding of powerful lived experience can only further improve responses and more carefully crafted care. The emergent language and voice can potentiate new borderline discourse, creative dialogues and meaning. By showing how these meanings have revealed themselves illustrates how a phenomenological educational stance is available to support and develop MHNs in crafting creative, transformative, spiritual approaches (van Manen**,** 2014).

Professionally and critically, my own confidence and competence in developing an exploratory spiritual pedagogy is growing, in delivering topic specific sessions about spirituality and mental health. Reaching a wider audience, I was invited to speak at a Study Conference for learner teachers in April 2016 and in August 2016 where I presented at the International Bodytalk Student Conference. The first event, enabled me to develop the study findings from a developmental well-being perspective, while the second event provided an opportunity to critically reflect on the significance of voicing and transitional waypoints in recovery and restoration. Significantly with each step and each unveiling I have developed an intersubjective andragogic stance, to the point where I include spiritual learning strategies throughout my practice, ensuring that classes include time for movement, breathing, reflexivity, creativity and community.

5:8 Recommendations

The goal of the work has not been just to describe and interpret but to change things for the better and intended disseminations of the findings are doorways for further

discussion and interpretation. The hermeneutic spiral, not being quite complete leads into the possibility of further exploration. The results indicate not only the deep significance to these women of meaning and value, but also provide moving insights into ways of intervening therapeutically, within diverse world-views.

In nurse education, the study is a hopeful invitation in the consideration of the bridges can be constructed between nurses, teachers, students, service users and policy makers, so that the practice of interpersonal mental health nursing can (re)become an authentic holistic, healing craft, practiced with, and for, the patient. If nurse education is to radically change, it will be from the ground up, fuelled by the clamour of services users and students questioning existing models and ideologies. The next collaborative step will be to invite the participants to publish and speak about their part in the study and the findings. The educational framework will be further developed, and the resulting learning experiences studies and disseminated with students using social media to build cultures of belonging. The concept of intersubjective andragogy for the creative, embodied, contemplative and hopeful intentions in the development of whole persons in vocational education, will be critically developed.

The intended priorities for these next steps are included in figure 5.3 below, proposing local and national developments.

Priorities for Study Findings

In-House Opportunities
- Develop and disseminate intersubjective andragogy model
- Expand teaching sessions to include other fields of nursing
- Develop programme for advanced study in spiritualties and mental health

Academic Opportunities
- Make connections with universities where spiritualties and health are studied for joint work and research opportunities
- Presentation to national bodies for MHNs (MHNA and MHNP Conference)
- Use study findings to develop and study spiritualties in MHN education
- Develop and publish a text book on diverse spiritualties in mental health
- Build on recent presentation for medical humanities conference

Practice Opportunities
- Disseminate key concepts within local MH Trusts- staff and service users
- Build a community of practice with interested practitioners, service users, teachers and students
- Develop ongoing work with local religious groups on spirituality and mental health
- Investigate new service opportunities for women with BPD

Policy and Public Health Opportunities
- Representation to the NMC regarding the exclusion of spirituality the current code of conduct (NMC, 2015)
- Representation to NICE for involvement in new BPD guidance (NICE, 2009)
- Proactive raising of the profile of spiritualties and mental health
- Develop project work with local charities and schools regarding sprituallities and mental health of young people (QIC)
- Work with communities of people living with BPD to promote voice and public awareness

Figure 5:3 Priorities for Study Findings

5:9 Reflective Becoming

The study speaks ultimately of deep connections with moments of re-enablement and re-storying in lives in need of healing and hope. My ardent wish has been to fulfill my promise to each of the women that their story would be told and would in some small way make a difference. This is both the position and the mission of the thesis and in this venture, I am able to say on our behalf, we are successful. My current work, increasingly takes me to new locations of learning and transformative community projects in the furtherance of these aims. This includes working with students locally developing an innovative MHN society at the university and nationally collaborating with the DH in developing the first Future MHN Conference for students on February 14th 2015. Working with phenomenology has been challenging, yet, enlightening and

deeply satisfying. As a result, I have deeply experienced what it is to speak and write as other, while at the same time learning to speak as myself, becoming a researcher and writer. The passion to uncover unheard voices, adding something creatively different to complex stories of human journeying is undiminished. The thesis poses an an invitation for practitioners, in nursing and education to hear the voices, engage with the meanings and reconsider, recreate and transform aspects of practice.

For myself, a journey is only just beginning into worlds changed beyond imagining. Reflectively floating in-between worlds of darkness and light, terror and redemption has birthed a new compassionate contemplative spirituality. The doctoral study is my bridging. The study reveals that the women have a mode of being which is already becoming. They are awakening but their awakening is unrecognised. These narratives, developed in experiences of *borderline* shifting and fluidity illustrate a pathway for processual subjectivity, relevant to all and any in transition. For subject development to occur, individuals must continue to orientate themselves towards, what Irigaray (1985; 2004) refers to as, a divine horizon, the never-realised goal that facilitates continual transformation; nurturing newness for human becoming and Irigaray's new morning;

> *… acknowledging*
> *The importance of interdependence*
> *To which we all, could, and should, contribute …*
> *…something more kindly, uniting and hopeful.*

Trivedi (2007:68)

