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Bridging Lived Experience and Neurodiversity: An Interpretative Phenomenological Analysis of Engagement Amongst Young People with Borderline Personality Disorder Features and a Systematic Review of Comorbid Borderline Personality Disorder Features and Attention Deficit Hyperactivity Disorder

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Chapter 1

Borderline Personality Disorder Features and Attention Deficit Hyperactivity Disorder in Adolescents:
A Systematic Review of Comorbidity and Shared Mechanisms

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Abstract

Background: The diagnosis and management of psychiatric disorders are often complicated by overlapping phenotypes, co-morbidities, and blurred diagnostic boundaries. Borderline Personality Disorder (BPD) and Attention Deficit Hyperactivity Disorder (ADHD) exemplify this complexity given their overlapping presentations. BPD typically develops in adolescence, and the onset of ADHD is in childhood; developmental trajectories of both disorders significantly influence clinical presentation, symptom severity and functional outcomes. Establishing the prevalence of this co-morbidity during its emergence, alongside the possible mechanisms, is critical for targeted early intervention. Accordingly, this systematic review aimed to: (1) estimate the prevalence of co-occurring BPD/BPD features and ADHD in adolescents through a meta-analysis, and (2) synthesise evidence on the potential mechanisms.

Methods: A systematic search across four databases (PsycINFO, MEDLINE, Embase, CINAHL) identified seven studies which met the eligibility criteria (1,828 participants). Studies were independently appraised by two reviewers using the Crowe Critical Appraisal Tool (CCAT). A random-effects meta-analysis was performed to estimate the pooled co-morbid prevalence rates, and a narrative synthesis was utilised to integrate findings on possible mechanisms underpinning the developmental trajectories of BPD/BPD features and ADHD.

Results: The pooled prevalence of co-morbid BPD/BPD features and ADHD was 12.6% (95%, CI: 6.7% - 22.4%). A high rate of heterogeneity was observed across the included studies (I^2 = 88.2%; $p < 0.0001$), likely attributable to variation in sample characteristics and diagnostic methods. The CCAT quality appraisal indicated differing levels of risk of bias across reviewed studies. The narrative synthesis revealed converging evidence for shared mechanisms involving deficits in impulsivity, inhibitory control and arousal.

Conclusions: Co-morbid BPD and ADHD represents a clinically significant and developmentally meaningful constellation of symptoms associated with heightened impulsivity and complex clinical presentations. The current findings highlighted the necessity of comprehensive early identification, integrated assessment and developmentally informed intervention models that target transdiagnostic features. These findings are preliminary, with future research needed to address heterogeneity through standardised diagnostic practices and larger sample sizes, thereby strengthening the evidence base.

Key words: Borderline Personality Disorder, Attention Deficit Hyperactivity Disorder, Co-morbidity, Mechanisms, Adolescents

Background

Borderline Personality Disorder (BPD) is a serious mental illness associated with persistent instability in interpersonal relationships, self-image, affect and impulsivity (American Psychiatric Association, 2013). Such difficulties often manifest in high levels of distress, impulsive risk-taking behaviours, and self-harm. Epidemiological evidence highlights the profound long-term adverse impacts on individual, social, emotional and occupational functioning, and society at large due to reduced life expectancy and increased mortality (Hastrup et al., 2022; Schneider et al., 2019). Features of BPD typically peak between adolescence and young adulthood (Chanen et al., 2020), a key developmental period marked by increasing independence whilst cognitive and emotional functions continue to develop into adulthood (Sharp, 2020). Despite the controversy in diagnosing BPD in adolescence, there is increasing evidence supporting its reliability and clinical validity (Miller et al., 2008). Identifying the aetiological processes to support early detection reduces the likelihood of missed opportunities and enables early intervention to mitigate or prevent the long-term outcomes associated with BPD (Kaess & Cavelti, 2025).

The developmental pathways for BPD can be understood by examining the dynamic interaction of biological, psychological and sociocultural factors across critical developmental periods (Wilson et al., 2021). For example, invalidating experiences (e.g., maladaptive parenting or trauma) are central to BPD development, and show a complex interplay with a child's temperament vulnerabilities, including behavioural and emotional dysregulation (Crowell et al., 2009). The association between exposure to childhood trauma and development of BPD is well established (Yuan et al., 2023). However, the science behind maltreatment and neurobiology of childhood trauma is typically more complex than a deterministic and reductionist view of maltreatment outcomes. Most of this research is limited in its design and an exclusive focus on trauma neglects the complex interplay of heritable and temperamental factors (Lang et al., 2023).

Neurodivergence is a key factor associated with maltreatment; research indicates that maltreated children are at a higher risk of neurodevelopmental load, which is not causal, but explained best by shared familial factors including, genetics, environment or both (Dinkler et al., 2017). Children with both neurodivergence and trauma exposure are at double the risk of developing severe mental illness later in life (Gajwani et al., 2022), suggesting neurodivergence may play a more significant role in the aetiology of BPD than previously realised. One influential theory which may account for this co-occurrence is Linehan's (1993) biosocial theory which conceptualises how co-morbidity may arise due to the interaction between innate biological vulnerability and an invalidating environmental. The multifaceted interplay of BPD and neurodivergence is further complicated by shared features, including impulsivity and emotional dysregulation, which may obscure diagnostic distinctions or mean individuals with trauma-related disorders have unidentified neurodivergence.

Attention Deficit Hyperactivity Disorder (ADHD) and BPD share common behavioural and neuropsychological impairments which may reflect a developmental link; despite this, this association has received comparatively less attention in the literature. ADHD is one of the most common neurotypes that manifests in childhood and persists into adulthood and is characterised by inattention, hyperactivity and impulsivity (American Psychiatric Association, 2013). Common mechanisms between BPD and ADHD may include dysfunction in the prefrontal cortex, thereby implicating overlapping neurological and behavioural mechanisms, such as impulsivity and poor emotional regulation (Dowson et al., 2004; Philipsen, 2006). Research has also identified childhood hyperactivity and impulsivity, alongside adverse experiences, as predictors of BPD, thus necessitating the consideration of neurodevelopmental vulnerabilities which may shape the development of BPD (O’Grady & Hinshaw, 2023).

Studies have demonstrated greater-than-chance co-occurrence of BPD and ADHD. Strong associations have been found in adult populations: 30-60% of adults with BPD also met criteria for ADHD (Matthies & Philipsen, 2016) and up to 34% of those with ADHD had co-occurring BPD (Ditrich et al., 2021). Co-morbid BPD and ADHD has also been evidenced among adolescents and is known to have a profound influence on a young person’s clinical presentation, symptom severity and increased externalising pathology (Speranza et al., 2011). However, the majority of the literature is largely focused on adult populations and prevalence variation is common due to differences in sampling, measurement and age windows. Neglecting the critical development period of adolescence also withholds the opportunity to consider early intervention.

Clinically and scientifically, it remains unclear whether overlapping presentations indicate comorbid BPD and ADHD, or whether the apparent diagnosis of one of these conditions arises from overlapping symptoms or diagnostic overshadowing. Failure to accurately distinguish BPD from ADHD can be problematic as BPD is associated with an elevated risk of self-harm and suicide and has potentially unique treatment needs from ADHD (Ditrich et al., 2021). Equally, patients with ADHD who are misdiagnosed or unidentified will not receive effective treatments and may experience sequential mental health and psychosocial impairments (Okumura et al., 2021).

Overall, the heterogeneity of phenotypes, co-morbidities and categorical boundaries for disorders poses a challenge to the diagnostic process and management of mental health disorders (Robbins et al., 2012). A full understanding of one disorder is not complete without understanding the common co-morbidities and underlying mechanisms. Moreover, accurate diagnoses enables a shared understanding and influences how a person learns to relate and be related to by others (Kazdin et al., 1997); BPD and ADHD are two disorders subject to this complexity. The existing literature, largely focussed on adults, demonstrates co-occurrence and mechanisms (Dowson et al., 2004; Philipsen, 2006), which may underlie the developmental trajectory. A systematic review aimed at establishing the pooled-prevalence and mechanisms across BPD/BPD features and ADHD in adolescence would contribute to diagnostic clarity and inform early intervention initiatives. The aims of this systematic review are two-fold: (1) To estimate the prevalence of co-occurring BPD/BPD features and ADHD in adolescents through meta-analysis, and (2) synthesise evidence on the potential mechanisms underlying this co-morbidity.

Review Questions

Primary Research Question

- What is the prevalence of co-occurring BPD/BPD features and ADHD in adolescents?

Secondary Research Question

- What are the possible mechanisms that explain the association between BPD and ADHD in adolescents?

Methods

Registration

This review was registered (https://www.crd.york.ac.uk/PROSPERO/view/CRD420251020825) with the International Prospective Register of Systematic Reviews (PROSPERO), and written in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) checklist (Appendix 1).

Search Strategy

A systematic search was carried using the following electronic databases: PsycINFO (Ovid)**,** MEDLINE (Ovid)**,** Embase (Ovid) CINAHL (EBSCO) on 16th December 2025. Search terms were developed following a scoping search and informed by Cochrane reviews carried out in both diagnostic groups (Storebø et al., 2020, 2023). ICD-11 and DSM-V classifications were considered to capture the full breadth of research and limit the risk of publication bias meaning search terms for both terminologies (BPD and EUPD) were included. Consultation with a librarian enabled the search strategy to be refined over time, balancing sensitivity and relevance. All searches were created using Boolean operators (OR and AND) and limited to English language and human subjects. See Appendix 2. for search strategies.

Eligibility Criteria

Inclusion Criteria

This review is exploratory and comparative in nature and does not focus on the effectiveness of an intervention. Therefore, the SPIDER framework, as opposed to the PICO framework, was used to define the inclusion and exclusion criteria (Cooke et al., 2012):

- Sample: Studies were included if their sample consisted of adolescents aged 10-19-years-old. Participants had to present with BPD features or diagnosis. A BPD diagnosis was not necessary as it is historically underdiagnosed in adolescence. For diagnostic clarity, ADHD diagnoses were considered instead of traits.
- Phenomenon of Interest: Explicit examination of the co-occurrence between BPD/BPD features and ADHD in adolescents.
- Design: Empirical peer-reviewed studies using observational, cross-sectional, longitudinal or cohort designs and published in English Language.
- Evaluation: Inclusion of at least one relevant outcome: Prevalence rates, or overlaps and differences in mechanisms (e.g., impulsivity and emotional dysregulation).
- Research type: Quantitative.

Exclusion Criteria

Studies were excluded based on the following criteria:

- Sample: Studies which solely focus on adults aged above 19-years-old or did not separate the adolescent data from their adult counterpart. Studies which exclusively relied on self-reported traits of ADHD were excluded since the diagnostic criteria requires symptoms to be present in childhood (American Psychiatric Association, 2013).
- Phenomenon of Interest: Sole focus on either ADHD or BPD/BPD features without co-morbidity.
- Design: Non-peer reviewed studies, case studies, reviews, editorials or commentaries will not be included.
- Evaluation: Excluded studies may have employed measures with a broader focus and not report on key outcomes, such as prevalence or mechanisms.
- Research type: Purely qualitative studies were excluded since they do not produce prevalence estimates or quantifiable comparisons.

Review Process

Using the pre-specified search terms related to BPD, ADHD, and adolescence, relevant databases were searched by the lead reviewer (EM) and all records retrieved were exported to Rayyan (https://www.rayyan.ai/), a systematic review management platform. Rayyan supported the process of removing duplicates. The lead reviewer carried out an initial screen of non-duplicated papers using the title and abstract against the inclusion criteria. A second reviewer (KO, Trainee Clinical Psychologist) screened 10% of these papers (104/1048), and interrater concordance was 96.15% at this stage. Discrepancies arose in relation to insufficient reporting of participant age and ambiguity around inclusion of ADHD diagnosis in the abstract; however, these were discussed during a consensus meeting until there was 100% agreement.

Full text versions which met the inclusion criteria were retrieved and subject to a full-text screening by the lead reviewer. A sample of these were reviewed by the second reviewer (4/38); interrater concordance was 100%. It was intended that a third reviewer could determine the inclusion of any studies, but this was not required. Backwards and forwards citation searching was also carried out on included papers.

Data Extraction and Quality Appraisal

Data extraction and quality appraisal for all included studies were conducted using the Crowe Critical Appraisal Tool (Crowe & Sheppard, 2011b; see Appendix 3. for CCAT and user-guide). The CCAT was selected for its versatility in assessing studies across diverse designs and its demonstrated construct validity, grounded in research-method theory and empirical testing (Crowe & Sheppard, 2011a). The CCAT includes 22 items across eight different domains, including: Preliminaries, Introduction, Design, Sampling, Data Collection, Ethical Matters, Results and Discussion. Each domain is scored using a 5-point scale to create a total score and percentage. Although CCAT does not provide categorisation of scores, the present review converted the total scores into quality categories akin to existing reviews in the field of Child and Adolescent Psychiatry (Walker et al., 2025). The categories were as follows: Very High-Quality (VHQ; ≥35), High-Quality (HQ; ≥30), Moderate-Quality (MQ; ≥20), or Low-Quality (LQ; <20).

