

## RESEARCH ARTICLE



# Experiences of a peer group for people diagnosed with borderline personality disorder: A qualitative interview study

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## Abstract

There is a notable lack of literature evaluating peer support for people with a diagnosis of borderline personality disorder (BPD). Peer-led groups have been shown to positively impact outcomes related to empowerment, hope, and self-efficacy beliefs for consumers diagnosed with serious mental illness and may also be a helpful option for those experiencing personality disorder symptoms. We outline the coproduction of a peer group for people with a lived experience of BPD and a qualitative analysis of feedback post-group participation. Twenty-two consumers participated in post-group interviews and described their experiences of peer support. Interview transcripts were coded, and three main themes were identified: growth and change, connection and feeling understood, and creating safety. The findings suggested that participation in a coproduced peer support group for people with a diagnosis of BPD facilitated positive personal transformation as well as opportunities to develop connection through shared experiences in a safe environment grounded in mutuality. These themes were particularly powerful for participants because they countered previous experiences of not feeling safe, understood, or equal when seeking treatment. These findings support the acceptability of implementing a coproduced group for people diagnosed with BPD in a community mental health setting.

## INTRODUCTION

Borderline personality disorder (BPD) is a serious mental health condition associated with debilitating symptoms such as intense emotions that are difficult to manage, identity confusion, and significant challenges in interpersonal relationships (*Diagnostic and Statistical Manual of*

*Mental Disorders: DSM-5*, 2013). It is estimated that 1–2% of the Australian population meet diagnostic criteria for BPD (Jackson & Burgess, 2001). While a number of psychological approaches have been found to be effective in treating the symptoms of BPD (Cristea et al., 2017; Storebø et al., 2020), Australian studies exploring the experiences of carers and consumers have identified

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treatment barriers such as long waiting lists, out-of-pocket expenses, and a lack of access to services in rural and remote regions (Lawn & McMahon, 2015). Alternative models such as stepped care (Choi-Kain et al., 2016; Grenyer, 2014; Laporte et al., 2018) and coproduced interventions (Jewell et al., 2022) may increase treatment engagement and accessibility as well as address important domains of personal recovery, that is, “to love and work” (Grenyer et al., 2022).

Carrotte et al. (2019) asked consumers with a diagnosis of BPD about the perceived benefits and challenges associated with the treatments available to them. All participants identified challenges when seeking support and treatment for BPD, and most participants expressed pessimism regarding recovery. The authors noted an absence of positive representation of people living with BPD and recommended that health systems be better designed to support the recovery needs of people with a diagnosis of BPD. Stigma and discrimination towards people with a diagnosis of BPD from professional staff (Ring & Lawn, 2019) and across health systems (Klein et al., 2022) has been consistently flagged as problematic. The active involvement of people with a lived experience of BPD in the design and facilitation of interventions within health systems may be a powerful mechanism for challenging negative stereotypes, strengthening consumer engagement and participation, and shifting the focus from clinical outcomes towards personal recovery.

Traditionally, recovery from BPD has been clinically driven and measured in terms of symptom remission and/or returning to previous levels of functioning (Gunderson et al., 2011; Zanarini et al., 2010). However, consumer-driven perspectives of personal recovery take a more holistic view of mental health (Ng et al., 2016). For example, Anthony (1993) described personal recovery as a unique and deeply personal process where one's attitudes, values, feelings, goals, skills, and/or roles change over time. Ng et al. (2019) sought to understand via interviews how consumers with a diagnosis of BPD conceptualized recovery. The researchers found that people reported moving between three stages which included feeling stuck, being diagnosed, and improving experience. Movement between recovery stages was facilitated or hindered by processes including active engagement, hope, treatment, meaningful activities, and relationships (Ng et al., 2019). These researchers also examined the priorities of consumers, clinicians, and carers with respect to improving services for people with a diagnosis of BPD (Ng et al., 2020). Participants recommended that the views of service users guide service design and provision. They also noted the importance of developing peer support services to incorporate lived experience within the treatment team. Indeed, provision of peer support in

mental health settings has been found to promote hope in recovery and empowerment, increase consumer self-esteem and self-efficacy, promote self-management, facilitate social inclusion and engagement, and increase social networks (Repper & Carter, 2011).