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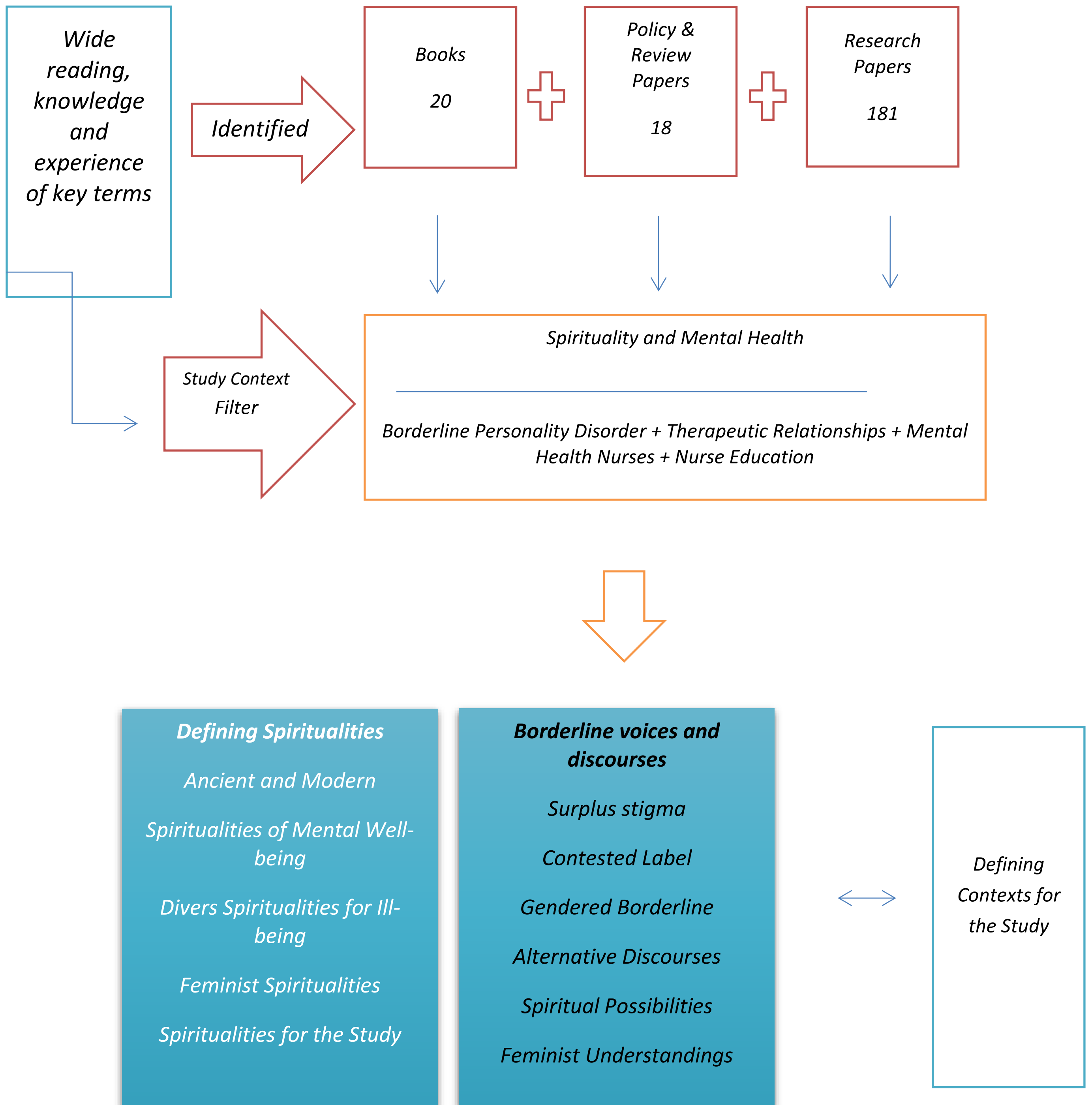
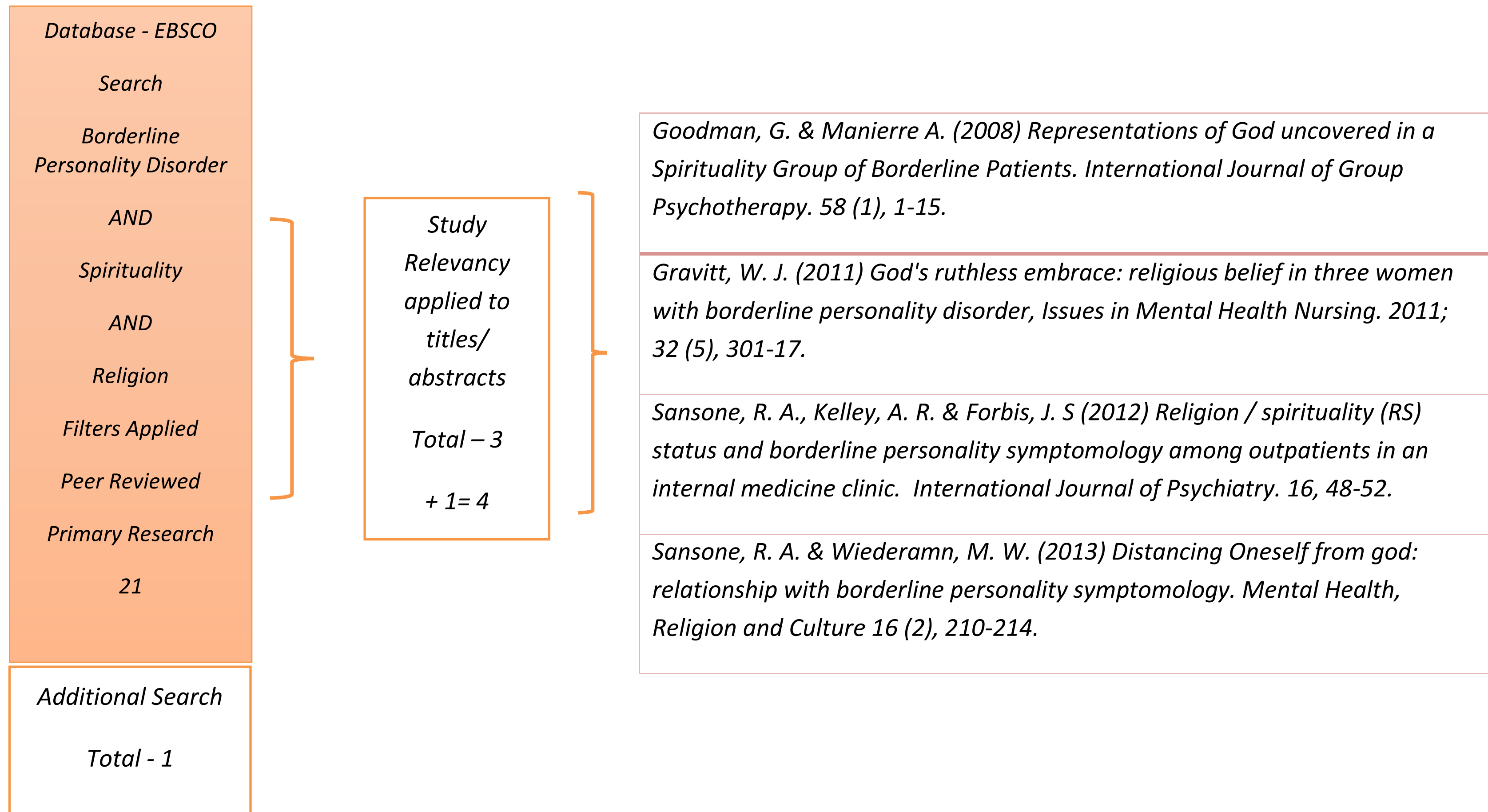
APPENDICES