Quality assessment of all included studies was carried out by the lead reviewer using the CCAT. To minimise subjective bias, enhance reliability, and ensure consistent use of the CCAT the second reviewer (KO) also carried out an independent assessment on included studies (*n* = 7). There was initial agreement on six out of seven included studies regarding their final quality category (inter-rater agreement = 85.7%). A structured discussion referencing the CCAT criteria resolved discrepancies for the one paper where the initial quality category differed. This process resulted in 100% agreement across all final quality category ratings. Differences in interpretations at the CCAT domain level were discussed until 100% agreement was achieved.

Data Analysis

The primary aim of this systematic review was to determine a prevalence estimate of co-morbid BPD/BPD features and ADHD in adolescence. Therefore, a meta-analysis was conducted to determine an overall pooled prevalence of the co-morbidity among the included studies. Studies were eligible for inclusion in the meta-analysis if they reported sufficient data for a proportion to be calculated, e.g., total sample and count of co-morbid BPD+ADHD. A binary raw data meta-analysis was performed using RStudio software.

A random-effect model was implemented using a Generalised Linear Mixed-effects Model (GLMM). This provided a unified framework which appropriately handles the distributional properties of proportion data and anticipated heterogeneity in diagnostic methods and study designs (Schwarzer et al., 2019). Within this, logit transformation was used to stabilise and account for the raw prevalence rates being constrained between 0 and 1, thus improving adherence to the assumptions of random-effects meta-analysis. Cochran's Q Statistic was calculated to ascertain whether heterogeneity was present across estimates and whether this was compatible with chance. The Higgins Inconsistency Index (I^2) quantified the inconsistency of the prevalence measures and was interpreted as having either Low (25%), Medium (50%), or High (75%) heterogeneity (Higgins et al., 2003). A forest plot was included to visualise the range of proportions across studies. Assessment of publication bias using Egger's regression test was not performed because fewer than ten studies were available. This decision was consistent with methodological recommendations which caution that the test has limited power and may yield unreliable results in a small meta-analyses (Sterne et al., 2011).

A narrative synthesis (Popay et al., 2006) was conducted to group studies according to the type of mechanism investigated. Patterns, consistency and divergence were examined, with close attention paid to the developmental context and methodological quality. The narrative approach allowed for a theoretically informed integration of evidence, and heterogeneity in study design, measures and conceptualisation of mechanisms to be accounted for.

Results

Study Selection

A total of 1,770 records were retrieved when combining the results of each database search (APA PsycInfo = 448; Embase = 820; MEDLINE = 369; CINAHL = 133). Following removal of duplicates (*n* = 722), 1,048 unique records were identified and subject to screening. Of these, 1,010 articles were excluded based on the screening of title and abstract. Of the 38 relevant articles suitable for full review, 32 of these were excluded. One paper was identified for inclusion during backwards and forwards citation searching. This resulted in seven articles being eligible for review. Of these, six provided sufficient information for inclusion in the meta-analysis. Figure 1. details the search, screening and selection process.

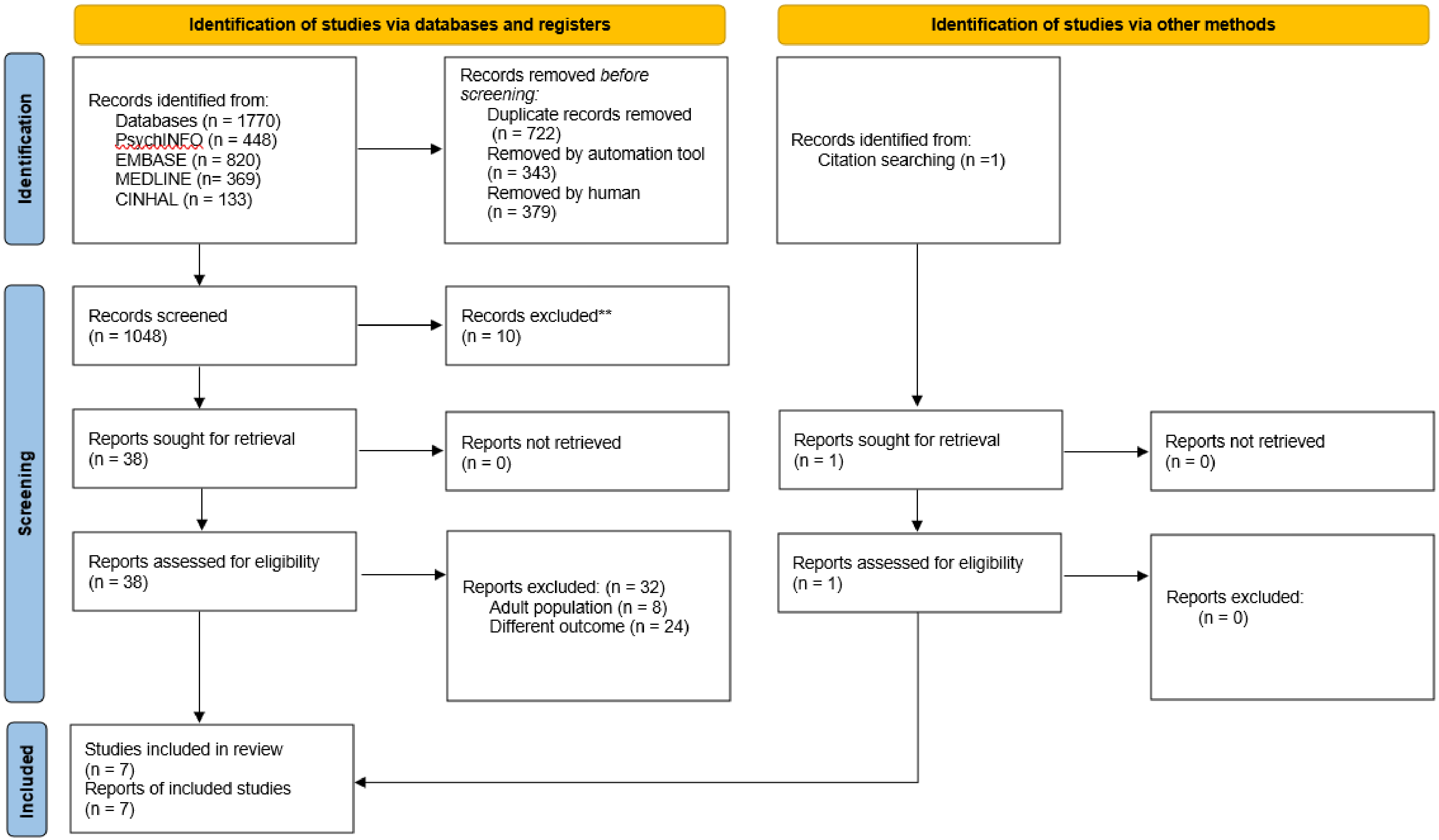

Figure 1 PRISMA 2020 Study Identification Flowchart

Study Characteristics

All included studies (*n* = 7) were cross sectional in nature, with the majority (*n* = 4) being observational (Akça et al., 2020; Burket et al., 2005; Korsgaard et al., 2016; Speranza et al., 2011), two experimental (Calancie et al., 2023, 2024) and one epidemiological (Guilé et al., 2021). The studies were conducted in a range of countries.

Participant Characteristics

Overall, the total sample of the seven studies was 1,828 participants. Across the six studies which reported a breakdown in participant demographics (Akça et al., 2020; Burket et al., 2005; Calancie et al., 2023, 2024; Korsgaard et al., 2016; Speranza et al., 2011), the majority were female (*n* = 85%), and the mean age was 15.8. For the co-morbid BPD and ADHD participants, three studies reported a breakdown in their demographics which highlighted higher co-morbid prevalence amongst females compared to males (Guilé et al., 2021; Korsgaard et al., 2016; Speranza et al., 2011). When considered alongside the two studies who utilised an all-female sample (Calancie et al., 2023, 2024), the mean age of co-morbid BPD and ADHD across all five studies was 16. A diverse range of assessment methods were employed across the studies. There was significant variation across study sample setting. Table 1 provides the details of included studies.

Table 1 Summary of Study Characteristics

Study	Country	Study Design	Sample Characteristics	Sample Setting	Measure of BPD diagnosis or features	Measure of ADHD diagnosis
Akça et al. (2020)	United States	Cross-sectional comparative observational	Total = 550 Gender = 63% female Age = 12 – 17, M = 15.37, SD = 1.43 Ethnicity = 77.6% White, 5.8% Multiracial or other, 3.3% Asian, 1.6% Black or African American, 0.2% American Indian or Alaskan Native, and 11.5% Unspecified	Inpatient	CI-BPD (Shaffer et al., 1996) and PAI-A (Morey & Ambwani, 2008)	DISC-IV (Shaffer et al., 2000)
Burket et al. (2005)	United States	Cross-sectional observational	Total = 37 Gender = 100% female Age = 14 – 17, M = 15.32, SD = 0.88 Ethnicity = 92% White, 8% African American	Inpatient	SIDP-R (Stangl, 1985)	DICA-R-A (Reich, 2000)

Calancie et al. (2023)	Canada	Cross-sectional experimental	Total = 80 Gender = 100% female Age = 11 – 18, M = 15.9, SD = 1.6 Ethnicity = not reported	Outpatient	SCID-PD-5 (First et al., 2016)	Pre-existing diagnosis of ADHD by Child and Adolescent Psychiatrist
Calancie et al. (2024)	Canada	Cross-sectional experimental	Total = 102 Gender = 100% female Age = 11 – 18, M = 16.1, SD = 1.4 Ethnicity = not reported	Outpatient	SCID-PD-5 (First et al., 2016)	Pre-existing diagnosis of ADHD by Child and Adolescent Psychiatrist
Guilé et al. (2021)	Canada	Population based cross-sectional epidemiological	Total = 799 Gender = not reported Age = 12 – 14 Ethnicity = not reported	General Population	Ab-DIB (Guilé et al., 2009)	DISC-2.25 (Breton et al., 1998)
Korsgaard et al. (2016)	Norway	Cross-sectional observational	Total = 153 Gender = 61.4% female Age = 14.1 – 18, M = 16, SD = 1.1 Ethnicity = not reported	Outpatient	SIDP-IV (Pfohl et al., 1997)	MINI-PLUS (Sheehan et al., 1998)

Speranza et al. (2011)	Europe (Belgium, France and Switzerland)	Cross-sectional observational	Total = 107 Gender = 87% female Age = 15 – 19, M = 16.3, SD = 1.4 Ethnicity = not reported	Inpatient and Outpatient clinics across five university psychiatric centres	SIDP-IV (Pfohl et al., 1997)	K-SADS-PL (Kaufman et al., 1997)

Study Quality

The quality assessment scores for each study is presented in Table 2. The total quality scores ranged from 27 to 33 out of 40, corresponding to 68% to 83% overall quality. Two studies fell into the HQ category, and the remaining five were of MQ.

Studies generally scored well in preliminaries reflecting appropriate use of titles, abstracts and text. The introduction domain had a variability in scores; four studies provided less thorough framing of the gap in the literature and/or explicit linking to their current aim (Calancie et al., 2023, 2024; Guilé et al., 2009; Speranza et al., 2011), and one study did not provide a directional hypothesis where appropriate (Calancie et al., 2023). Scores for study design highlighted limitations in methodological clarity across all studies, with a significant lack of justification for study design choices and missed opportunities to account for bias. Critically, included measures were occasionally not suitable for the population (e.g., use of adult measures) or over-relied on one informant when multi-informant and multi-methods would have increased quality of outcomes.

Furthermore, sampling quality varied with two studies demonstrating a detailed protocol which could be replicated (Akça et al., 2020; Guilé et al., 2009). Only one study provided a power calculation (Calancie et al., 2023), but the majority had a small sample and/or a non-representative sample (e.g., all female or all inpatients non-responsive to treatment). Most studies consistently scored 3-4 in the data collection domain reflecting reasonable but occasional incomplete reporting of measurement methods, or procedures which did not account for bias. Ethical matters were generally well reported, especially concerning participant characteristics such as informed consent, safety from harm and confidentiality. Nevertheless, all studies lacked explicit consideration of subjectivities and how the researcher could have potentially impacted collection and interpretation of results. Reporting of results was generally strong across all studies with clearly presented findings and appropriate analysis. However, discussion quality was more variable as studies were typically limited in their generalisability, provided limited interpretation of their findings in light of existing theories, and occasionally did not consider directions for future research.