Barr et al. (2020) sought to establish models of peer support for people diagnosed with BPD. They found that sharing experiences brought hope and connection and demonstrated that recovery was achievable. In a follow-up study, the authors explored peer worker, consumer, and clinician experiences of peer support via questionnaire (Barr et al., 2022). Five people with lived experience reflected on their experiences of peer support in individual and group settings. Specifically, the benefits of peer support for people with BPD included the ability to hold and provide hope through recovery role modelling and the establishment of an authentic connection with less of a power imbalance than may occur in clinician-led support.

While many services employ peer support specialists, access to peer groups specifically developed for people with a diagnosis of BPD has been limited until recently. Rocca et al. (2021) describe a coproduced psychoeducational group which included participants with a diagnosis of BPD within a recovery college in the UK. Outcomes from the 11-week intervention were promising with participants ( $n = 68$ ) demonstrating significant improvements in knowledge about personality disorders, reduced borderline symptom severity, and improvements in work and social functioning (Rocca et al., 2021). Jewell et al. (2022) explored the effectiveness of an 18-week online peer-led art therapy group which included skills based upon dialectical principles and topics on self-stigma, invalidation, and anger. Participants who completed the programme ( $n = 31$ ) reported a significant reduction in emotional dysregulation. Qualitative analysis of post-group feedback suggested that participants experienced increased connection with others, hope for the future, self-understanding, and appreciation for peer facilitation.

In the current study, we describe the codesign and development of a peer group and the subsequent review of this intervention through the qualitative analysis of post-group interviews with 22 consumers who participated in the peer group. The development of group-based programmes using coproduction is advantageous as the process minimizes unequal distributions of power, fosters agency, and strengthens chances of successful implementation (Morris et al., 2019).

## METHOD

The Revised Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0; Ogrinc et al., 2016) are used

to provide a framework which guides the reporting of a quality improvement intervention in healthcare. Within the method, we will describe the design of the peer group and present the study undertaken to evaluate the impact of this intervention.

## Context

The BPD Collaborative (BPD Co) is a statewide tertiary mental health service in South Australia which was established in 2019. The BPD Co model of care was developed in consultation with people with a lived experience of BPD, and a strong call for peer support groups was evident. Review of the literature revealed a lack of evidence-based peer groups for people with a lived experience of BPD. As such, a coproduction approach was utilized to tailor the programme to local community need.

A committee was established, including the BPD Co lived experience project officer, the service development manager, and 10 community members with a lived experience of BPD. The committee met weekly for 2 h over the course of 11 weeks. The vision was to develop a peer group that would provide a safe place for people to explore the possibilities of recovery and where they could work towards a life more congruent with one's own definition of what was satisfying and meaningful. Additional aims included social connection, provision of information about supports, and psychoeducation in the context of peer support.

The committee found that taking a structured approach to the coproduction promoted safe and successful collaboration. This approach included discussion about the parameters of the project, a values-based group agreement that addressed power dynamics, and strategies to manage conflict and maintain individual well-being. Further detail about the coproduction process is available in Data S1.

## Intervention

A 10-week manualized peer group programme was designed, consisting of weekly 2-h sessions. The peer group was cofacilitated by a person with lived experience of BPD and a senior mental health clinician (e.g., mental health nurse, social worker, psychologist, or occupational therapist). The lived experience worker took a lead role in facilitating the group in acknowledgement that consumers may have experienced feelings of powerlessness in clinical settings in the past. The senior mental clinician's role involved delivering psychoeducation as appropriate, observing group dynamics, providing support to

**TABLE 1** Peer group session outline.

Activity	Time taken (min)
Welcome and acknowledgement	5
Grounding/mindfulness/relaxation activity	10
Icebreaker activities	10
Group member sharing	30
Short break	10
Hands-on activity and conversation topic	50
Check-in and shake it off	10

consumers if distressed and risk mitigation if required. In order to establish a predictable and reliable framework for the peer group, a session structure was introduced and adhered to, as outlined in Table 1.