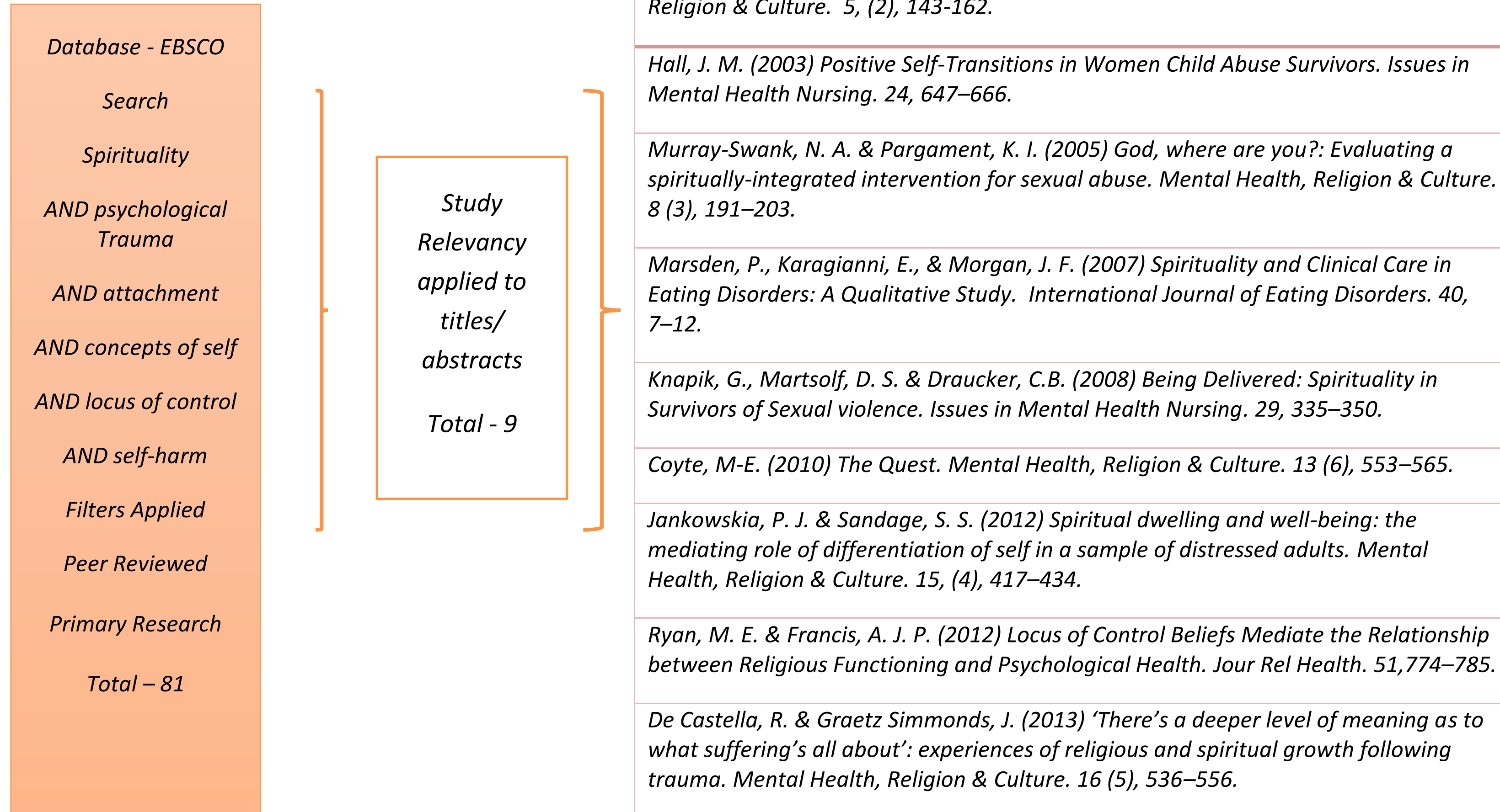
APPENDIX 1: Literature Search for Contextual Grounding



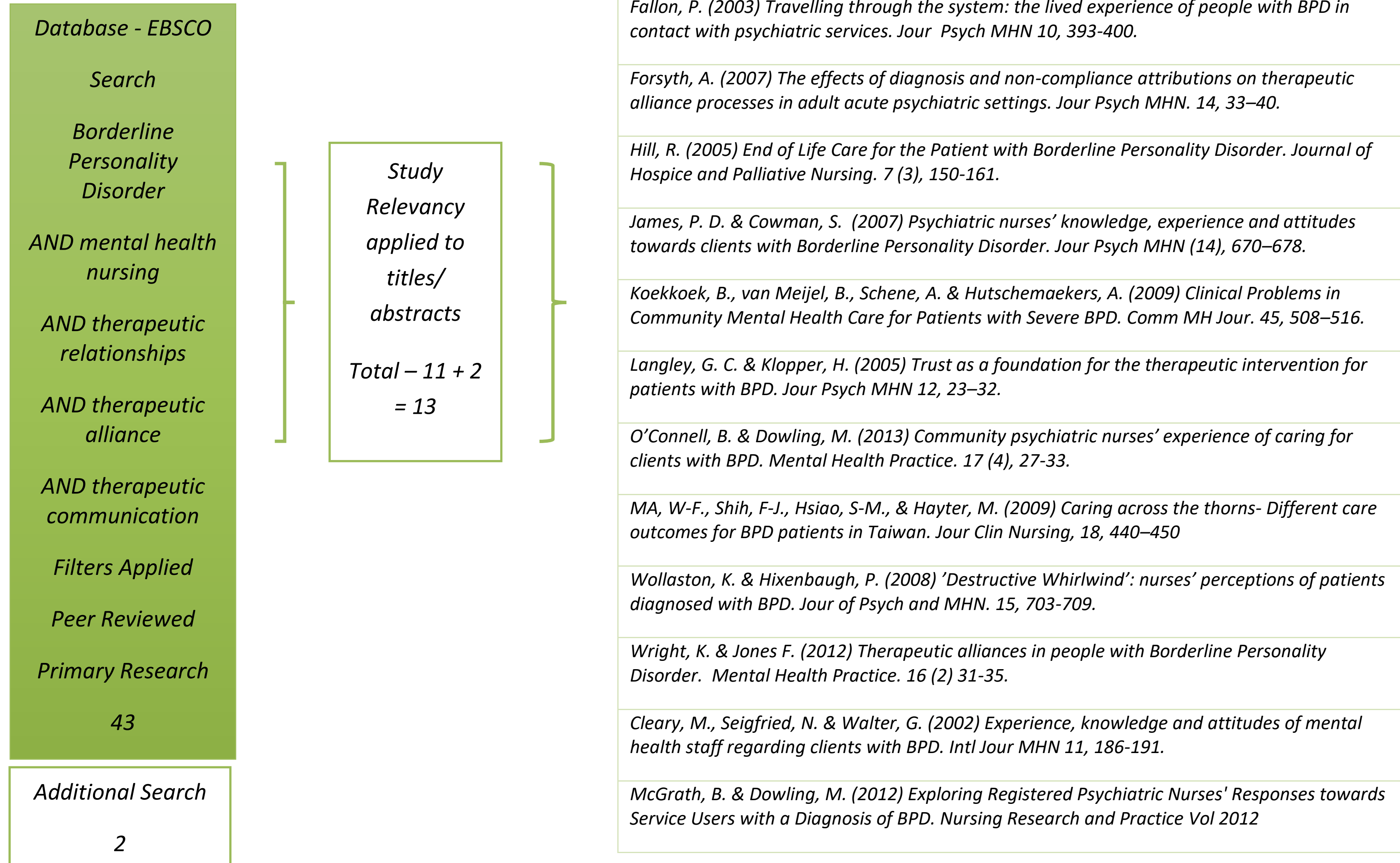
Appendix 2a. Diagrammatic Representation of the Literature Search BPD and Spirituality



Appendix 2b Diagrammatic Representation of the Literature Search '*Borderline*-type' and Spirituality



Appendix 2c. Diagrammatic Representation of the Literature Search for Therapeutic Relationships BPD and MHNs



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Cleary, M., Seigfried, N. & Walter, G. (2002) Experience, knowledge and attitudes of mental health staff regarding clients with BPD. Intl Jour MHN 11, 186-191.