Table 2 CCAT Scoring

Study	Preliminaries	Introduction	Design	Sampling	Data Collection	Ethical Matters	Results	Discussion	Total (/40)	Percentage	Quality
Akça et al. (2020)	5	5	3	3	4	4	4	5	33	83%	High
Burket et al. (2005)	4	4	4	3	4	2	3	3	27	68%	Moderate
Calancie et al. (2023)	4	2	4	3	3	4	4	4	28	70%	Moderate
Calancie et al. (2024)	4	3	3	2	4	4	5	4	29	73%	Moderate
Guilé et al. (2021)	4	3	4	4	3	4	5	4	31	78%	High

Korsgaard et al. (2016)	5	4	3	3	3	4	3	3	28	70%	Moderate
Speranza et al. (2011)	4	3	2	3	4	4	5	4	29	73%	Moderate

Prevalence of Co-morbid BPD and ADHD in Adolescents

A meta-analysis was conducted to estimate the pooled prevalence of co-morbid BPD/BPD features and ADHD in adolescents using a random-effects model. The meta-analyses of the prevalence was grouped by a random-effects model and presented with 95% CI because it assumes normal distribution across the studies, allowing for between-study variation (Munn et al., 2015). A total of six studies, comprising of 1,029 participants were included in the analysis. Using a random-effects model, the pooled prevalence of co-morbid BPD/BPD features and ADHD was 12.6% (95%, CI: 6.7% - 22.4%). A high rate of heterogeneity was observed across studies (I^2 = 88.2%; $p < 0.0001$). The variability in prevalence estimates which ranges from 3% to 28% is visually depicted in the Forest Plot in Figure 2.

Across the included studies, substantial methodological heterogeneity was evident, with variation in study design (observational, experimental, and epidemiological approaches), assessment tools for both BPD and ADHD, and reliance on differing informants (clinical interview, self-report, and pre-existing diagnostic status). This variability is likely to have contributed to the high level of heterogeneity observed in the meta-analysis (I^2 = 88.2%), limiting the comparability of prevalence estimates across studies. Sample characteristics also varied considerably, with a predominance of female, clinically referred adolescent populations alongside smaller proportions of population-based samples, potentially inflating estimates of co-morbidity severity. Consequently, the findings may not be fully generalisable to broader community samples or to male adolescents, who were underrepresented across the evidence base.

Egger's regression test of publication bias could not be calculated because the number of studies (<10) was considered too small to test for small study effects which may yield unreliable results. However, potential reporting and publication bias were considered elsewhere during the quality appraisal of included studies.

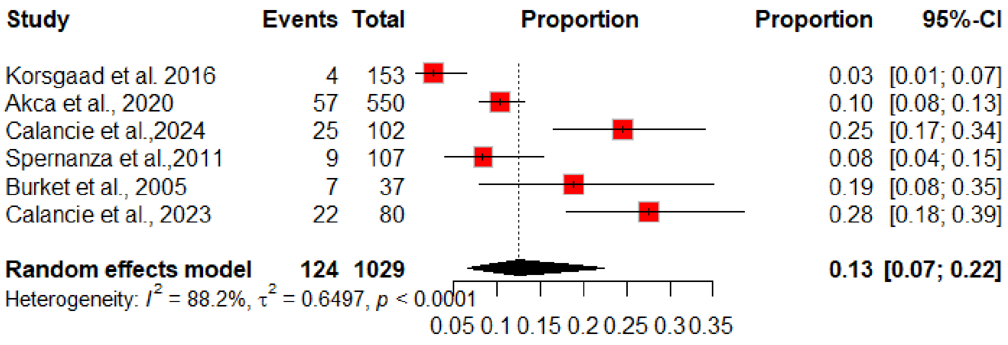

Figure 2 Forest Plot

Nature of Co-occurring BPD and ADHD in Adolescents

The highest prevalence rate (28%; Calancie et al., 2023) and lowest prevalence rate (3%; Korsgaard et al., 2016) among the included studies were both yielded in a substantial sample size of young people accessing mental health outpatient clinics. There was a consistent pattern found across both inpatient and outpatient samples demonstrating elevated BPD or BPD features and ADHD. For example, Burket et al. (2005) demonstrated that inpatient adolescent girls with ADHD were more likely to have a Personality Disorder (PD) than those without ADHD. Namely, BPD was one of the most common presentations across the clusters of PD presentations in girls with ADHD (19%). Similarly, in their high-quality study Akça et al., (2020) demonstrated a co-morbidity of 10% and elucidated that these young people experienced severe behavioural dysregulation, including heightened aggression, self-harm, suicidal ideation, and substance use. Importantly, BPD symptoms added incremental predictive value beyond ADHD symptoms alone, indicating that the two disorders contribute distinct forms of impairment. Taken together, use of inpatient samples may naturally reflect more severe psychopathology thereby limiting the generalisability due to a biased sample.

Further underscoring the clinical complexity, one moderate quality study demonstrated that ADHD in BPD was significantly associated with greater likelihood of disruptive disorders (e.g., Oppositional Defiance Disorder), and Cluster B PD (e.g., Histrionic, Narcissistic, and Anti-Social PD) (Speranza et al., 2011). Similarly, Borderline Personality Traits (BPT) displayed a very strong co-morbidity rate with ADHD alongside depressive and defiant/conduct disorders (Guilé et al., 2021). This highlights that clinical complexity is not unique to inpatient settings or BPD diagnosis; it is also apparent in outpatient settings (Speranza et al., 2011), and among the general population with BPT (Guilé et al., 2021).

Co-morbid BPD and ADHD was more common in girls than boys in the reviewed studies (Guilé et al., 2021; Korsgaard et al., 2016; Speranza et al., 2011). Korsgaard et al. (2016) added a novel contribution that these patterns may reflect gendered diagnostic bias. In their out-patient sample, BPD and ADHD association was only significant for girls. This may partly be due to a selection bias of only the most severely affected girls being referred to mental health outpatient clinics. Simultaneously, boys are more commonly assessed and diagnosed with ADHD suggesting there may be an underestimation of ADHD in girls. Furthermore, boys are generally diagnosed with ADHD earlier on in the developmental trajectory, whereas ADHD in adolescent girls may be camouflaged by their BPD symptoms. Notably, the significantly elevated BPD symptoms in adolescence within an ADHD sample remained significant following adjustment for age, gender and Axis I disorders. Consequently, Korsgaard et al. (2016) concluded that reliability-tested diagnostic interviews, such as the SIDP-V, were considered a feasible method for assessing BPD in adolescents with ADHD. Yet reliance on a single examiner, as employed in this study, may limit the external validity of diagnostic conclusions.

Guilé et al. (2021) offered valuable insight into the developmental trajectory by examining participants with BPT, as opposed to diagnosis. Their high-quality study emphasised the possibility that BPT can be identified as young as 12-years-old. Additionally, it was contended that childhood patterns of stable externalising and increasing internalizing symptoms is known to be highly predictive of BPT in early adolescence. Consequently, they conceptualised BPT as resulting from the additive effect of internalising symptoms on already present externalising symptoms, thus demonstrating the role of sequential comorbidity in adolescence, a developmental pattern whereby one disorder emerges first, and another develops later due to increased vulnerability. This framework is directly relevant to this review; ADHD, an externalising disorder which develops in childhood, may precede the later manifestation of BPD due to the accumulation of early externalising symptoms. Guilé et al. (2021) therefore considered it prudent to assess BPT when children with conditions such as ADHD transition to adolescence or present with increasing symptoms of depressive disorder in adolescence. Although adolescents can report their own subjective experience, this study was limited in its measurement of BPT, as it relied solely on self-report and did not include additional informants or secondary measures.

Mechanisms of BPD and ADHD in Adolescents

Across the included studies, impulsivity emerged as a key mechanistic pathway linking BPD and ADHD in adolescence across four studies. The specific components of impulsivity varied depending on methodological approach. Across moderate and high-quality studies, measures of cognitive and behavioural inhibitory control consistently showed that adolescents with co-occurring BPD and ADHD exhibited greatest impairments (Akça et al., 2020; Speranza et al., 2011). Greater severity, including higher levels of aggression, self-harm and broader psychiatric symptoms were apparent for those with the co-morbidity than in either disorder alone (Akça et al., 2020). Whilst impulsivity may be linked to these outcomes, evidence was insufficient in this study to determine whether ADHD symptoms directly contributed to aggression, or whether this association was mediated through shared impulsivity-related processes.

Interview-based assessments (Revised-Diagnostic Interview for Borderline), demonstrated that BPD+ADHD adolescents exhibited greater impulsivity, whilst those with BPD alone scored higher in the domain of cognition. Scale-based measures (Barratt Impuslivness Scale-11) indicated higher impulsivity across all domains in the BPD+ADHD group, with a clinically significant elevation in Attentional/Cognitive impulsivity (Speranza et al., 2011). These findings suggest that inhibitory-control deficits are primarily ADHD-driven and may become clinically significant when co-occurring with BPD. More specifically, these results indicate that the cognitive component of inhibition control may play a key role in the phenomenology of impulsive/developmental sub-type of BPD. This study’s findings are limited due to methodological bias, including over-reliance on cross-sectional design, use of retrospective ADHD diagnosis and use of adult impulsivity measures in an adolescent sample.

Calancie et al. (2023) included self-report measures of impulsivity which did not distinguish BPD from ADHD+BPD. The authors concluded that questionnaires alone are limited, and task-based measures are better suited to capture mechanistic differences. Task-based and neuropsychological measures further differentiated these mechanisms in two studies of moderate-quality (Calancie et al., 2023, 2024). A consistent pattern emerged in which inhibitory-control deficits and physiological arousal differentiated across adolescents with BPD, ADHD and both. Both studies used oculomotor paradigms to demonstrate core executive processes, such as response inhibition, temporal predictor and error monitoring, were preserved in the BPD group alone. Whereas adolescents with BPD and ADHD displayed increased anticipatory saccades under unpredictable timing conditions and a higher rate of premature responses, short-latency errors, and reduced error correction on pro-/anti-saccade tasks (Calancie et al., 2023, 2024). This supplements Speranza et al.'s (2011) finding that deficits in inhibitory control and waiting impulsivity are primarily attributable to ADHD.

Reinforcing the differentiation of impulsivity was the identification of heightened tonic automatic arousal, indexed by larger pupil sizes, as characteristic of the BPD-only group (Calancie et al., 2023). Whilst ADHD contributes additional executive-control and oculomotor-circuit disruptions, BPD is associated with elevated baseline arousal. The central finding of this study emphasised that impulsivity in comorbid BPD plus ADHD reflects the convergence of ADHD-driven inhibitory-control deficits and BPD-related arousal dysregulation, resulting in a more severe and complex neurocognitive profile than either condition alone. These results are, however, limited due to a biased design which failed to include an ADHD-only control group.

Discussion

Prevalence of Co-morbid BPD and ADHD in Adolescents

This review’s results and meta-analysis brings to the forefront the prevalence of co-morbid BPD/BPD features and ADHD in adolescence, providing the first pooled estimate of the two disorders within the developmental period (12.6%, 95% CI: 6.7% - 22.4%). These findings should be interpreted cautiously given the limited number of studies and the substantial heterogeneity observed across estimates. The pooled prevalence should therefore be understood as an indicative estimate rather than a precise population parameter. Nonetheless, the strong association between the two disorders is also evidenced in the adult population, however at higher rates of 30 – 60% (Matthies & Philipsen, 2016). The lower recorded rates of BPD and ADHD found within this review may reflect a reluctance to diagnose BPD in adolescence and delays in clinical recognition due to the overlap between core diagnostic features and typical developmental variability (Fonagy et al., 2015). However, the lower prevalence in adolescence compared to adulthood may also be reflective of the developmental course of BPD, whereby core features of BPD typically develop in adolescence and become more stable as individuals transition into early adulthood (Sharp & Fonagy, 2015).

From a lifespan perspective, longitudinal studies have shown a positive association between ADHD severity in childhood with adult BPD (Tiger et al., 2022). Importantly, the prevalence estimate from this review builds on existing findings and suggests that co-morbidity can emerge early in development and is not solely an adult phenomenon. Sequential co-morbidity is the norm in child and adolescent populations (Ditrich et al., 2021), with the overlaps of BPD and ADHD requiring careful consideration to optimise opportunities for treatment earlier on in the developmental trajectory. As also documented in this review, inadequate recognition of BPD traits in adolescents with ADHD may impede appropriate treatment planning and increase risk of treatment resistance.

Broader epidemiological evidence demonstrates that BPD is known to co-occur with mood and anxiety disorders in adolescence to the extent that BPD in adolescence might be a marker of severity of psychopathology (Jørgensen et al., 2024), thus emphasising how the current BPD and ADHD prevalence rate is part of a wider constellation of early-emerging emotional and behavioural dysregulation. Moreover, Wang et al.’s (2025) meta-analytic study reported a pooled prevalence rate of 11.3% for ADHD and depression in adolescents. Thus, suggesting our prevalence rate may not only reflect a specific co-morbidity but supports well-documented developmental trends in which ADHD poses as a transdiagnostic risk factor; however, the slightly elevated BPD-ADHD prevalence identified in this review underscores the importance of early identification for those who exhibit combined impulsive and emotional regulation difficulties.