Within this structure, the content varied between sessions. Topics and activities included the following: physical aspects of well-being, distress tool kit items, strengths, self-stigma, self-compassion and self-care, relationship flow, finding moments of joy and recognizing achievements, and self-care. Group norms were established in the first session through conversations about safe sharing and power dynamics, and prompting questions were used to help the group create a values-based group agreement (including their preferred way of managing triggering topics and accessing support).

Creative activities were integrated throughout the sessions and included pot painting, collaging, vision boards, and zentangle (i.e., a relaxing style of drawing repetitive patterns). These activities were included given evidence that creative art activities can be helpful for the mental health of people who experience personality disorder symptoms (Haeyen et al., 2018). Finally, facilitators drew on principles identified using qualitative interviews of a BPD self-help group (Bond et al., 2019) which suggested that the facilitators' capacities to bring humour, praise, and experiential knowledge to the group were important drivers of success.

## Study of the intervention

The BPD Co lived experience project officer and the team research coordinator codesigned the evaluation of the peer group. A mixed-methods approach incorporating both qualitative and quantitative methods was undertaken. Qualitative interviews enable an in-depth exploration of group participants' experience, without constraining this to predetermined constructs. Quantitative methods provide a complementary evaluation of the

**TABLE 2** Peer group focus group/interview questions.

1	What were your reasons for wanting to be involved in a peer group?
2	How is peer support different from other types of mental health support you have received?
3	What do you think is the role of peer support for mental health?
4	What were the things that you liked about this peer group and what did you enjoy the most? Prompting question; which topics/strategies in particular?
5	What were the things you disliked about this peer group? Prompting question; which topics/strategies in particular?
6	How do you think the group has impacted on your well-being?
7	What would you change about the group for peer support groups held in the future? For example, content or structure
8	What are your thoughts about the group delivery? a. Length of sessions and length of programme b. Timing c. Resources and materials d. Support available during the group
9	What other feedback/comments would you like to make about the programme, its contents, or your experience of it?

effectiveness of the peer group through the use of standardized measures, tracking service-users' responses to the intervention over time. The current paper describes the qualitative evaluation of the peer group.

The peer group programme was available to South Australians who met the following criteria: (a) past or present diagnosis of BPD; (b) aged 18 years and older; and (c) fluent in writing and speaking English. Self-referral to the peer group was encouraged. Following the peer group programme, the research assistant contacted participants who had consented to research participation and scheduled either a focus group (where at least two participants were present) or an individual phone interview. Interviews were conducted by a member of the research team who was not involved in the group facilitation to reduce the risk of social desirability bias.

## Measures

The interview/focus group questions explored what participants liked and disliked about the peer group and recommendations for improvement. All interviews were recorded electronically. A full list of the questions and prompts are outlined in Table 2.

## Analytic approach

Following the guide of Braun and Clarke (2013), reflexive thematic analysis was utilized to identify themes and patterns of meaning across the dataset. We took an inductive method to the analysis, seeking to produce "open" codes that were solely reflective of the content of the data (Braun & Clarke, 2013). A "complete coding" approach was undertaken to identify any data from the transcripts that were relevant to the research questions (Braun & Clarke, 2013). The analysis was semantic focussed, with themes generated from the surface and explicit meanings of the data, rather than attempting to ascribe deeper, potentially incorrect, meaning (Byrne, 2022). Overall, we followed the six-stage process of coding and thematic analysis outlined in Braun and Clarke (2013). Focus groups/interviews were transcribed, and participants were assigned a pseudonym to maintain confidentiality. Each interview lasted for approximately 30 min.