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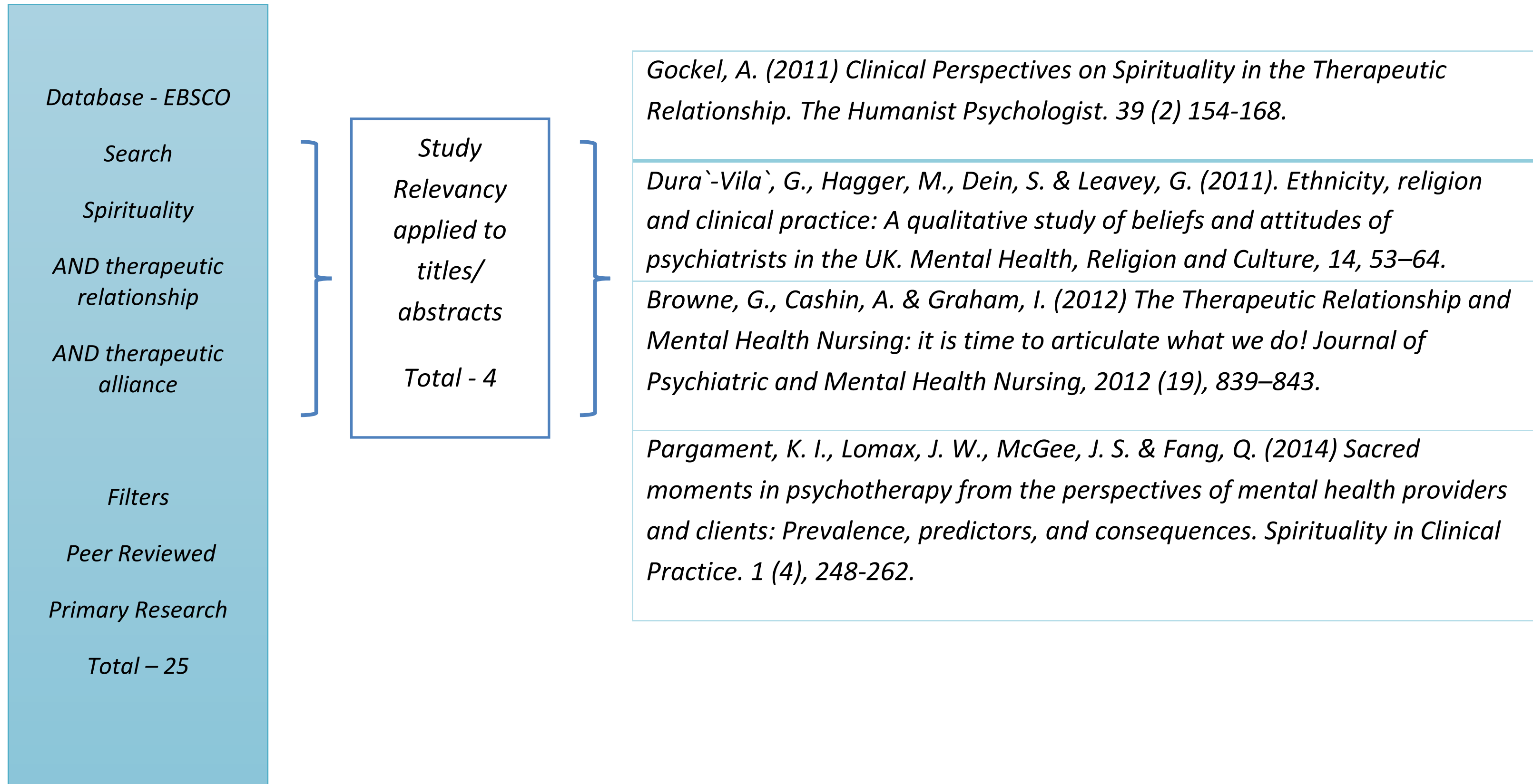
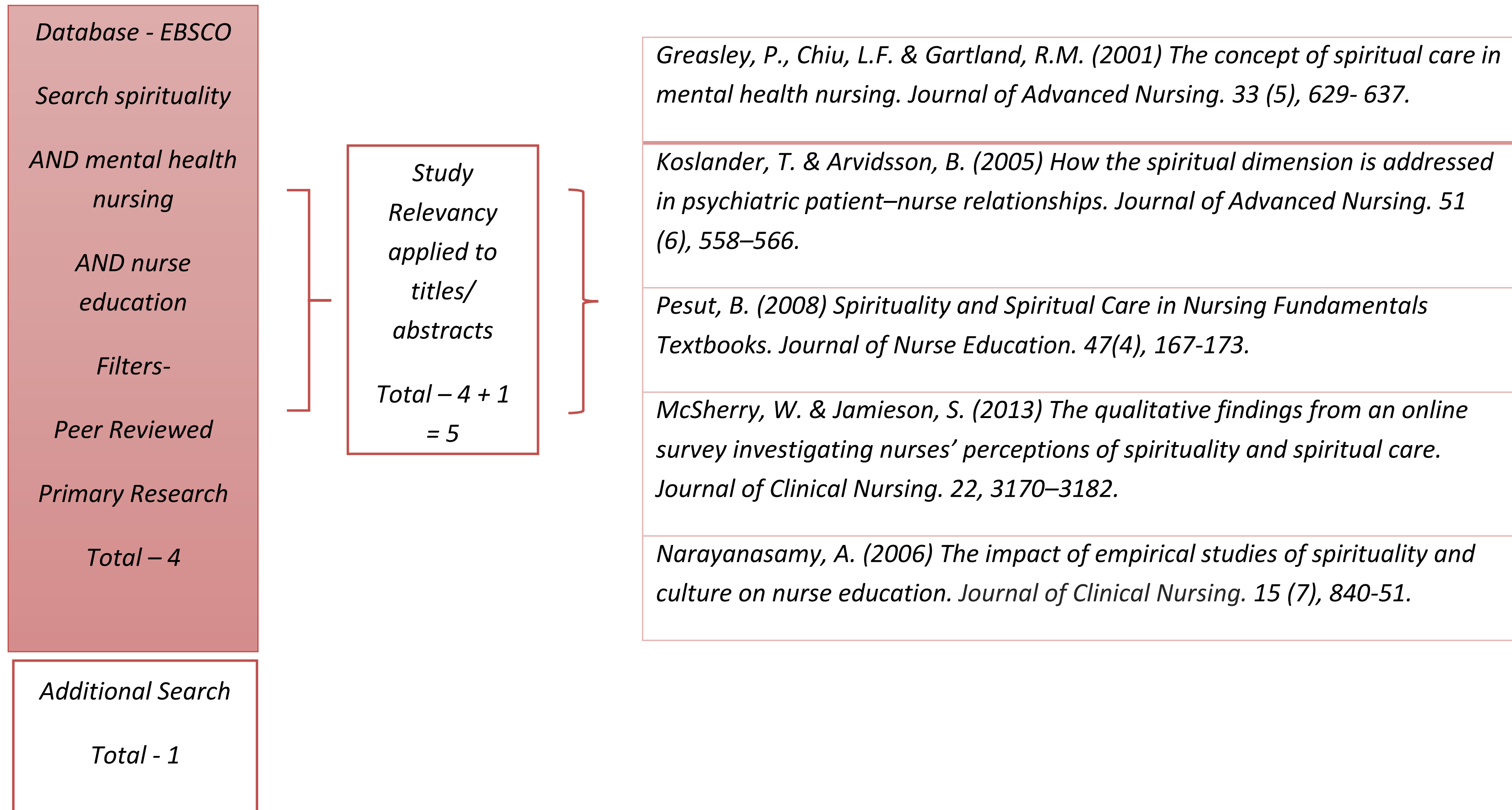
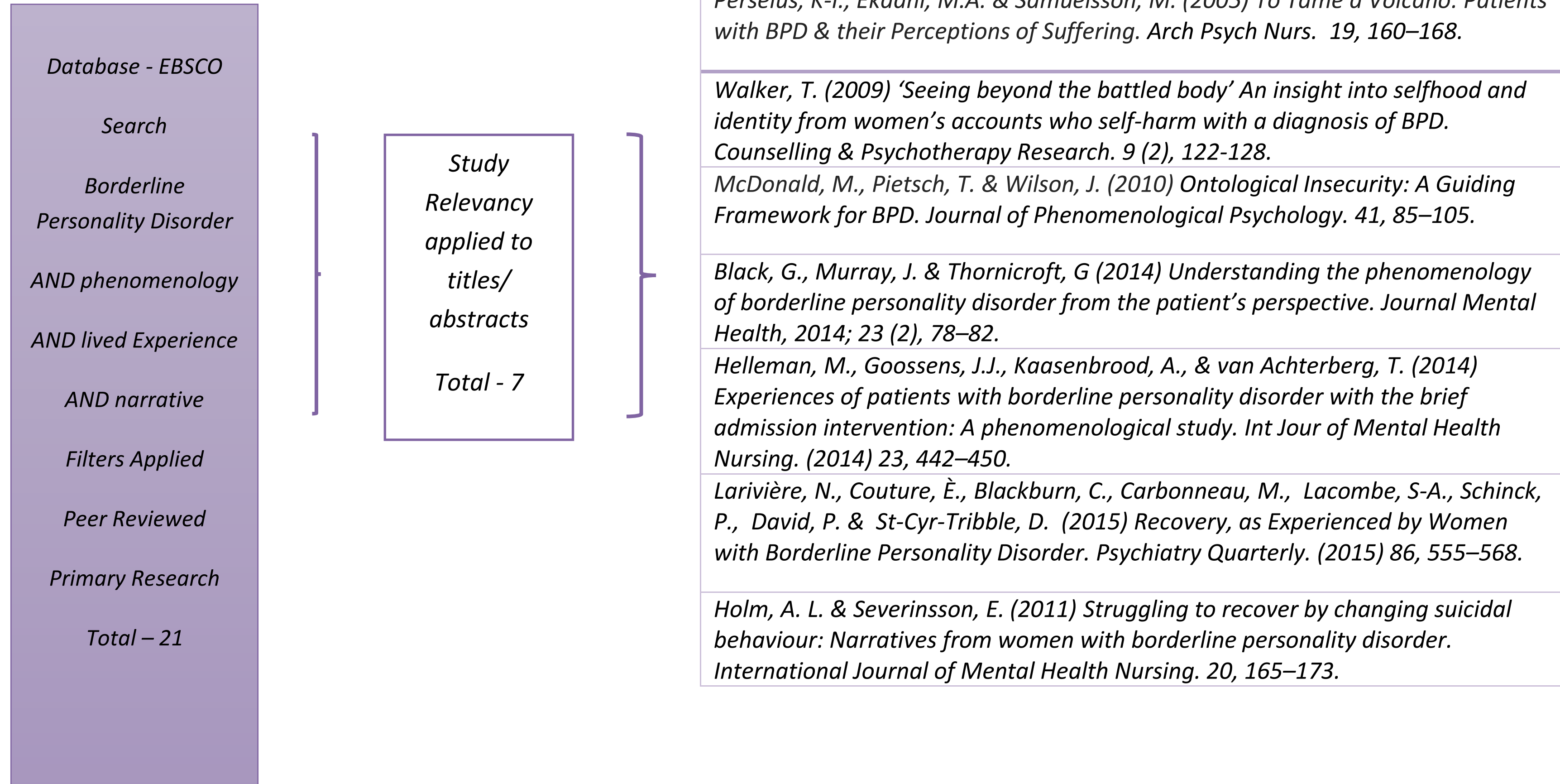
Appendix 2d Diagrammatic Representation of the Literature Search Spirituality in Therapeutic Relationships