The adolescent prevalence estimate established in this review represents an important finding within developmental psychopathology. However, interpretation should be cautious given the small number of included studies and variable study quality, with five rated as moderate. Additionally, the meta-analysis showed substantial heterogeneity across six studies. These findings are reflected in the literature where BPD is understood to be a highly heterogenous condition characterised by diverse symptom profiles and severities (Cavelti et al., 2021). This intrinsic heterogeneity likely contributes to the variability in the current prevalence estimate and is further complicated by methodological variability which is the norm in this field (Ramos-Suárez et al., 2026). The diverse range of sampling contexts amongst reviewed studies (e.g., community cohorts to specialised clinical populations) limits direct comparison or precise pooled prevalence estimates. These findings must also be understood alongside the evolving shift towards conceptualising personality disorders dimensionally, as opposed to categorical classification systems (Monaghan & Bizumic, 2023). Consequently, the true rate of co-occurrence may be greater if a dimensional framework was applied across all studies.

Mechanisms of BPD and ADHD in Adolescents

This systematic review synthesised studies which primarily investigated mechanisms of impulsivity in those with BPD and ADHD in adolescents. Across the included studies, different methodological approaches were used, including scales (Akça et al., 2020), interview and scale-based measurements (Speranza et al., 2011) and scales supplemented by task-based measures (Calancie et al., 2023, 2024). The current synthesis demonstrated converging evidence of altered function in the prefrontal and orbitofrontal cortex, key areas in attentional, emotional processing and impulsivity, in linking BPD and ADHD. Much of the existing neurobiological evidence comes from adult samples; shared abnormal patterns in temporoparietal profile and distinct patterns in fronto-striatal circuity have been documented, and pathways to personality disturbances is thought to stem from weak executive response inhibition mechanisms (Philipsen, 2006). The current findings elucidate how these converging neurological changes are also observed in adolescence, although the developmental timing, stability and causality remain unclear.

The multifaceted nature of impulsivity was evident in the findings of this review. Impulsivity in ADHD was primarily associated with cognitive and motor impulsivity which tended to manifest as impatience and errors; impulsive behaviour in BPD was more likely to be driven by emotional arousal among outpatient treatment seeking adolescent girls (Calancie et al., 2024). However, Speranza et al. (2011) suggested cognitive impulsivity was more heightened amongst adolescents with BPD alone. These finding may encourage a shift away from conceptualising impulsivity as the sole driver of BPD severity. Alternatively, it could correspond to a specific high-impulsivity subtype of BPD associated with ADHD, supporting arguments that BPD may comprise of two subgroups defined by presence or absence of ADHD (Ferrer et al., 2010).

In addition to shared neurocognitive features, this review also highlighted stress sensitivity and physiological arousal as potentially differentiating mechanisms between the disorders (Calancie et al., 2023). Although childhood trauma is implicated across the lifespan, adult research suggests it plays a more substantial mechanistic role in BPD than in ADHD, shaping emotional dysregulation trajectories into adulthood (Ferrer et al., 2017). This aligns with the well-established correlation between BPD and maltreatment (Schär et al., 2022), and comparatively limited stress-related alterations typically observed in ADHD (Kamradt et al., 2018). Whilst broader literature recognises impulsivity and emotional dysregulation as core mechanisms linking BPD and ADHD, emerging evidence suggests that social processes and subsequent negative peer experiences may enhance risk of BPD among girls with ADHD (Alacha et al., 2024). This suggests there are wider mechanisms not captured by this systematic review alone.

Theoretical and Clinical Implications

The findings of this review supplements models proposing that ADHD and BPD share underlying mechanisms related to impaired top-down regulation of information processing (Petrovic & Castellanos, 2016). According to these models, the key distinction lies in which regulatory domains are most affected (e.g., non-emotional or emotional), and akin to findings from this review, BPD+ADHD represents an additive, or even multiplicative burden on regulatory symptoms resulting in heightened severity and functional impairment.

The current examination of the co-occurrence of BPD and ADHD can be mapped onto existing developmental psychopathology principles of *equifinality* and *multifinality* (Cicchetti & Rogosch, 1996). In this review, equifinality can be understood as the potential for BPD symptomology to emerge through multiple developmental routes, including sequential co-morbidity. One such pathway involves early ADHD traits which may increase vulnerability to later BPD features as further internalising difficulties accumulate. However, equifinality also recognises that BPD can arise through entirely different pathways characterised by early trauma exposure. Equifinality therefore highlights the possibility for BPD to represent a convergent outcome which may arise though diverse combinations of risk factors i.e., sequentially following early traits of ADHD, following trauma-exposure or unique configurations of both (Gajwani & Minnis, 2023). Multifinality highlights the influence of shared early vulnerabilities potentially leading to divergent outcomes, which is particularly relevant for adolescents with ADHD. This accounts for how some individuals with childhood ADHD can achieve adaptive functioning, whereas others may develop complex psychopathology, including BPD (Gnanavel et al., 2019). Within this developmental framework, the ADHD related difficulties may present a transdiagnostic vulnerability which interacts with environmental stressors and ultimately shapes the developmental cascade towards BPD (Gajwani et al., 2022).

The integration of these two pathways provides a dynamic developmental framework for understanding variability which closely aligns with emerging dimensional models of mental disorders, such as the Hierarchal Taxonomy of Psychopathology (HiTOP). The HiTOP is a transdiagnostic, empirically derived framework that organises mental disorders based on their underlying symptom dimensions and shared liabilities (Kotov et al., 2017). This framework clarifies why certain adolescent psychopathologies follow trajectories characterised by co-occurrence and has practical implications to target shared mechanisms..

Lastly, findings of this review strengthens the case for prioritising early intervention in adolescent psychopathology (Kaess et al., 2024). Adolescence is a highly malleable developmental period in which treatment responsiveness is often high; therefore, the epidemiological clarity of BPD and ADHD provided by this review supports the need for earlier identification to allow more timely and meaningful case formulation; prevent misattribution of complex difficulties to dysregulation; and prevent unrecognised difficulties consolidating into more severe and chronic patterns (Gajwani & Minnis, 2023). This review's mechanistic findings on impulsivity contributes to the literature, highlighting the value of transdiagnostic formulations to inform individualised intervention and mitigate the risk of long-term psychosocial impairment (Sauer-Zavala et al., 2016; Sharp et al., 2025).

Strengths, Limitations and Directions for Future Research

A key strength of this systematic review is the novel contribution of prevalence estimates of co-morbid BPD/BPD features and ADHD during a critical developmental period. The focus upon adolescence addresses the notable gap in the literature which predominantly prioritises adult samples thereby neglecting earlier opportunities for identification within the developmental trajectory. This systematic review adhered to best practice guidelines to minimise researcher bias; registered with PROSPERO; and followed reporting procedures as per PRISMA guidelines. Despite this, findings of this review should be interpreted in the context of its limitations and quality of the limited included studies ranging from moderate to high.

An intentionally conservative methodological approach was taken when developing the inclusion criteria which necessitated that participants needed an ADHD diagnosis, rather than symptom-level reports. This potentially reduced the number of eligible studies. However, it enhanced the specificity and credibility of the pooled prevalence estimate by limiting cases of misclassification and reducing inflation of rates. This remained the case despite the inclusion criteria permitting studies to use BPD features instead of diagnosis, as most included studies employed diagnostic frameworks rather than relying on self-report alone.

Furthermore, impulsivity is particularly salient during the normative neurodevelopmental pathway, making it a prominent and observable mechanism that may link both disorders. However, the effects of trauma and emotional dysregulation may operate more indirectly and cumulatively into adulthood meaning cross-sectional studies in adolescence may not capture these nuances. The dominance of impulsivity may therefore reflect research feasibility. To overcome this limitation, larger samples with varied study design (i.e. twin data studies, longitudinal, experimental) and settings (i.e. outpatient clinics, prisons, primary care practice) within adolescence, would further provide evidence and insight to clarify the mechanisms underlying this co-occurrence.

Lastly, this meta-analysis assessed co-morbid prevalence, but a comprehensive sub-group analysis was not feasible due to the limited number of studies eligible for inclusion. The heterogeneity observed was likely driven by the variation in study design, diagnostic approaches, and samples, thereby limiting the generalisability of the conclusions. Nevertheless, these limitations should not deter future research. Instead, future studies should aim to reduce heterogeneity and increase generalisability through greater methodological standardisation. For example, harmonised diagnostic approaches for assessing BPD and ADHD would facilitate more consistent prevalence rates within a representative sample. Ultimately, addressing these methodological challenges is crucial for improving the accuracy of developmental assessments and informing interventions.

Conclusions

The co-occurrence of BPD and ADHD in adolescence represents an intersection of two disorders manifesting in significant developmental risk, heightened severity and long-term vulnerability. Pooled prevalence estimates from this review confirmed that this co-occurrence is not unique to the adult population or incidental due to meaningful patterns of shared mechanisms. The conclusions drawn should be interpreted in the context of a small, methodologically diverse evidence base, and therefore represent preliminary but not definitive inferences regarding the developmental co-occurrence of ADHD and BPD. These findings also expose the striking gaps that persist due to fragmented and heterogenous research. This underscores the importance of coherent and mechanistically informed research to clarify causal processes and opportunities to guide early intervention. Ultimately, this review emphasises the need to move beyond siloed frameworks towards an integrated model that reflects the intertwined nature of BPD and ADHD. Addressing this challenge has the potential to improve diagnostic accuracy and outcomes, whilst positively influencing the life-course trajectories of young people with particularly complex clinical needs.

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Chapter 2

“Working with me, and not against me”: Understanding the Lived Experiences of Engagement Among Young People with Borderline Personality Disorder Features in The BRIDGE Project

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Plain Language Summary

"Working with me, and not against me": Understanding the Lived Experiences of Engagement Among Young People with Borderline Personality Disorder features in The BRIDGE Project

Background: Borderline Personality Disorder (BPD) is a severe mental disorder which means individuals may have challenges managing their emotions and impulses. As a result, people may experience quick mood changes, difficult relationships, see themselves in a negative way and possibly harm themselves. Research tells us that BPD tends to develop between the teenage and early adult years. Treatment is needed early on to reduce the seriousness of poor outcomes, such as difficulty with relationships or keeping a job. Research has shown that young people with BPD do not always get the most well-suited treatment. So, it is important to understand how individuals with these difficulties view their experience of engagement with mental health services.

Aim and Research Questions

This study aimed to explore:

- How do young people with features of BPD experience and make sense of their engagement?
- What do young people with features of BPD believe helps and hinders their engagement?
- How do young people with features of BPD make sense of their future and managing their BPD?

Methods

This study involved individuals who took part in the BRIDGE project which used a brief intervention for young people with BPD symptoms in the Glasgow community. Participants were included in the study if they were:

- Aged between 14 – 24-years-old.
- Experienced at least three out of nine symptoms of BPD.

Participants were not able to take part in the study if they:

- Were receiving or previously received treatment for BPD.
- Had a main diagnosis that required treatment from Psychiatry e.g., Psychosis or an Eating Disorder.
- Could not engage in the interview due to English fluency difficulties.
- Lived out with the NHS Glasgow City health board.

Participants from the BRIDGE project were recruited by the team presenting study information to local community settings (e.g. GPs, mental health teams, job centres, college counsellors). Online advertising was also used. Participants took part in a semi-structured interview with some specific questions, and optional prompts to allow flexible discussions. To identify themes, this study used Interpretative Phenomenological Analysis (IPA) because it focuses on understanding how individuals make sense of important life experiences.

Main Findings and Conclusions

Participants highlighted previous experiences of feeling rejected and misunderstood by services, often because their BPD was not recognised. Participants shared the importance of positive connections with staff, having a shared explanation for their experiences, and opportunities to make sense of their experiences in remaining engaged. They also recognised engagement was not straightforward as they had to face difficult emotions and deal with stigma around BPD. Despite this, positive experiences of engagement helped young people function better in everyday life and provided them hope for their future. These findings highlight the importance of identifying BPD in young people and encourages services to use approaches which focus on connecting and understanding young people with BPD.

Abstract

Background Borderline Personality Disorder (BPD) is a severe mental disorder which is marked by instability in interpersonal relationships, self-image, affect and impulsivity. BPD in young people uniquely predicts adverse personal, social and economic outcomes later in life. Despite recognition of the importance of early detection and intervention, many young people with BPD have trouble accessing appropriate and timely assessment and intervention. Additionally, literature around patient engagement (active involvement in their care) rarely incorporates lived experience. This study therefore aims to shed light on how young people with BPD features experience engagement with services in the context of the BRIDGE project, a Feasibility-Randomised Controlled Trial.

Methods: This qualitative study analysed the transcripts of 13 semi-structured interviews which were conducted with young people aged 14 to 24 with BPD features (sub- or full threshold). The interviews were analysed using Interpretative Phenomenological Analysis and maintained reflexive engagement throughout.