Prior to any coding of the transcripts, the consumers were sent a copy of their verbatim transcript for member checking, a step involved in qualitative research methodologies to ascertain the intent of the consumer's responses and the accuracy of the transcripts (Birt et al., 2016). Transcripts were analysed thematically to generate in-depth understandings of the consumer's experiences, thoughts, and opinions of participating in the peer group. Authors D. B. and S. D. initially coded the transcripts separately and then discussed the results to identify discrepancies. S. D. then generated an initial set of themes.

The co-authors (S. D., D. B., J. G., and K. K.) read through the themes and met approximately five times to review them. During this stage, we considered which themes contained insufficient meaningful data or inadequate context and discussed the boundaries of those themes which comprised more data (Byrne, 2022). Disparate themes were identified and set aside, that is, those that did not capture the most important elements of the data in relation to our research question. This process involved continuous and ongoing reference back to the initial codes from the transcripts and was not conducted in a linear fashion. The themes that were generated from the data were considered by all authors to constitute an appropriate representation.

## Ethical considerations

Ethics approval was gained from the Central Adelaide Local Health Network Human Research Ethics Committee (reference number: 13317). Consumers who attended the peer group programme were advised that the programme was being evaluated, provided an information

sheet explaining the nature of the research, that participation in the evaluation was voluntary, and nonconsent would not impact on their access to the intervention. Consumers who signed and returned either a hardcopy or electronic consent form were contacted by the BPD Co researchers to participate in a post-group qualitative interview or focus group in person or over the phone. Consumers who travelled to the BPD Co office to participate in the focus groups/interviews had their travel expenses reimbursed. No other financial incentive was provided for research participation.

## RESULTS

### Participants

Forty-seven people registered for the peer group between July 2020 and April 2022. Thirty-two people consented to research participation, and 22 consumers attended either a focus group ( $n = 6$ ) or individual semistructured interview ( $n = 16$ ) post-group. Participants were aged between 21 and 68 years ( $M = 42.59$ ,  $SD = 11.90$ ); 87% were cisgender women and 13% cisgender men. Participants attended one of six groups which were delivered in the time frame. Two groups were delivered face to face ( $n = 9$ ), three online ( $n = 9$ ), and one group moved from face to face to online ( $n = 4$ ) as necessitated by local emergency directives during the pandemic. Most participants were Australian (87%), and no participants indicated that they were Aboriginal and/or Torres Strait Islander. Participants were located across South Australia including metropolitan and regional areas.

### Reflexive thematic analysis

Three main themes were identified from the data. First, consumers reported that the peer group gave them an opportunity for personal growth and change. Second, consumers discussed how they felt socially connected to others within the peer group which led to feeling understood. Finally, consumers identified the ways in which the group helped them to feel safe, describing and depicting the mechanics of group.

#### Growth and change: What I gained from the peer group

Participants appreciated the content of peer group sessions and shared reflections on how this influenced growth and change in their lives.

... learning different strategies to recognize our triggers and how to lessen the intensity of our triggers. There was always something that we could pick up, a new strategy of having to deal with it and get through our triggers and our moments, our meltdown moments.

Participants associated particular learnings to increased self-confidence and empowerment. For example,

I just noticed this morning when I got these cards \*holding cards and shuffling through them\* there are some messages here that I never had when I was growing up like “believe in yourself,” “have fun and play,” “you’re protected and safe” ... it is so ... empowering and I really believe that is really important.

One participant likened the group to “opening a present” and “soaking your thirst,” with reference to being able to access a group environment that offered skills and suggestions which she had not been able to find before. Similarly, another participant described the significance of the group for them as follows:

If it wasn’t for the group, I would probably still be sitting in the corner in the foetal position rocking back and forwards trying to get an understanding of it [BPD] .... Yeah, I just have a better understanding of everything that is going on and I know now if one thing doesn’t work to calm the situation, I know that there’s other things that I can go to as well.

Noteworthy within this theme was the concept of stigma, with one participant noting that peer groups in mental health can hold a “destigmatising role.” Another participant described his own growth and reduction in self-stigma:

... not being alone in this diagnosis and this experience was absolutely invaluable in terms of my ... the sense that I could recover ... but also being able to move from the stigma. I had a lot of self-stigma about my diagnosis, well, not only the diagnosis but ... probably more the concern that I didn’t actually have a diagnosis and that, you know, I was just being weak or not being ... “stiff



upper lip” and all those things men are supposed to be in particular. So, I think that even though I was in a group of women, it actually helped break that down which was great.