Appendix 2e. Diagrammatic Representation of the Literature Search for Teaching Spirituality to MHNs



Appendix 2f (i.) Diagrammatic Representation of the Literature Search BPD and Lived Experience



Appendix 2f (ii) Diagrammatic Representation of the Literature Search BPD and Lived Experience

Additional Search

Study Relevancy applied to titles/ abstracts

Total - 4

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Appendix 3 Literature Matrix: Key Research Question: What does the current research literature reveal about the nature, essence, language and symbols used to define spirituality in (i) women who have BPD, (ii) people who have *borderline*–type issues?

Author Journal	**Date**	**Country**	**Title**	**Paradigm/ Approach**	**Methodology**	**Aim**	**Sample**	**Findings**	**Critique**
(i)	**Borderline Specific**								
1 Gravitt, W J. Issues in Mental Health Nursing 32: 301-317	2011	USA	Gods Ruthless Embrace: Religious Belief in Three Women with Borderline Personality Disorder	Phenomenology Narrative Exploratory	Qualitative, explorative multiple case study of 3 women with BPD from Christian backgrounds in USA. All currently in psychological therapy. 4 x sessions per participant: 2 x face-to-face semi-structured interviews, a projective test administered by a certified art therapist, and a semi-structured interview with the participants' therapist. Protocol was to elicit specific and comprehensive material about	To determine if 3 BPD viewed religion in characteristic and unique ways. To form a thesis and compare it with theoretical, psychodynamic construct – that of object relations/ attachment. Determine- will faith soothe or upset?	3 - selected by therapist	Participants shared a faith style resulting from developmental failure meaning that their representations of God matched early dysfunctional mother/ child dyad. In short, the belief systems of the participants seemed to represent a re-enactment of a dysfunctional mother-infant dyad.	**Strengths** Exploratory study giving voice to these unheard women. Theoretically sound. Method sought to elicit specific and comprehensive material Logically consistent (cf. Bateman) Information gathered 4 ways to provide consistency of findings. Addressing knowledge gap. **Weakness:** Small sample, all Judeo-Christian. Specific worldview has potential to become problematic when interviewing those with alternative perspectives. Limited theoretical vision inhibits women's voice. (cf my own research which is broader though less specific) Poor understanding of HOPE