Results: Four Group Experiential Themes were developed: (1) *Hidden in Plain Sight with a Longing to be Seen*; (2) *The Value of a Relational and Responsive Approach;* (3) *Re-claiming Identity and Re-writing Narratives through Shared Understanding; and* (4) *The Dual Impact of Recovery: Where Pain and Healing Intersect*.

Conclusions: Engagement appears strongest when services prioritise relational connection, recognition, and shared meaning-making. These elements had a transformative impact on how young people understood themselves and envisioned their future. Meaningful engagement with services is, however, not without its challenges; young people must tolerate the confronting nature of recovery and navigate stigma. These findings support research which advocates for early recognition of BPD. Future research should integrate practitioners' perspectives and co-designed methodologies to shape clinical services capable of meeting the needs of young people with BPD features.

Keywords: Borderline Personality Disorder, Patient Engagement, Young People

Background

Borderline Personality Disorder (BPD) is typically characterised by a pervasive pattern of difficulties across interpersonal relationships, self-identity, affective dysregulation and marked impulsivity (American Psychiatric Association, 2013). The manifestations of BPD symptoms are interwoven across an individual's psychological, social and occupational functioning, and are known to have a profound impact (Beeney et al., 2018; Hastrup et al., 2022). BPD is associated with long-term adverse outcomes, such as high rates of comorbid mental health disorders, more frequent use of outpatient and inpatient services, unemployment, poorer relational functioning and high rates of suicide (Álvarez-Tomás et al., 2019; Biskin, 2015). The clinical need of this population is heightened by their markedly elevated mortality rate; patients with BPD die on average 14 to 32 years earlier than the general population (Temes et al., 2019). For men with BPD, there are 2.4 times greater odds of death (95% CI: 1.9- 2.6), and for women, a 2.2 times greater odds (95% CI: 2.1-2.8), compared to those without BPD (Schneider et al., 2019). BPD is the most common personality disorder with an estimated prevalence rate in the general population of 2.4%, higher than earlier estimates from the early 2000s which ranged from 0.7-1.5% (Ramos-Suárez et al., 2026). This further elucidates how BPD is an essential area for clinical research.

Research on the developmental pathways for BPD contend that markers of severe and complex clinical presentations in later life are evident early on, with a complex interplay between nature and nurture (Wilson et al., 2021). BPD susceptibility is influenced by a variety of risk factors ranging from neurobiological (i.e. Hypothalamic-Pituitary-Adrenal axis regulation) to environmental (i.e. adverse childhood experiences) and genetic factors (i.e. gene coding for dopamine transporter) (Chanen & Kaess, 2012; Hutsebaut & Aleva, 2021; Wilson et al., 2021). Typical onset and peak prevalence of BPD is between puberty and emerging adulthood (Chanen et al., 2020). However, there is a reluctance to offer a diagnosis in adolescents meaning under-identification, and delays in the diagnosis and treatment of BPD is the norm (Griffiths, 2011). This is potentially attributable to the fear of stigmatisation and BPD features being perceived as normative (Sharp, 2017). Due to the compelling evidence outlined by advocates of early intervention, there is now a stronger consensus that diagnosis in youth is both appropriate and useful; early identification of BPD (or subthreshold features) is necessary in the timely mobilisation of clinical and functional support to mitigate individual suffering and societal costs (Chanen et al., 2020).

There is a growing body of specialised evidence-based psychotherapies for BPD which are supported by evidence from RCTs in adults (Cristea et al., 2017), and more recently in young people (Bourvis et al., 2023). However, Jørgensen et al. (2021) systematically examined the effectiveness of psychological therapies for adolescents with BPD or BPD features and highlighted several limitations of the evidence to date. Of the 10 RCTs included, a minority demonstrated psychotherapies to be efficacious for adolescents with BPD symptoms in the short term. Crucially, their overall finding indicated that control groups receiving comparator interventions were just as effective as those who received psychotherapies tailored for BPD. However, the confidence in effect estimate is limited due to high risk of bias, imprecision and inconsistency. It remains unclear whether the observed symptomology decrease was due to treatment effectiveness, natural improvement or regression towards the mean. Therefore, treatments for young people with BPD are underdeveloped, and the effects of specialist treatments are modest and unlikely to be scalable (Holmes et al., 2020).

In practice, early intervention is only available to a small number of help-seeking individuals who successfully hurdle service requirements. De Panfilis et al. (2012) indicate that patients with BPD find it challenging to remain engaged in psychosocial treatments as reflected by high outpatient dropout-rates (15-77%). This may be the result of treatment being offered too late or too sparsely during the course of BPD in the form of inaccessible and highly specialised services, thus reinforcing functional impairment, disability and therapeutic nihilism (Chanen, 2015). Chanen (2015) proposes that core features of BPD, such as suicidal ideation and impulsivity, may actively hinder help-seeking because these symptoms may reduce individual capacity to engage with services. These potentially inherent barriers to engagement underscores the importance of early intervention, to improve long-term functional outcomes and actively engage non-help seeking young people (Minnis et al., 2022).

Patient engagement is crucial for enabling healthcare delivery, ensuring equity, and management of long-term conditions (Weil, 2016). Patient engagement has broadly been defined as the process of actively supporting individuals to contribute to their healthcare and decision making (Carman et al., 2013). Hickmann et al. (2022) emphasise that patient engagement depends on empowerment, motivation and ability, and that healthcare providers play a critical role in enabling these, thus reinforcing engagement as a deeply relational process. However, variations in the conceptualisation of ‘engagement’ and a limited focus of the process in research means engagement is often measured via a static lens of clinical and economic outcomes, rather than a dynamic one. Furthermore, patient voice in defining engagement is under-represented in the literature (Barello et al., 2012).

To address these gaps, this study aimed to uncover the perspectives of young people with BPD features, who may or may not have trouble accessing services, regarding their experience of engagement and related hopes for the future. Qualitative research exploring their experiences can provide insight and be valuable in determining the barriers and facilitators of engagement when implementing future interventions.

Aim and Research Questions

Aim

The aim of this study was to explore the perspectives and experiences of engagement among young people with BPD features who participated in the BRIDGE project, a single-blind, parallel groups Feasibility-Randomised Controlled Trial (f-RCT) using Cognitive Analytic Therapy (CAT) for young people (aged 14-24) with BPD features (sub- or full-threshold), in a community sample of Glasgow, Scotland. Qualitative insights from this study aimed to supplement the primary quantitative outcomes (recruitment and retention) from the broader f-RCT in which this work was embedded (Gajwani et al., 2024).

Primary Research Question

- How do young people with features of BPD (sub- and full- threshold) experience and make sense of their engagement during the BRIDGE project?

Secondary Research Questions

- How do young people with sub- and full-threshold features of BPD perceive the barriers and facilitators of their involvement with the BRIDGE project?
- How do young people interpret and envisage their outcomes and recovery when navigating and managing their sub- and full-threshold features of BPD during the BRIDGE project?

Methods

The BRIDGE project

This study was embedded in a single-blind, parallel groups f-RCT, the BRIDGE project (ClinicalTrial.gov ID NCT03791086), which follows the Medical Research Council (MRC) Complex Intervention Framework (Craig et al., 2008). The BRIDGE project is a f-RCT of a brief intervention programme using Cognitive Analytic Therapy (CAT) for young people (aged 14-24) with BPD features (sub- or full-threshold), in a community sample of Glasgow, Scotland. Recruitment took place between October 2021 and September 2023. After a two-stage screening process, eligible participants were invited to a baseline research assessment and then randomised to BRIDGE intervention and Service as Usual (SAU) or SAU alone (Gajwani et al., 2024). BRIDGE intervention consisted of comprehensive assessment, shared contextual formulation, and up to 16 sessions of CAT (Ryle et al., 1997).

Design and Procedure

Aligned with the research aims, this study employed an exploratory design using Interpretive Phenomenological Analysis (IPA) given its firm roots in phenomenology to explore how humans experience their world (Smith et al., 2022). Data was gathered by members of the BRIDGE trial team, and first author (EM) using semi-structured interviews lasting approximately one hour (Appendix 1 for Interview Schedule), with the lead author conducting two of the interviews. In line with IPA, semi-structured interviews using open-ended questions were conducted on a one-to-one basis to explore the experiences more deeply and authentically than a structured interview or questionnaire. Interviews were conducted based on participant preferences, either in-person at the University of Glasgow or remotely, whilst being audio-recorded.

Participant Recruitment

A novel contribution of BRIDGE was that it endeavoured to recruit and engage young people with BPD features from both health services and the community. The aim was to identify young people with BPD features who might already be known to services, or 'hidden' young people who might otherwise be missed due to not 'fitting' traditional service models or diagnosis. The wider f-RCT utilised purposive recruitment via a digital platform (www.bridgeproject.co.uk) to ensure the widest possible scope and prevent the possibility of specialist services gatekeeping participants. Presentations by the trial team to disseminate the research outline enabled referrals from: NHS Greater Glasgow and Clyde (GGC), social work, forensic services, youth support services and third sector organisations.

Participants were eligible to participate in the BRIDGE project if they were aged between 14 and 25-years-old and met a cut-off score of three or more threshold symptoms on the SCID-II BPD module (First et al., 2016). Participants were excluded if: they received psychological treatment for BPD prior or during study participation; presented with acute risk which necessitated specialist intensive psychiatric treatment (e.g., DSM-V Psychosis or severe Anorexia Nervosa); had insufficient English fluency; or lived outside the NHS GGC health board area.

Participants retained throughout the duration of the BRIDGE project were contacted by phone and invited to a final interview to gather their views and experiences in line with this study's aims, approximately six months after their input ended.

Sample

The concept of data saturation in qualitative research is contested; whilst it is sometimes considered appropriate for Thematic Analysis, which seeks to yield distinct themes across participants, it is less compatible with IPA. IPA places a strong emphasis on uncovering and understanding individual lived experience, therefore a reasonably small sample is effective to conduct an in-depth analysis (Smith et al., 2022). There is limited consensus on adequate sample sizes for IPA; published studies using IPA vary from single cases (Shinebourne & Smith, 2009) to bigger sample sizes of 19 participants (Taylor et al., 2021). In the BRIDGE project, 25 young people were randomised, 13 of whom consented to participate in the qualitative interviews used in this study.

Participants

The demographic characteristics for the 13 participants at the time of this study are presented in Table 1 using pseudonyms.

Table 1 Patient Demographic Characteristics

Participant	**Age***	**Gender Identity**	**Ethnicity**	**Employment Status**	**BRIDGE randomisation**
Sienna	20	Female	White Scottish	Student	Service as usual
Finn	21	Transgender	White Scottish	Student	BRIDGE Intervention
Amelia	21	Female	White Scottish	Student	BRIDGE Intervention
Tamzin	27	Female	White Scottish	Student	Service as usual
Sofia	27	Female	White European	Student	BRIDGE Intervention
Madelyn	24	Female	White Scottish	Unemployed	BRIDGE Intervention
Cole	24	Transgender	White Scottish	Student	Service as usual
Jamie	21	Non-conforming	White Scottish	Student	Service as usual
Samual	22	Male	Black African	Student	BRIDGE Intervention
Imogen	20	Female	White British	Student	BRIDGE Intervention
Grace	25	Female	White Scottish	Unemployed	BRIDGE Intervention
Harper	23	Female	White Scottish	Employed	BRIDGE Intervention

Alex	19	Prefer not to say	Prefer not to say	Prefer not to say	BRIDGE Intervention

*Mean age = 22.62 years (SD = 2.63)

Ethics

The BRIDGE project was granted ethical approval from the UK Research and Ethics Committee (Reference: 21/NW/0209) (Appendix 2). Approval for the first author to be added as a named researcher was granted by the sponsors, NHS GGC. Ethical considerations during data collection, analysis and writing of this study were: informed consent, confidentiality, data storage and safeguarding. All participants provided informed consent for their data to be used in the BRIDGE project.

Analysis and Reflexivity

The exploratory and inductive nature of this study warranted IPA as the most appropriate analytic approach compared to alternatives. For example, Grounded Theory is focused upon theory development and Thematic Analysis lacks an epistemological background and aims to identify patterns *across* individual narratives. Whereas IPA is committed to examining the individual meanings participants attribute to events by positioning them as active contributors who co-construct the meaning of their experiences. Simultaneously, the researcher attempts to understand the participant's world via the participant's own lens, which is naturally complicated by the researcher's interpretations. Consequently, a double hermeneutic, two-stage interpretation is key to IPA. The seven-stage procedure for IPA by Smith et al. (2022) was adhered to, and joint analysis between authors was conducted on two transcripts to enhance credibility and rigour. Please see Appendix 2.7 for the Detailed Data Analysis Plan, and Appendix 2.8, and 2.9 for examples of IPA processes.

The lead author analysing data they partially collected may minimise bias and enhance the credibility of findings due to the current researcher having fewer personal stakes in the outcomes (Smith et al., 2022). The lead researcher considered their reflexivity in a positionality statement (Appendix 3) and utilised a reflective diary to support ongoing examination and to facilitate discussion within supervision (Appendix 4 for example diary excerpt).