Finally, the role of the group in facilitating meaningful activity was noted by one participant:

Every week I looked forward to doing that “creative thing,” to keep continuing on whatever it was that I was working on ... and yeah I think it impacted my mental health really well just to know that even if I was having a bad week, that was something to look forward to.

### Connection and feeling understood: How peer group helped

This theme was dominant within the research, and it was striking how this was also woven within other themes. Every participant, at some point during their interview or focus group, commented on feeling a sense of connection in the group, emphasizing the value in feeling connected both with other group members and also the facilitators. One consumer described it as “really liberating to be with people who have lived through and understand the trials and tribulations and also the good points of having BPD,” and another consumer noted “I’m suddenly listening to all of these people and realizing that they kind of are like me, you know, in ways thinking and behaviour and yeah, so it certainly does, it breaks the isolation.” Consumers appreciated the opportunity to socialize in a safe environment, with at least four participants who reported that they had struggled with socialization skills. For example, “I found it good to be in a social environment where it wasn’t high-pressured. Yeah, ‘cos my social skills are not great, so I just found that actually really good.”

There was mixed feedback about the experience of groups when delivered in an online format and the impact this had on connection. Participants in a focus group discussed this as follows:

Person 1: It is that you’re missing a lot of the visual cues and just ... and I think it’s probably a bit harder for the facilitators too, because they’re like talking to a dead audience, do you know what I mean? It’s like being a comedian and everybody is going “no.”

Person 2: It’s just not the same as this face-to-face interaction, it’s a different ....

Person 1: There’s no flow really. But I think they did well under the circumstances.

Person 2: I totally agree with you ....

Person 1: It was better to have it than not, yeah.

Feedback about the challenges of the online group also reflected practical difficulties such as technological challenges like access to devices and stable internet. This was particularly challenging when the group shifted to online delivery unexpectedly compared with when people had specifically opted for this modality. In contrast, other participants noted that they still felt connected even when the group was online: “I felt like it [connection to the group] was still quite strong and I think because we were at home and we also had our pets there.”

### *Shared experiences*

The subtheme of shared experiences illustrated how crucial it was for participants to feel understood. Sharing a diagnosis of BPD served to normalize and validate their struggles and reduce isolation. As articulated by one of the consumers:

It’s not as scary to talk about whatever it is relating to BPD in a room full of people with BPD, as it would be trying to talk about with other people who either don’t know what it is or might have their own interpretation of what it is.

This consumer went on to describe being able to find “relatableness” in the room, which instantly made her feel better. The sense of a shared experience also negated stigma, with participants demarcating the group from other places in their lives where they did not feel understood. Feelings of connection and solidarity felt by participants extended beyond their direct participation in the group, as one participant remarked.

When I’m not doing well, and I think no one understands, I remember them [the peer group consumers] and I remember they do and they’re actually living in the real world right now. So they’re out there and they’re pushing forward so you can keep going as well.

### Creating safety: The mechanics of group

Creating safety in group was articulated in several different ways. Participants appreciated the values held in

group such as acceptance, transparency, and equality and also the more practical and tangible elements which scaffolded the group, such as commencing with a check-in each session and planning how to address sensitive topics. While this structure provided safety, participants noticed the flexibility within it and described feeling comfort which enhanced safety, as evidenced within the following reflection:

It was good that there was a positive atmosphere, everyone seemed very supportive of each other, and everyone was considerate in the information shared. They did not disclose information that could be triggering to other people. Also, what they were saying, there was a degree of honesty but there was also a degree of making sure that we can learn from each other.