					participants' religious beliefs in an honest & non-intrusive manner.				as concept- no understanding of recovery approaches. Bias in language.
2 Sansome, R.A., Kelley, A.R. & Forbis, J.S International Journal of Psychiatry 16: 48-52	2012	USA	Religion/ spirituality (RS) status and borderline personality symptomology among outpatients in an internal medicine clinic	Quantitative	Self-Report Survey questionnaires of RS, BPD	Exploration of evidence to test hypothesis that people with BPD would evidence low rates of RS	308 BPD outpatients USA - 74.0% female, 26.0% male, 18 to 92 years White/Caucasian (86.9%); however, 6.8% African-American, 2.6% Asian, 2.3% Hispanic, and 0.6% Native Am.	As BPD symptomatology increases, overall level of RS well-being decreases. This might be because BPD less RS (Snyder) or BPD tend to come from homes with less RS. It may also be that relationship between RS and BPD is explained through early traumatizing experiences & current re-victimization experiences (" If there were a higher force, how could this continue to happen to me? ")	**Strengths:** large group, with high uptake. Systematic methodology. Use of e-b tools. Findings consistent and robust **Weakness:** Self report survey. Lacks depth. RS tool – spirituality may require a broader concept. Snapshot - no follow up to check meanings.
3 Sansome, R.A. & Wiederamn, M.W. Mental Health, Religion	2013	USA	Distancing Oneself from god: relationship with borderline personality symptomology	Quantitative	Multi page survey + BPS scale Four data sets over two years	To measure the possibility that intentionally distancing self from God is a form of punishment which	1511 -, 496 males, 1014 female and one did not indicate sex. Ages	Distancing self from God may be a form of punishment (self-harm) behaviour associated with BPD - generating continuing conflicts over one's relationship with God	**Strengths:** Large diverse sample, (though 86.7% Caucasian) taken over time. Interesting results, which can support spiritual intervention for BPD. **Weakness:** pathologises spirituality. Lacks detail

and culture 16 (2): 210-214						emerged in data from Self harm inventory	18 to 97 years, 87.6% were White/Caucasian.	provides a practical venue for repetitively engaging pastoral and/or other counsellors into frequent contact – in an effort to generate ongoing support OR suggestive of underlying character pathology as opposed to religious/spiritual conflict??	with no history of individual spirituality. Fails to see spirituality as dimension of the whole self. No control –maybe other people also punish themselves in this way during periods of self-doubt, crisis or concern. Turning away from God may be a misguided way of getting Gods attention? Data are self-report subject to recollection, misinterpretation, denial.
4 Goodman, G & Manierre A. Int J Group Psychother. 58(1):1-15	2008	USA	Representations of God uncovered in a Spirituality Group of Borderline Patients	Qualitative Exploratory Psychodynamic	Group dynamic psychotherapy using group processes and art therapy to elaborate representations of God - described their clinical experience with a psychoanalytically oriented exploratory spirituality	To explore how a spirituality Group can facilitate change in BPD	9 female inpatients with BPD	Identified two general patterns of God representation: (a) a punitive, judgmental, and rigid God (a description that seemed to directly reflect participants' parental representations) and (b) a de-personified, inanimate, idealised and abstract God represented by flowing water and wind (a description that seemed to compensate for	**Strengths:** Richness of data- drawings and narrative. Introduction of a helpful and interesting approach to this issue. **Weakness:** Captive audience Analysis and findings are not in keeping with spirituality literature. There is no 'blind' evaluation of the data. Bias in the language. Misunderstanding of spiritual concepts (God-centric)

								Findings	Critique
								parental representations). With regard to relationships between RS and God as transitional object, loaded with parental traits.	
(ii)	**Borderline Type**								
Author Journal	**Date**	**Countr y**	**Title**	**Paradigm/ Approach**	**Methodology**	**Aim**	**Sample**	**Findings**	**Critique**
5 Coyte, M-E Mental Health, Religion & Culture Vol. 13, No. 6, Septembe r 2010, 553–565	2010	UK	The Quest	Service User Narrative	Critical reflection on collected Service User Narrative. One narrative transcribed in its entirety	To highlight importance to service users and survivors of being listened to in their own words and being able to tell their story as they choose	1 (2,3) real identifie d people –Fatima (and Ann and Mary Ellen Coyte)	Theme of quest is prevalent in all cultures and has relevance in Western, psychiatric contexts. Mental health difficulties are something, which can prompt quest. 'People with mental distress remain fixed in other people's world view' but become themselves through understanding and externalising their own story, 'I am' People find healing through mysticism and transcendent experiences such as prayer and forgiveness. Transcendent experience can be negative without adequate boundaries	**Strength** It's real lived experience - the individual accounts of persons I can link this to Premila's paper on Mariam Maule. Rich, meaningful, powerful. **Weakness** over-weighting and bias, involvement of researcher. Lacks theoretical consistency/ structural framework

								(see Nelson 94) Notes parallels between scientific/ faith communities determined their belief systems shall prevail, cannot accommodate mental distress within that in a healthy way.	
6 de Castella, R & Graetz Simmonds J Mental Health, Religion & Culture, 2013 Vol. 16, No. 5, 536–556	2013	Australia	There's a deeper level of meaning as to what suffering's all about'': experiences of religious and spiritual growth following trauma	Phenomenology	Transcribed data from semi-structured interviews with 10 women, self-identified as Christian, who had experienced spiritual or religious growth following various trauma were analysed using Interpretative Phenomenological Analysis.	To examine participants' phenomenological experiences of spiritual and religious posttraumatic growth (PTG).	10 women: experiencing trauma (incl. sexual abuse, domestic violence, traumatic bereavement, car accident serious illness) 1 yr prior to study, had experienced positive religious or spiritual	Results indicated how religion provided a framework that assisted participants to incorporate life changes, and to find meaning in their suffering. The most salient themes identified in relation to religious and spiritual PTG included: process of spiritual and religious growth, strengthening of religious and spiritual beliefs, and personal and spiritual growth and healing. Participants' trauma and associated distress prompted a process of questioning and meaning-making that facilitated deeply experienced personal and spiritual growth, and was related to intrinsic religiosity.	**Strengths:** Depth of analysis and richness of data. Variety of women's experiences. Meaning-making. Powerful, inspirational testimony, valuing experience and voice. **Weakness:** Bias and over-weighting. Small sample (but within parameters for his type of research)

							growth following event.		
7 Hall, J.M. Issues in Mental Health Nursing, 24:647–666,	2003	USA	POSITIVE SELF-TRANSITIONS INWOMEN CHILD ABUSE SURVIVORS	Feminist Narrative	Secondary narrative analysis of interviews with women child abuse survivors detailing positive transitions related to healing from childhood maltreatment. Considered both risk and resilience as aspects of marginalized individual and group experiences (Hall, Stevens, & Meleis, 1994; Hooks, 1984)	To answer: (a) What were transitional experiences associated with childhood abuse & after-effects as described in narratives? (b) What were dynamics of life transitions involving self-change that had positive outcomes? (c) What themes included in stories of positive transitions involving self-transitions after abuse?	55 African America n low-income women survivors of child abuse and neglect in recovery from substanc e abuse from Midwest ern inner city area.	Categorized themes from the narrative data into two processes—epiphanies and maintaining momentum—and six elements constituting the content areas of self-change: self-centering, ownership, interpersonal insulation, wilfulness, seeing options, and spiritual connection. Participants used the word “connection” frequently- It was the fact of connection, more than the object of the connection that was held in common. Maintaining momentum and shortening the time between epiphanies was found to be central. Tentative clinical implications discussed.	**Strengths:** Explicit genre - solidarity/ empathy with participants and abuse survivors, critique of social structures, using women’s voices as a source of critique of social structures. Positive, seeking resilience rather than perpetuating victimisation **Weakness:** The study was preliminary in that it was a secondary analysis**.** Bias – over-weighting? Over-identification?
8 Jankowski, P.J. & Sandage, S.S	2012	USA	Spiritual dwelling and well-being: the mediating role of differentiation of self in a	Quantitative	Data were collected on a sample of distressed graduate students at a Protestant-affiliated	To provide theoretical framework and examine mechanisms of the spirituality-	140 graduate students from a Protesta nt seminary	Higher levels of DoS (Differentiation of Self) will have greater capacities for (1) spiritual and interpersonal intimacy	**Strengths:** larger sample. Suggests sp maturity is a process of integration of sp searching and sp dwelling which leads