Service user involvement and IPA methodology can mutually reinforce and strengthen qualitative methodology, and interpretative validity (Mjøsund et al., 2017). Patient and Public Involvement and Engagement (PPIE) has been central to the BRIDGE co-design (Collins et al., 2025). Therefore, this study also gained feedback from a Youth Advisory Group (YAG) during analysis to ensure themes remained closely aligned to lived realities of young people. The YAG met on 9th

September 2025 and emphasised the importance of maximising opportunities for adolescents to re-engage with life, and remain on positive developmental trajectories, potentially avoiding the need for specialist or inpatient care. This strengthened not only practical relevance and resonance of findings but also addressed epistemic justice by encouraging the often marginalised and misunderstood voices to be integrated into the interpretative process.

Results

Following the in-depth qualitative analysis, four Group Experiential Themes (GETs) were formulated, namely: *Hidden in Plain Sight with a Longing to be Seen; The Value of a Relational and Responsive Approach; Re-claiming Identity and Re-writing Narratives through Shared Understanding; and The Dual Impact of Recovery: Where Pain and Healing Intersect.* Within the GETs, 12 sub-themes were identified and presented in Table 2. The four GETs were endorsed by the majority of participants, and there was a varying degree of convergence and divergence of sub-themes across individual narratives. For conciseness, illustrative quotes were selected for each theme.

Table 2 Group Experiential Themes and Sub-themes

Group Experiential Theme (GET)	**Sub-themes**
(1) Hidden in Plain Sight with a Longing to be Seen	1.1 Services neglected the neglected
	1.2 Contact without connection
	1.3: "I wish I could go back": missed opportunities to name BPD
(2) The Value of a Relational and Responsive Approach	2.1 "Working with me and not against me": the role of collaboration
	2.2 Connection and authenticity as catalyst for engagement
	2.3 The comfort of relational safety, and challenge of letting it go
(3) Re-claiming Identity and Re-writing Narratives through Shared Understanding	3.1 Mapping difficulties: from chaos to coherence
	3.2 Being understood by naming "it" not shaming or avoiding BPD
	3.3 Gaining the "why": the need to reflect on the past to inform the future
4) The Dual Impact of Recovery: Where Pain and Healing Intersect	4.1 The emotionally demanding and confronting nature of self-discovery and growth
	4.2 Trying to find acceptance of BPD in a stigmatising society
	4.3 Gaining hope: making the once impossible possible

GET 1: *Hidden in Plain Sight with a Longing to be Seen*

Across 10 participant narratives there was a profound sense that individual journeys of help-seeking begun before the BRIDGE project. Individual narratives indicated that previous experiences of (non)-engagement shaped their expectations of interactions and quality of care.

1.1 Services Neglected the Neglected

Participants often did not receive adequate support, despite a desire to be supported. Within the individual contexts, some participants described how thresholds of services often meant they went unnoticed, and consequently unsupported in a system where they were already neglected. Tamzin shared how social work missed signs and therefore neglected imminent needs:

> *I…often, kind of, fell through the cracks. I think it was because there wasn't quite enough neglect or abuse for, um, us to be taken from the home…social workers as well obviously kind of failed a wee bit because there were obvious signs…that just weren't followed up. (Tamzin)*

Some participants were able to initiate contact with services but felt as though they were dismissed. This occurred despite the difficulties which brought them to the attention of services, including the absence of a support system. This is illustrated in Sofia's account of being discharged following a suicide attempt:

> *"Can you not call any friends?" I was like "I don't have any friends". "How can you not have any friends?" I just looked at the woman and I'll never forget it. I was like "I tried to kill myself; do you think I have many friends to hang out with and to get support from?" (Sofia)*

Discharge from services were a common experience across young people, to the extent that it became the norm for Cole who described their experience as "come and see us and get discharged". Cole highlighted their frustration at the ongoing "massive vicious circle" of being seen and discharged "for years", despite still struggling to manage difficulties independently.

1.2: Contact without Connection

Seven participants reported regular contact with services, but the support they received did not meet their needs. Harper described their first experience of CAMHS as "awful", and that "they wouldn't actually listen to the words I was saying". This contributed to feelings of being dismissed and misunderstood, despite contact with mental health services intended to support their needs.

Another reoccurring experience of invalidation was that presenting difficulties were often mis-attributed to the developmental stage by professionals. For Amelia this was described as impersonalised care minimising of their difficulties:

> *[Psychiatrist and Psychologist] weren't really sure what to do with me. There was a lot of like safety planning…something they do with everybody; it wasn't really personalised care. It was just kind of "Okay, well, you're a teenager, you're growing up, there's hormones, you'll grow out of that", whatever. (Amelia)*

1.3 "I wish I could go back"; Missed Opportunities to Name BPD

Participants also felt let down by services as opportunities to identify and address BPD were missed, regardless of the young people's efforts to advocate for their own mental health. Jamie's description highlights their awareness of CAMHS taking a tentative approach to a BPD diagnosis:

> *I was…very aware of all my [BPD] symptoms. I can go into depth…I understand, what these symptoms are…I brought it up quite a lot of times with CAMHS being like, "I know this is what my diagnosis is like please can I see the psychiatrist, and we talk this through" …but most of the time they didn't 'cause I think CAMHS aren't very happy to give out diagnoses.* (Jamie)

In a few cases where diagnosis was given, participants described delays; Grace reflected on the passing of time and a desire to have been listened to when their difficulties first emerged in early childhood. The level of deterioration in their mental health meant they wished to "go back" and "work from there instead of where [they are] today". It appeared that when an opportunity for validation was missed it contributed to a sense of loss and grief for Grace:

> *I wish I wasn't so dismissed and discharged and say "all right, go off again" kind of thing and "let's just forget about you" …it was like every couple of months I was back there and…I just wish they would have caught it. I know it's not like a disease or something, but it's like I just wish people would have, like, listened to me more and took it on board. (Grace)*

GET 2: *The Value of a Relational and Responsive Approach*

Although reflecting on their previous experiences of services, 12 out of 13 participants valued approaches grounded in relational connection, and the opportunity to have their experiences mentally represented by others, instead of ignored.

2.1 "Working with me and not against me": The Role of Collaboration

For six participants the relationship with the BRIDGE trial team supported their decision to return as they felt a sense of collaboration and as though the team were working alongside them. Previous opportunities for working “with”, rather than “against”, were likely undermined by services avoiding naming BPD, thus unintentionally increasing the risk of iatrogenic harm. Harper’s recollection highlights how genuine collaboration increased their motivation to engage:

> *I actually wanted to come back each week. It was more of a…positive approach to actually working on myself to get better. And that was enforced by [therapist] …just being the way she was, like actually working with me instead of working against me. (Harper)*

Sofia’s account also highlights the helpfulness of a tailored and collaborative approach as opposed to prescriptive and diagnosis-dependent support. Their apparent guilt associated with the experience of collaboration suggests this experience was a foreign concept, but equally the key ingredient for effectiveness:

> *No matter what my diagnosis, this was about me. This was about my emotions, this was about my experiences, this was about my coping and my patterns, and it was about me. And it sounds so wrong. It doesn't really, because it's meant to be about me, isn't it? It is my therapy. This is me; it's my health. But it feels wrong to say it out loud. Like it needed to be about me. Yeah. I wanted it to be all about me. Um, but I think…that was what was right with it. (Sofia)*

2.2 Connection and Authenticity as a Catalyst for Engagement

The BRIDGE trial team’s supportive approach from the first contact also positively shaped participant experience and willingness to return/re-engage. Feeling informed and involved throughout the process increased motivation to engage as illustrated by Grace’s experience:

> *I've never stuck to any sort of like therapy and I never felt comfortable enough or even like, even honestly bothered...this is just a completely different vibe…it was still so professional, but…everybody is just so more approachable…the whole process was just simple and everything's explained properly….as soon as I was speaking in my first appointment, I kind of knew what to expect and I felt comfortable going forward. (Grace)*

2.3 The Comfort of Relational Safety, and Challenge of Letting it Go

Another facilitator of engagement was the opportunity to develop a sense of safety and comfort within a professional relationship. Participants randomised to service-as-usual, including Jamie, highlighted the importance of consistency in their interactions and how they felt “very comfortable each time [they] spoke to someone” in the BRIDGE trial team. Equally, those engaged in the therapeutic arm of the trial shared how a safe space to be vulnerable was key in enabling change; Amelia believed “If I didn’t have the relationship that I had with [therapist] then I wouldn’t have benefited from the content of the therapy”, and that this was facilitated by the creation of a “safe” space imbued with choice.

However, with great value comes fear of loss. Participants’ accounts highlighted that when relational safety is achieved, it can create anxiety, and adjustment difficulties when the relationship ends. This speaks to how influential the relationship was in the first place in that it creates a void. Linguistically, the adjective of “jarring” and repetition of not feeling “right” in Finn’s account strengthens their felt sense of struggling to accept the ending of their weekly input from BRIDGE:

> *...that was quite jarring at the end of it and then out of it…the last time I spoke to her…then I left, and it was a bit weird like the next Wednesday, and I was like, oh, I'm not doing it. And then I was a bit off for a couple weeks because I just didn’t feel right, didn’t feel right. (Finn)*

Within the theme of relational safety and endings, other participants also described containing transitions and attributed this to the use of therapeutic letters (a core feature of CAT) which appeared to provide a sense of continuity in supporting the shift out of the therapeutic relationship.

GET 3: *Re-claiming Identity and Re-writing Narratives through Shared Understanding*

Participants’ experiences converged around the importance of co-constructed understanding between them and the BRIDGE trial team. Young people described how they re-shaped the way in which they saw themselves and developed more compassionate self-stories through being seen and validated. This was a valued opportunity endorsed by 11 out of 13 participants.

3.1 Mapping Difficulties: From Chaos to Coherence

Participants allocated to the intervention expressed how a visual depiction of their difficulties in a relational mapping of patterns that kept them stuck actually enabled meaning-making. For Harper, an increased understanding of themselves created an inner structure which could be relied upon in times of inevitable confusion or misunderstanding:

> *[Therapist] was able to make me aware of a lot of things that I wasn't quite aware that I was doing. It was a whole kind of cycle thing she wrote…I wasn't aware that certain things led to certain…feelings or situations. So, it did help me have a better understanding of myself. More of a structure, I think again, or more of a foundation to fall back on. (Harper)*

Similarly, Finn described how increased insight into their patterns brought around positive, and measurable change of “healthy” behaviours in the context of a comprehensive assessment and mapping of difficulties in a visual way:

> *I was kind of just like running myself into the ground…but then through like those maps…I kind of like figured out how to stop myself from getting, like stuck in these sorts of patterns of doing stuff over and over again that weren't like healthy for me. So, I found that helpful…because I’ve been sober for, I think, 2 months now, which is really good, and I think a big part of that is because of those like maps that we put in place. (Finn)*

3.2 Being Understood by Naming “it”, not Shaming or Avoiding BPD

Eight participants spoke of the experiential shift from non-recognition to explicit naming of BPD as part of their engagement with BRIDGE. Participants within the trial were not receiving a diagnosis, however they gained a shared explanation of their emotions and behaviours, and no longer had to internalise them as personal failings, as articulated by Cole:

> *I used to be very critical of my own mental health, as much as I knew it was a personality disorder whenever I had symptoms of it I’d be very self-judgemental, oh like “Why can’t you just like get over it”…I’d spend time hating myself for it. But since kinda coming to BRIDGE, it’s made me realise it’s an actual thing that I can get help for. (Cole)*

The linguistic components of how participants referenced their BPD also highlighted the transformational impact that BRIDGE had on their experiences. For example, Finn initially referred to BPD as “it” which gives a sense of their attempt to distance and/or externalise the disorder from themselves. However, over the course of their interview they transitioned into naming ‘BPD’ and credited BRIDGE in contributing to their ability in “communicating what BPD is and how [they] deal with it and also… what to do…if [they’re] not feeling well, because [they] know what helps [them] now”. Although BRIDGE was not a diagnostic service, the opportunity to have their experiences of emotional and relational patterns named and identified seemed to enable a sense of control and ownership over their recovery.