Another consumer said, “I feel safe here because I’m with people who have training and expertise in understanding BPD. I’m with people who have lived experience of BPD, I feel accepted.” A particularly striking account of safety was evident in the following account:

Just offer it [peer group] again because there are going to be people who once upon a time may not have accessed that help ... I’ve tried so many other things, I’ve been turned away from emergency departments because they tell me that I’m just attention seeking, you know? That’s what I mean about this huge sigh of relief because it’s like ... finally there is a place for people who are diagnosed with BPD to be able to feel safe, to be able to feel like we are understood, we do have people who are knowledgeable and who can offer us the tools and the skills and just the socialization I find that I crave that sort of help and that very specific assistance because, you know, it is, it’s a very ... emotionally harrowing disorder.

Creating a space where people could speak without pressure was valued by one consumer who noticed “it was very open and transparent and easy to talk and open up because it was allowed in a space where you could say what you wanted to say without feeling like you had to say anything at all.”

### *Equal footing*

This subtheme illustrated differences between experiences of peer support and other professional supports.

The equality or validation noted in peer group was contrasted with a clinician-led approach, which one consumer described as casting them “as sick or damaged or ... not quite right.” Another consumer made the following distinction:

I find the difference is within a peer support group it’s more ... I guess, the participants work together with the facilitators to run the groups ... but it’s less of a traditional teaching and learning model ... this group was a bit more fluid ... I think ... you sort of felt more on an equal footing with everyone rather than the facilitators were the ... gatekeepers of the knowledge ... I just felt that it was more of a collaborative kind of learning and group.

While this equal footing was considered beneficial by most participants, one participant identified that the peer group environment may not work for someone in crisis who may instead benefit from a more controlled environment, while another stated:

In the detriment category, it’s sort of like, well they’re arriving with their own problems, and they don’t actually, you know, they’re trying to solve their own, they can’t help you with yours in a way. So, it was good for bonding, but it wasn’t necessarily helpful for recuperation.

This reflected the importance of a holistic approach to mental health care in which people have access to both peer and clinical support.

## DISCUSSION

The current study explored participant experiences following engagement in a peer group programme for people with a diagnosis of BPD, developed and implemented using principles of coproduction. A qualitative approach enabled an in-depth exploration of participant feedback. Key themes suggested that people experienced “growth and change” from participating in the group. Second, the group provided the consumers with a sense of “connection and feeling understood” through the exchange of “shared experiences,” although it was noted that in those instances when the group needed to move to an online modality, some consumers struggled to maintain connection. Third, peer group seemed to have an important function of “creating safety” with an emphasis on “equal

footing” between facilitators and participants, something that differentiated the group from usual clinical support.

The themes identified in the feedback from peer group participants align with the extant literature regarding benefits of peer support for people with serious mental illness, specifically social support, empowerment, increased self-efficacy, and promotion of self-management (Repper & Carter, 2011), and demonstrated that this is also achievable for people diagnosed with BPD in a group setting. The findings parallel qualitative feedback in the evaluation of a skills-based peer-led art group for people with difficulties in emotional regulation and BPD, in which participants reported benefits in being able to be vulnerable and connected with others, with the role of peer facilitation bringing authenticity to the experience (Jewell et al., 2022). Our findings emphasized how a peer-led group helped people to feel safe and overcome some of the barriers that may be perceived in clinical settings, given consumers may be less concerned about power dynamics when interacting with peer workers (Barr et al., 2022).

The peer group facilitated the sharing of experiential knowledge which was also identified as valuable within a self-help group for people with a diagnosis of BPD (Bond et al., 2019). Shared experience held particular significance for participants as it directly contrasted previous experiences of feeling misunderstood or judged. Bond et al. (2019) described this commonality, noting that it reduced the likelihood of feeling like an outcast. Given people with BPD experience significant stigma in relation to their diagnosis (Ring & Lawn, 2019), it makes sense that the creation of a space which emphasized safety and inclusion for people with BPD would be perceived as valuable. These findings align with the recommendation that enhanced empathy is needed to overcome stigma associated with BPD (Ring & Lawn, 2019).