Mental Health, Religion & Culture Vol. 15, No. 4, April 2012, 417–434			sample of distressed adults		university- given questionnaires	wellbeing association.	at a Midwest university from initial sample of 416	and (2) persevering during times of struggle. Results supported two hypotheses, thereby offering support for the differentiation-based spirituality premise that the mechanism by which spiritual dwelling is associated with well-being involves the capacity to regulate negative emotion. Findings discussed in context of existing mediation models in the literature & implications for future research on DoS and spirituality.	to wellbeing. Highlights complexity **Weakness:** overly specific in measuring DoS- not a widely accepted concept so in spite of larger sample may not be generisable. Small and predominantly Euro-American distressed sample from a Christian-affiliated university in the Midwestern US. Research Paradigm, methodology and procedure unclear
9 Knapik, G., Martsolf, D.S & Draucker, C.B. Issues in Mental Health Nursing, 29:335–350, 2008	2008	USA	Being Delivered: Spirituality in Survivors of Sexual violence	Grounded theory	Data drawn from open-ended interviews. Grounded theory used to develop core category of Being Delivered, reflecting participants' experiences of being rescued, saved, or set free from the effects of sexual violence by a spiritual being or power.	A grounded theory study proposing a theoretical framework to describe how women and men use spirituality to respond to experiences of sexual violence.	50 - 27 women and 23 men who participated in a larger, ongoing study of women's and men's responses to sexual violence.	Theoretical framework, Being Delivered composed of 3 dimensions: Spiritual Connection, Spiritual Journey, Spiritual Transformation. Frame-work can be used to guide discussions of spirituality and healing with survivors of sexual violence. Findings do not suggest that religious dogma played significant role in healing; rather what was important was	**Strengths:** Open questioning of respondents and representation of them. Lovely rich data, well written and presented. Represents shared experience. **Weakness:** Lack of diversity in sample – all Christian. Recalling the past may promote bias (like my study?) Framework is basic

								survivors' relationship with a divine being, the spiritual path they took, & possibility of transformative spiritual experience	and requires further detail in use
10 Leibrich, J. Mental Health, Religion & Culture Volume 5, Number 2,	2002	NZ	Making space: spirituality and mental health	Autobiographical narrative	Lecture given by a survivor of mental illness—	Communicate the importance of both spirituality and mental health in terms of the experience of the self	1	Value of communication and sharing experiences via personal stories. Contrasts communication and control, emphasizes the importance of making space to accept our own and others' imperfections and vulnerabilities. Discusses way in which mental illness can lead to spiritual progress, and ultimately to mental health.	**Strengths:** Powerful autobiographical testimony. I love his paper – it has wisdom and depth **Weaknesses :** Loses the thread sometimes – lacs under-pinning theoretical framework or structure
11 Marsden, P., Karagianni, E., & Morgan, J.F. Int J Eat Disord 2007; 40:7–12)	2007	UK	Spirituality and Clinical Care in Eating Disorders: A Qualitative Study	IPA Phenomenology	Method: Qualitative study using purposeful sampling, applying audiotaped and transcribed depth interview, subjected to interpretative	Potential links between ED & religious asceticism. This study aimed to examine relationships between ED, religion, treatment.	10 adult Christian Women receiving inpatient treatment for anorexia or bulimia nervosa.	5 categories emerged: locus of control, sacrifice, self-image, salvation, maturation. Appetitive control held moral connotations. Negative self-image common, based more on sin than body-image. Medical treatment seen as salvation, with religious conversion manifesting quest for healing, but treatment	**Strengths:** In-depth interviews providing rich and interesting data on a little researched area. Quest comes up again **Weakness:** Lack of SU involvement in research process- lack of voice of both researcher and researched.

								failure threatened faith. Beliefs matured during treatment, with prayer, providing healing relationship. Religious beliefs affect attitudes and motivation in eating disorders. Clinicians' sensitivity determines how beliefs influence clinical outcome. Spiritual practice is helpful for some patients in recovery from ED & spiritual development is synchronous with positive psychological changes - evident in category of 'maturation'. Others experienced difficulty in untangling religious practice from illness, consistent with previous findings, e.g. one used ritualized prayer to assert sense of autonomy & control.	
12 Murray-Swank, N.A. & Pargament, K.I. Mental Health,	2005	USA	God, where are you?: Evaluating a spiritually-integrated intervention for sexual abuse		Manualized sessions from the intervention, Solace for the Soul: A Journey Towards Wholeness, with an individual therapist.	Evaluation of effectiveness of spiritually-integrated intervention in order to demonstrate importance of	2 female survivors of sexual abuse	Both clients increased in positive religious coping, spiritual well-being, and positive images of God. In addition, ARIMA intervention analyses revealed significant changes during course of intervention (e.g.	**Strengths:** Unusual in the literature in that this study evaluates a spiritual intervention. Number of different measures were used **Weakness**: bias of researchers who set

Religion & Culture September 2005; 8(3): 191–203					Comprehensive measures of spiritual well-being, religious coping, and images of God pre and post-intervention, and 1–2 months later	Intervening with clients in the midst of spiritual struggles to aide process of mental, physical, spiritual recovery.		increased daily use of positive religious coping). Spiritually-integrated programs, such as Solace for the Soul, show promise in enhancing spiritual recovery from childhood sexual abuse.	out to 'prove a point' using a theistic view of spirituality and their own intervention
13 Ryan, M.E. & Francis, A.J.P. J Relig Health (2012) 51:774–785	Aus	2012	Locus of Control Beliefs Mediate the Relationship Between Religious Functioning and Psychological Health	Quantitative	Participants recruited from churches in the Western suburbs of Melbourne, Australia. Questionnaire measuring (1) psychological and physical health, (2) the religious variables of awareness of God, instability and impression management, and (3) God, internal d external LOC domains.	This study investigated associative relationships and pathways of mediation between religious functioning, locus of control (LOC) and health.	The sample consisted of 122 Christians (79 women, 43 men) predominately Catholic, ranging in age from 18 to 80	Results: awareness of God & internal LOC associated with better health; external LOC and instability associated with poorer health. Internal LOC associated with health benefits; external LOC associated with poorer health outcomes. Results support claims that religious functioning can ameliorate symptoms of poor mental health or even help avoid mental illness altogether	**Strengths:** Only study found explicitly studying LOC and spirituality. Interesting findings and thoughts about relationship with God and the protectiveness of internal LOC?? Ethnic diversity of sample **Weakness:** Confusing presentation and over-complication of findings

APPENDIX 4: PARTICIPANT ADVERT

Faculty of Education and Health

Request for Study Participants

Borderline Personality Disorder and Spirituality

Are you interested in taking part in a research study?