3.3 Gaining the ‘why’: The Need to Reflect on the Past to Inform the Future

Participants also valued the opportunity to connect and consider how their previous experiences contributed to their current presentation and patterns of responding. Madelyn reported that they didn’t previously attempt to make sense of their experience, but found it helpful to understand them rather than purely enduring their feelings:

> *I feel like [therapist] was really good at…prompting you…giving you a wee nudge forward to…think back and deeper into why you're feeling. Cause I always just thought that "Oh, I'm anxious because I'm anxious" but she…prompted you to think back to when you first became anxious, to when you first became angry, and your relationships with people and I thought that was really helpful. (Madelyn)*

Learning how past experiences shaped their responses also supported participants to feel a reduction in self-blame and fostered greater self-compassion. Grace's repetition of the word "why" highlighted the significance of gaining previously unanswered questions to how their difficulties developed, and how this contributed to transformational acceptance:

> *[Therapist]…actually helped me so much for…so many things in that short amount of time…to just understand my feelings…why I'm reacting like that. Like, why, do you know, just why I am the way I am…I don't feel shamed or embarrassed…about how I'm feeling…kind of taught me, like, be in my feelings in the moment and just accept them. (Grace)*

GET 4: *The Dual Impact of Recovery: Where Pain and Healing Intersect*

Lastly, there was a high degree of convergence amongst nine participants as to how they perceived their ability to manage their difficulties, and ultimately how they imagined the future. It became apparent that navigating recovery is not without its barriers, making it a contradictory and possibly challenging journey.

4.1: The Emotionally Demanding and Confronting Nature of Self-discovery and Growth

When reflecting on the recruitment, assessment and intervention processes of BRIDGE it was evident across participant interviews that truly engaging in the process was emotionally and physically taxing, highlighting the importance of pacing as described by Imogen:

> *Sometimes we split [the sessions] up a bit…because they were just really, really they were - it was really heavy going. I was like exhausted afterwards…I could have like fell asleep pretty much 'cause it just felt like everything…it took all my brain power. (Imogen)*

The theme of navigating change in the context of self-growth was also perceived as confronting since new insights likely challenged existing ways of thinking, and therefore temporarily de-stabilised participants. However, as described by Samual the "confrontational" approach enabled both hope and a way forward:

> *I think [therapist] was very direct and upfront with me. I almost want to say like confrontational, but in a way that is good because she really challenged what I thought therapy was going to be like…[Therapist] was like "Yeah it'll be fine, but you need to put in the work"…that was something I've not heard before, and I think it really made me think about how I wanted to progress and move on in um…getting better. (Samual)*

4.2 Trying to Find Acceptance of BPD in a Stigmatising Society

Participants also had to overcome challenges due to the reality of living with their BPD difficulties whilst navigating systems which have pre-conceived ideas about personality disorders. As described by Harper, the portrayal of people with BPD as "villains" or "crazy characters" in TV or film contributes to the sense that people with BPD are "insane or can't be functional in society". Alex further highlighted the debilitating role of stigma as it exists in family and professional contexts, consequently impacting the helpfulness of diagnosis:

> *I thought it would actually just be really good if I did get to, like, speak to my Mum again and be like, "Oh this is what's wrong, you can stop figuring it out", but then I actually realised…my Mum's actually got, like, a big stigma around it…so I'm not actually sure [a BPD diagnosis] would help that much. Then I heard that…not many professionals look at [BPD] quite nicely. (Alex)*

Furthermore, Harper also commented on how the most accessible information available via Google does not provide a sense of hope or optimism and therefore contributed to their reluctance to accept the "label". This highlighted the importance of services like BRIDGE which offered support to dispel the misconception that BPD is incurable.

4.3 Gaining Hope: Making the Once Impossible Possible

Although participants recognised how challenging recovery can be, they also expressed how their engagement with the BRIDGE project provided them with hope. Sofia went as far as saying their "faith in getting help from anyone in healthcare was nearly destroyed, but BRIDGE was hope".

Participants' hopes for the future varied depending on the individual. For some their priority was related to their functioning and returning to a form of education or employment, whereas for others, relationships with themselves and others was important. However, the commonality was that BRIDGE enabled them to achieve outcomes which they had previously not even considered possible. Whilst Sofia acknowledged how their difficulties have not been completely eradicated there was an emphasis on how their engagement with BRIDGE positively altered their perception of the future:

> *I am able to have friends now. I'm able to, I mean, I still have episodes. It didn't magically resolve anything. It's not meant to. But I'm able to have a life which last year seemed nearly impossible. Seemed like a dream far away dream and something that it's taken a while obviously, and I'm still working on it. It's not resolved fully, but it feels like there's light at the end of the tunnel. That's how bridge feels like. The light at the end of the tunnel. (Sofia)*

Discussion

This study aimed to explore the phenomenological experience of young people with BPD features by examining the intersubjective meaning of engagement within the context of the BRIDGE project. Four distinct GETs were identified with inter-related sub-themes.

The first GET of *Hidden in Plain Sight with a Longing to be Seen* uncovered the paradoxical visibility of young people; participants felt simultaneously overlooked yet highly attuned to the possibility of being recognised. The current findings may suggest that young people with BPD process and experience social inclusion in a biased manner consistent with literature indicating that they often exclusion and feel a threat to their social needs, irrespective of the degree of inclusion (Weinbrecht et al., 2018). The hypersensitivity processing theory of BPD proposes that the core difficulties in BPD arise from heightened sensitivity to emotional and interpersonal stimuli, combined with difficulties regulating and integrating these experiences (Bortolla et al., 2020). This theory may explain the current findings that participants perceived rejection from services. However, this stance alone neglects the role in which services play in engaging young people with BPD. For example, as described by our participants, services not recognising BPD is harmful and linked with significant iatrogenic harm (Campbell et al., 2020).

Historically BPD was seen as a disorder of exclusion, and although there is some progression (Cannon & Gould, 2022), adolescents with BPD still face significant barriers in accessing care. Wall et al. (2021) contend that engagement with services for adolescents with BPD is shaped not only by individual characteristics, but equally by the health system. System level characteristics identified by Wall et al. (2021) were reflected in participant narratives from this study, such as limited unified services; poor treatment acceptability due to stigma; lack of formal diagnosis and limited treatment appropriateness due to all or nothing approaches.

Central to the second GET of *The Value of a Relational and Responsive Approach* was a collective consensus amongst participants in this study around the importance of feeling engaged within a positive interpersonal relationship rooted in connection. This supports findings that suggest consistent, validating and structured care can model stable and reliable interactions to patients

(Gunderson & Links, 2014) and subsequently challenges theories that hypersensitivity inevitably undermines relational stability (Bortolla et al., 2020). Moreover, the values of transparency, managing expectations, and collaboration were key to the relational approach in BRIDGE and echoed a sense of inclusion, not passivity for participants. These benefits are supported by the literature around psychotherapies for BPD which favour a collaborative stance and stress the importance of treating individuals as competent, capable and active in their care (Bateman & Fonagy, 2008).

Therapist responsiveness is known to be key in cultivating a positive alliance for individuals with BPD (Culina et al., 2023). Research has shown that adaptations to approaches, whilst adhering to treatment protocols, have positive outcomes for the patient, which is also reflective of the current findings in the context of BRIDGE (Esposito et al., 2024). For our participants, the value of connection and feeling “held in mind” was valued. This supports theories of mentalisation which posit that opportunities for individuals with BPD to perceive communication as safe and meaningful fosters engagement (Folmo et al., 2021). These findings are also consistent with broader psychotherapy research, which highlights that therapeutic alliance and respect of individual autonomy are central contributors to positive outcomes across mental-health disorders (Norcross & Wampold, 2019). In addition, similar to our findings, Oldham (2020) argues that care which incorporates information about one’s personality into the working relationship optimises engagement and outcomes.

In addition, participants’ views on the process of engagement highlighted the value of shared understanding as depicted in *GET 3: Re-claiming Identity and Re-writing Narratives through Shared Understanding*. In this study, participants spoke of the opportunity to re-frame their difficulties by understanding how their learnt patterns of responding developed; engaging with a comprehensive assessment and co-creating new narratives (i.e. relational formulation) enabled a shift from internalised shame to a more compassionate understanding of their experience. It is understandable that relational formulation is valued in young people with BPD to make sense of their emotional and interpersonal patterns; however, its emphasis on collaborative and compassionate meaning-making reflects core principles that are applicable across wider mental-health difficulties (Thrower et al., 2024). Research supports the role of an unstable sense of self being central to BPD because it affects emotional instability, chronic emptiness and relationship difficulties (Meares et al., 2011). Basten and Touyz's (2020) six-factor model of Sense of Self (SOS) further elucidates how interventions for BPD can address SOS deficits by fostering a sense of continuity, cohesion and agency. A core feature of CAT is collaborative mapping of maladaptive patterns in the context of the young person’s developmental and relational history (Ryle et al., 1997). CAT was integral to the BRIDGE intervention, and the current findings stress the utility in engaging young people with BPD to help them develop insight and ultimately a more stable SOS in non-stigmatising ways.

The final GET, *The Dual Impact of Recovery: Where Pain and Healing Intersect* revealed how participants in this study articulated change and recovery, marked by emotional demand, stigma, and hope, as reflected in the subthemes. Participant narratives highlighted that a safe and attuned space actively promoted change to increase motivation and engagement, and ultimately facilitated recovery, despite it being a challenging process. The current findings of the nonlinear process is supported by research which demonstrates change as a dynamic process of achievement and setbacks (Katsakou & Pistrang, 2018). Participants in this study also acknowledged how their journey of growth and acceptance occurred in the context of pre-existing stigma. Stigma held by health professionals must be challenged to increase system readiness and enhance engagement for young people with BPD. For example, co-designing research and clinical services in collaboration with lived experience, as core to this study, is known to tackle stigma (Collins et al., 2025).

Participants in this study highlighted that recovery was about hope and change in their functioning and not necessarily "symptom reduction." This perspective aligns closely with the 'personal recovery' model articulated in the broader mental health field which contends that living well with difficulties, regaining agency, and developing hope is more meaningful than removal of distress (Leamy et al., 2011). This conceptualisation is therefore not unique to BPD and strengthens the need for services to consider a cross-diagnostic shift towards relational and functional definitions of recovery. Our current findings also strengthens research which argues that active inclusion of lived experience perspective is needed to define and measure engagement (DiBenedetti et al., 2023).

In addition, the experience of hope and achievement for many participants in this study directly challenged the outdated notion that BPD is untreatable, although there is still some evidence in the adult BPD literature that personality traits can persist and long-term functional recovery is challenging (Gunderson, 2011). Crucially, as articulated by participants in this study, identification and intervention in adolescence allowed them to resume a healthier trajectory, and attain social and vocational functioning. The current findings provide a hopeful account from young participants that supports early identification and intervention which may lead to greater change over the lifelong course of BPD (Biskin, 2015; Chanen et al., 2022).

Strengths and Limitations

A key strength of this study lies in the use of IPA which allows for a rich, idiographic insight into the lived experience of an under-researched group. By addressing the nuanced process of engagement this study addresses the proposed research questions, which were developed in the context of gaps in the literature. Adherence to COREQ also ensured reflexivity, rigour and high-quality reporting (Appendix 5).

The current findings should be interpreted in light of some limitations. Participation in this study is an indicator of engagement and suggests these participants may have felt a degree of connection, safety or investment meaning positive experiences of engagement may be overrepresented in this sample. Self-selection bias may also mean individuals who felt more ambivalent or mistrustful of services are less likely to participate. Additionally, sampling characteristics, such as the need to verbalise their experiences, may unintentionally favour participants who are confident, have proficient communication skills or are familiar with reflective activities, further shaping the narrative captured. However, the added novel contribution of this study is the inclusion of 'hidden' young people, who had either disengaged or were not previously known to services, which subsequently shed light on contributors of previous non-engagement.

The current sample consisting of young people with BPD features may limit the generalisability of findings given their interpersonal sensitivities and fluctuating emotions may have shaped how they interpreted and reported their experiences. However, understanding how young people with BPD experience engagement was central to this study's aim, and the findings closely align with pre-existing patterns of facilitators of engagement within the broader mental health literature, suggesting this sample and subsequent findings remains both appropriate and informative.

Additionally, this study was conducted within a f-RCT which may limit its applicability to other settings that operate with varying models of care, resources or understanding of BPD; engagement is shaped by the systemic factors of service organisation, funding, and staff training meaning this may vary widely across contexts. Lastly, the lead author who conducted the IPA did not conduct all interviews. The lack of direct involvement in every interview may have reduced access to subtle contextual and relational nuances; reflexivity and triangulation in supervision attempted to overcome this limitation. However, this separation may reduce potential bias as the author was able to approach analysis with neutrality and greater distinction between individual account and interpretative lens, therefore enhancing the credibility of findings (Morrow, 2005).

Clinical Implications and Direction of Future Research

The current analysis underscores the centrality of recognition, relationships and meaning-making in shaping how young people with BPD engage with services. Meaningful engagement most likely arises when services prioritise relational consistency across all clinical encounters, and align with relationally grounded, developmentally informed and identity-supportive models of care, as opposed to rigid treatment protocols. Developmentally attuned and comprehensive assessment which offers young people the opportunity to re-frame their difficulties in a coherent and non-stigmatising way should be a standard element of care. These findings highlight that early identification of BPD should not be avoided *if* the young person is seeking to understand their experiences; reflections of hope and achievement strengthened the argument that naming a typically distressing experience enabled understanding and ultimately change towards recovery; investment in early recognition and intervention appears to enable meaningful engagement and influence clinical outcomes.