I am looking for volunteers who are women aged 19-40 who have been given a label of borderline personality disorder, but who are not currently undergoing treatment for that disorder. You cannot take part in this study if you are a current NHS patient including outpatient or community services.

The study involves attending a one hour taped interview with me, as the primary researcher and talking about your experiences and your spirituality.

Travel expenses can be reimbursed and I can travel to meet you.

For more information, please contact me on:

Deborah Watkins d.watkins@gre.ac.uk 020 83318072

Doctorate in Education Student, University of Greenwich, Southwood Site, London SE9 2UG

APPENDIX 5: PARTICIPANT INFORMATION SHEET

Participant Information Sheet

Borderline Personality Disorder and Spirituality

Thank you for your interest in this study

Purpose of Study

The purpose of this study is to explore the experience of spirituality for women with borderline personality disorder (BPD) in personal and clinical contexts in order to inform therapeutic relationships. The study is being carried out by Deborah Watkins, EdD Student at the University of Greenwich. I am a registered mental health nurse and a qualified university lecturer. This doctoral study has been approved by the university research committee and is supervised by Francia Kinchington f.kinchington@gre.ac.uk and David Evans D.T.Evans@gre.ac.uk who may contacted for further details.

Participation Requirements

You need to have been diagnosed with BPD.

You must not to be currently receiving any treatment or support for this disorder from NHS services

You consider yourself to be in a state of relative wellbeing and stability, not currently in an 'acute' phase of distress

You need to have an identifiable support network in place

What you will be asked to do

Participation in this study will require you to attend *a meeting with the researcher in a private setting for an interview of approximately one hour during which time you will be asked some questions about the topic and encouraged to share your experiences.*

Risk of possible harms

Whilst the risks of harm coming to you are judged to be low, the exploratory nature of the interview may reveal themes that you find difficult or distressing. If you become distressed due to anything brought up by the interview, I will encourage you to access your support

network. You may also access additional support via Rethink's extensive list of mental health crisis contacts and on-going support services on:

http://www.rethink.org/about-us/our-mental-health-advice/crisis-contacts.

Local mental health support and information can also be accessed via these links:
http://www.slam.nhs.uk/patients-and-carers/crisis-support
http://www.oxleas.nhs.uk/advice-and-guidance/how-to-get-help/

If I believe the interview is causing any undue distress, I may suggest that it would be better for you to cease participation. This does not reflect any failure on your part, only that perhaps it is not the right time for you to be taking part. Participation is entirely voluntary and you are free to withdraw from the study at any point, without giving any reason.

Confidentiality

Once the interview has been completed and you are happy with your answers, I will transcribe the interview into a word document. Names of people and/ or places will be replaced with pseudonyms to ensure confidentiality. Having used the information in my analysis, it will be stored in a secure place then destroyed. Other than me, access will be available to my doctorial advisors, Francia Kinchington and Dr David Evans. Whilst any information about you will be kept secure and confidential, in the event that during the course of the interview information is revealed that represents a serious threat to anyone's safety, it may be given to the relevant authorities to prevent serious harm occurring.

Expected outcomes

By revealing how women given the label of BPD view themselves and others in relation to spirituality, it is hoped to influence education and practice in mental health. It is also hoped those taking part or reading the results will be in a better position to argue for more sensitive helpful practice. There is no reward for taking part in this study other than the knowledge that you will be assisting in a project that aims to improve the quality of care for individuals who share your diagnosis.

The results

The results of the study will take the form of a written report exploring the findings and my conclusions as to what they mean. This will be presented in full in my thesis and summarised in a 'research report paper' that will be available to you electronically. It may also be published in a mental health journal and presented at mental health conferences.

Questions you may have:

Where will the meeting take place?

I can meet with you in any private, secure place at a time that suits you. The room we will meet in will be a safe space where you will not be overheard or interrupted.

How long will it take?

One hour will be allowed for the meeting but we can stop at any time should you wish to.

What other information will I be required to provide?

Basic demographic information will be asked for including name, date of birth, ethnicity, faith and cultural background and a history of your diagnosis and your support networks.

How will the information be stored and who will have access to it?

The interview will be taped and a typed transcript will be made. All the information will be stored anonymously in a secure location. The information may be shared with my research supervisors who are Francia Kinchington and Dr David Evans

Will I be contacted again?

Yes. Once the data is collected I will contact you to give you an opportunity to comment

Will I be able to read the research?

Yes. You will be given an opportunity to view the research once it is completed

How will the information be used?

The information will be disseminated through published papers and conference presentations and in the longer term may form the basis for changes to education for mental health professionals.

Can I withdraw from the study once I have given consent?

Yes. You can withdraw your information from the research at any time prior to publication of the research. You will be informed of this date by letter.

Deborah Watkins d.watkins@re.ac.uk 020 8331 8072

EdD Student, University of Greenwich, Southwood Site, London SE9 2UG

If during the course of participating you wish to make a complaint you can make this to my research supervisor Francia Kinchington f.kinchington@gre.ac.uk

APPENDIX 6: INTERVIEW QUESTIONS

Participant Questions

Faculty of Health and Education

The participant will be asked 3 main questions with subsidiary questions, if required, in order to facilitate their personal narrative about their experiences of spirituality and mental health.

Q1. What does the term spirituality mean to you?

Subsidiary Questions:

What experiences do you consider to be spiritual?

What sustains you? What gives you hope?

What is the nature, essence and context (background) of your spiritual experience?

Q2. How does your spirituality relate to your mental health?

Subsidiary Question:

Do you consider your spirituality to be harmful or helpful in relation to your mental health?

Q3. Is there a relationship between your spirituality and your therapeutic experiences?

Subsidiary Question:

Have you ever discussed your spirituality with someone who helps you?

APPENDIX 7: ETHICAL APPROVAL LETTER

Deborah Watkins
School of Health & Social Care
Department of Family Care and Mental Health
University of Greenwich
Avery Hill Campus
Avery Hill Road
Eltham
London
SE9 2UG

Direct Line 020 8331 8842
Direct Fax 020 8331 8824
Email research_ethics@gre.ac.uk
Our Ref UREC/12.5.5.17
Date: 2nd August 2013

Dear Deborah,

University Research Ethics Committee – Application ref. 12.5.5.17

Title of Research: Exploring the role of spirituality in therapeutic relationships of women with borderline personality disorder (BPD) in their relationships with mental health nurses.

I am pleased to confirm that the above application has been **approved** by the Committee and that you have permission to proceed.

I am advised by the Committee to remind you of the following points:

You must notify the Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Committee and/or which would raise questions about the safety and/or continued conduct of the research;

You must comply with the Data Protection Act 1998;

You must refer proposed amendments to the protocol to the Committee for further review and obtain the Committee's approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).

You are authorised to present this University of Greenwich Research Ethics Committee letter of approval to outside bodies in support of any application for further research clearance.

On behalf of the Committee may I wish you success in your project.

Yours sincerely

John Wallace
Secretary, University Research Ethics Committee