Implementation of the above will benefit from future research focused on quantifiable outcomes and integration of practitioners' views to enhance and demonstrate effectiveness. However, this study highlights a persistent gap in patient-engagement research which prioritises quantitative methods over lived experience accounts. Future research should, akin to this study, continue to consider the marginalised voices and embed their insights into service design to ensure support reflects the complexity of needs experienced by young people with BPD features.

Conclusions

This study offered an interpretative phenomenological account of how young people with BPD features understood their engagement. Engagement appeared to be a dynamic and fragile process shaped by fluctuating emotions, relational sensitivities and ongoing longing for safety and validation. Key facilitators for participation included recognition of BPD, interpersonal attunement, and opportunities to make sense of their experiences, whereas stigma and emotional overwhelm posed as barriers. Yet participants envisaged their recovery as an evolving process in which positive service engagement renewed engagement with their life. Meaningful engagement cannot solely be the responsibility of young people; services must also be accessible, responsive and grounded in the lived experience of those most in need.

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Appendices

Appendix 1.1 PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	7
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	8
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	9-11
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	11
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	12
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	11
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Appendix 2
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable,	13

Section and Topic	Item #	Checklist item	Location where item is reported
		details of automation tools used in the process.	
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	13
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	12-14
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	12-14
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	13
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	14
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing	14

Section and Topic	Item #	Checklist item	Location where item is reported
		summary statistics, or data conversions.	
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	14
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	14
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	14
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	14
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	14
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	15-16
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were	N/A

Section and Topic	Item #	Checklist item	Location where item is reported
		excluded.	
Study characteristics	17	Cite each included study and present its characteristics.	18-20
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	21-23
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	24-27
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	24-27
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	24
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	24
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	24
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A

Section and Topic	Item #	Checklist item	Location where item is reported
evidence			
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	32-34 27-31
	23b	Discuss any limitations of the evidence included in the review.	31-32
	23c	Discuss any limitations of the review processes used.	31-32
	23d	Discuss implications of the results for practice, policy, and future research.	30-32
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	11
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	11
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A
Competing interests	26	Declare any competing interests of review authors.	N/A

Section and Topic	Item #	Checklist item	Location where item is reported
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	N/A

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. This work is licensed under CC BY 4.0. To view a copy of this license, visit https://creativecommons.org/licenses/by/4.0/

Appendix 1.2. Search Terms Across Databases

APA PsycInfo <1806 to August 2025 Week 3> OVID	1 exp borderline personality disorder/ 8901 2 (((borderline or border-line) adj3 (state* or PD or disorder* or patient* or personalit*)) or BPD).ti,ab,id. 18467 3 (emotional* unstable adj5 (person* or client or patient* or PD or PDs or state* or disorder*)).ti,ab,id. 187 4 ("Axis II" or "Cluster B").ti,ab,id. 3723 5 1 or 2 or 3 or 4 21646 6 exp attention deficit disorder with hyperactivity/ 33397 7 ((attention* or behav*) adj3 (defic* or dysfunc* or disorder*)).ti,ab,id. 81560 8 ((disrupt* adj3 disorder*) or (disrupt* adj3 behav*) or (defian* adj3 disorder*) or (defian* adj3 behav*)).ti,ab,id. 15328 9 6 or 7 or 8 95923 10 exp adolescent development/ 77439 11 (adoles* or ((Emerg* or young*) adj2 (adult* or person or person* or people)) or teen* or youth or juvenile or child*).ti,ab,id. 1166500 12 10 or 11 1167586 13 5 and 9 and 12 513 14 limit 13 to english language 448
Embase <1974 to 2025 August 20> - OVID	1 exp borderline state/ 18860 2 (((borderline or border-line) adj3 (state* or PD or disorder* or patient* or personalit*)) or BPD).ti,ab,kw. 36431

	3 (emotional* unstable adj5 (person* or client or patient* or PD or PDs or state* or disorder*)).ti,ab,kw. 303 4 ("Axis II" or "Cluster B").ti,ab,kw. 4856 5 1 or 2 or 3 or 4 46403 6 exp attention deficit hyperactivity disorder/ 92217 7 ((attention* or behav*) adj3 (defic* or dysfunc* or disorder*)).ti,ab,kw. 122264 8 ((disrupt* adj3 disorder*) or (disrupt* adj3 behav*) or (defian* adj3 disorder*) or (defian* adj3 behav*)).ti,ab,kw. 16546 9 6 or 7 or 8 172576 10 exp adolescent development/ 5023 11 (adoles* or ((Emerg* or young*) adj2 (adult* or person or person* or people)) or teen* or youth or juvenile or child*).ti,ab,kw. 2986906 12 10 or 11 2987235 13 5 and 9 and 12 888 14 limit 13 to english language 820
Ovid MEDLINE(R) ALL <1946 to August 21, 2025> - OVID	1 exp Borderline Personality Disorder/ 8658 2 (((borderline or border-line) adj3 (state* or PD or disorder* or patient* or personalit*)) or BPD).ti,ab,kw. 24455 3 (emotional* unstable adj5 (person* or client or patient* or PD or PDs or state* or disorder*)).ti,ab,kw. 174 4 ("Axis II" or "Cluster B").ti,ab,kw. 3575 5 1 or 2 or 3 or 4 28815 6 exp Attention Deficit Disorder with Hyperactivity/ 37920

	7	((attention* or behav*) adj3 (defic* or dysfunc* or disorder*)).ti,ab,kw.	88681
	8	((disrupt* adj3 disorder*) or (disrupt* adj3 behav*) or (defian* adj3 disorder*) or (defian* adj3 behav*)).ti,ab,kw.	12695
	9	6 or 7 or 8	108261
	10	exp Adolescent Development/	5635
	11	(adoles* or ((Emerg* or young*) adj2 (adult* or person or person* or people)) or teen* or youth or juvenile or child*).ti,ab,kw.	2320831
	12	10 or 11	2321317
	13	5 and 9 and 12	406
	14	limit 13 to english language	369
CINAHL – EBESCOhost	S1	MH "borderline personality disorder"	3,862
	S2	TI (((borderline or border-line) n2 (state* or PD or disorder* or patient* or personalit*)) or BPD) OR AB (((borderline or border-line) n2 (state* or PD or disorder* or patient* or personalit*)) or BPD)	7,314
	S3	TI ((emotional* unstable n4 (person* or client or patient* or PD or PDs or state* or disorder*)) OR AB ((emotional* unstable n4 (person* or client or patient* or PD or PDs or state* or disorder*))	54
	S4	TI ("Axis II" or "Cluster B") or AB ("Axis II" or "Cluster B")	877
	S5	S1 OR S2 OR S3 OR S4	8,687
	S6	MH "attention deficit hyperactivity disorder"	20,485

	S7	TI ((attention* or behav*) n2 (defic* or dysfunc* or disorder*)) OR AB ((attention* or behav*) n2 (defic* or dysfunc* or disorder*))	26,643
	S8	TI ((disrupt* n2 disorder*) or (disrupt* n2 behav*) or (defian* n2 disorder*) or (defian* n2 behav*)) OR AB ((disrupt* n2 disorder*) or (disrupt* n2 behav*) or (defian* n2 disorder*) or (defian* n2 behav*))	4,557
	S9	S6 OR S7 OR S8	39,257
	S10	MH "adolescence"	642,147
	S11	MH "adolescent development"	6,715
	S12	TI (adoles* or ((Emerg* or young*) n1 (adult* or person or person* or people)) or teen* or youth or juvenile or child*) OR AB (adoles* or ((Emerg* or young*) n1 (adult* or person or person* or people)) or teen* or youth or juvenile or child*)	835,929
	S13	S10 OR S11 OR S12	1,183,376
	S14	S5 AND S9 AND S13	136
	S15	S5 AND S9 AND S13 Limiters - English Language	133

Appendix 1.3. CCAT Form and User Guide

Available for download: https://conchra.com.au/2015/12/08/crowe-critical-appraisal-tool-v1-4/

Appendix 2.1: Interview schedule

Available: https://osf.io/5wbjp

Appendix 2.2: Ethical Approval

Ethical Approval removed due to confidentiality issues.

Appendix 2.3: Reflexivity Statement

Reflexivity Statement

Prior to embarking on this research process, I was motivated to engage in a process of self-reflection to ascertain my motivations as to why I was drawn to study this population. For example, my interest has been shaped not only by academic curiosity, but also by professional and ethical considerations which were illuminated in my previous roles as an Assistant Psychologist in CAMHS and in an adult forensic setting. Both of which provided me insight into the stigma, associated reluctance to diagnose, and possible long-term adverse outcomes when individuals to not receive adequate support for their BPD. These influences interact in ways that illuminate both my positioning as a researcher, and values which underpin this research dedicated to prioritising early intervention for a population who are often misunderstood in the clinical context.

Furthermore, I am aware that my personal and professional background will inevitably influence the research process whilst studying young people with BPD features. Being a white female, having a BA (Hons) Degree in Psychology and working towards a Doctorate in Clinical Psychology may introduce preconceptions and biases to this study. As the principal investigator I had no previous relationships with any of the study participants, and those I interviewed were aware of the research being conducted as part of my clinical training. Part of my clinical training necessitates me to develop both clinical and research skills and strike the balance when they two prioritise differing objectives. For example, in clinical practice it is considered key to draw on prior theoretical knowledge to formulate presenting difficulties. However, I was astutely aware and endeavoured to remain mindful of individual interpretation during research interviews and IPA analysis to not stray far from individual accounts and ensured themes were supported with direct quotations.

In summary, my motivations, prior experience and personal characteristics potentially influence how I interpret individual narratives. Such differences can create opportunity but also challenges when attempting to understand lived experience. To mitigate this, I first recognise the possibility of my interpretations being shaped by these differences. Secondly, I endeavour to maintain a reflective stance during the research process by utilising a journal to critically examine any thoughts, feeling or possible biases. I will also utilise regular discussions with supervisors to challenge my interpretations gathering a nuanced understanding of experience which is guided by the *participant's* voice.

Appendix 2.4: Reflective Diary Example

Available at: https://osf.io/b69ft

Appendix 2.5: COREQ

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:

Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care. 2007. Volume 19, Number 6: pp. 349 – 357

Item No	**Guide Questions/Description**	**Reported on Page No.**
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/ facilitator	Which author/s conducted the interview or focus group?	Pg 50
2. Credentials	What were the researcher's credentials? E.g., PhD, MD	Pg 95
3. Occupation	What was their occupation at the time of the study?	Pg 95
4. Gender	Was the researcher male or female?	Pg 95
5. Experience and training	What experience or training did the researcher have?	Pg 95
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Pg 95
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research?	Pg 95
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Pg 95
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Pg 52
Participant selection		
10. Sampling	How were participants selected? e.g., purposive, convenience, consecutive, snowball	Pg 50
11. Method of approach	How were participants approached? e.g., face-to-face, telephone, mail, email	Pg 50
12. Sample size	How many participants were in the study?	Pg 50
13. Non-participation Setting	How many people refused to participate or dropped out? Reasons?	Pg 50
14. Setting of data collection	Where was the data collected? e.g., home, clinic, workplace	Pg 50
15. Presence of nonparticipants	Was anyone else present besides the participants and researchers?	N/A
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Pg 51-52
Data collection		
17. Interview guide	Were questions, prompts, and guides provided by the authors? Was it pilot tested?	Pg 87
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Pg 50
20. Field notes	Were field notes made during and/or after the interview or focus group?	N/A

21. Duration	What was the duration of the interviews or focus group?	Pg 50
22. Data saturation	Was data saturation discussed?	Pg 50
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	Pg 52
25. Description of the coding tree	Did the authors provide a description of the coding tree?	Pg 100
26. Derivation of themes	Were themes identified in advance or derived from the data?	Pg 52
27. Software	What software, if applicable, was used to manage the data?	Pg 100
28. Participant checking	Did participants provide feedback on the findings?	N/A
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g., participant number	Pg 53-62
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Pg 53-62
31. Clarity of major themes	Were major themes clearly presented in the findings?	Pg 53-62
32. Clarity of minor themes	Is there a description of diverse cases or a discussion of minor themes?	Pg 53-62

Appendix 2.6: Final Approved MRP Proposal

Available at: https://osf.io/zuqkm

Appendix 2.7: Detailed Data Analysis Plan

Available at: https://osf.io/9eypk

Appendix 2.8: Example of Exploratory Noting

Available at: https://osf.io/6r2fe

Appendix 2.9: Example of Personal Experiential Themes (PETs) development

Available at: https://osf.io/jz2se

Appendix 2.10: Data Availability Statement

All anonymised data from the wider f-RCT, the BRIDGE project, will be safely deposited in a repository within a year of study completion. In the meantime, please contact the corresponding author for any queries about the data used in this study.

Appendix 2.11: Declarations

Consent for Publication

Not Applicable; this study does not contain any data from any individual person. All data is anonymised.

Competing Interests

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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