Participants in the current study noted personal growth through knowledge, skills acquisition, and engaging in meaningful activity. Reflections by consumers regarding reduction in “meltdowns” and an increased ability to bring about calm may be likened to therapeutic goals around emotion regulation.

Similar to Jewell et al. (2022), integrating creative activities into the group structure was important and may increase treatment engagement for people who find traditional therapeutic environments overwhelming or a poor fit to their needs. The literature suggests that while some people with borderline symptoms go on to achieve personal recovery (stable functioning with good interpersonal relationships, self-worth, and vocational functioning), those that do not improve over time may benefit from programmes that specifically focus on activities of daily living and interpersonal relationships (Grenyer

et al., 2022). Certainly, the narratives of some of the participants interviewed in the current study indicated that the group provided them with something to look forward to each week, adding structure to their routine. Further, given the strong themes of connection and feeling understood, the peer group may be particularly helpful for people with BPD who are socially isolated.

The peer group appeared to address an unmet need within treatment options currently available for people with BPD. In the codesign phase of the current peer group, a review of the literature revealed several evaluations of peer group programmes developed for people who are diagnosed with severe mental health conditions (Aschbrenner et al., 2016; Cook et al., 2012; Lyons et al., 2021), but it was difficult to identify programmes specific to people with a diagnosis of BPD with only a few papers published in more recent years (Bond et al., 2019; Jewell et al., 2022; Rocca et al., 2021). This is interesting considering that relational difficulties are hypothesized to be core to personality disorder pathology and would be a reasonable target for intervention. Research into the long-term recovery from personality disorders suggests that while symptoms may remit over time, difficulties in psychosocial functioning continue for many (Gunderson et al., 2011; Zanarini et al., 2008). The findings of the current study suggest that the group provided participants with connection and social support in the short term.

## Limitations and strengths

There were a number of limitations to the current study. First, participation in the post-group interviews was optional and feedback may be positively skewed given that people who dropped out were less likely to be interviewed. Future research could explore factors contributing to drop out among those who do not complete peer groups. Second, research participants were predominantly cisgender women. There is a lack of literature into men's views of peer support and whether it would need to be tailored differently to meet their needs. The peer group was adapted to an online setting during the global pandemic. We noted mixed feedback from participants about the group being delivered online which was compounded for some by practical difficulties accessing devices and stable internet. While some people noted that online groups increased their socialization, others may benefit from groups run in person, highlighting the need for different options to be available. Further research into the factors underlying the benefits of face-to-face and online peer groups is needed. Finally, the findings of the current study speak to the acceptability of the



intervention based on the analysis of qualitative interviews. An analysis of the group effectiveness tracking participant outcomes over time will be reported in a separate paper. Despite these limitations, this paper describes one of the few coproduced peer groups designed specifically for people with a diagnosis of BPD.

## Clinical implications

This codesigned peer group for people with BPD, with facilitation led by someone with a lived experience of BPD, seemed to fulfil an unmet need. While it is not clear why peer groups for people with BPD are not widely available, it is possible that this is due to a wariness around establishing nonclinical groups for people who experience relational difficulties as a result of heightened interpersonal sensitivity. In contrast, the themes from interviews suggest that consumers who completed the group found it to be a safe space for them and the bringing together of people with a shared experience of BPD was noticed and valued by participants.

It should be noted that the group was coproduced with a clear structure designed to mitigate potential challenges with the group dynamic. For example, the first session focussed on the group values-based agreement and what to do when power differentials were at play. This addressed boundaries, and both facilitators and participants understood what to share, what to refrain from sharing, what to do if there were disagreements, if triggered or needing support, and how to relate to one another during these difficult conversations.

## CONCLUSION

This study adds to the limited literature about codesigned peer groups specifically for individuals diagnosed with BPD. Based on the reported experiences of over 20 consumers who participated in the group, there was a consistently positive response. Participants described experiences of growth and change, valuing the sense of “connection and feeling understood” through the exchange of “shared experiences.” Peer group also had an important function in “creating safety” with an emphasis on “equal footing.” These themes held power for participants because they contrasted favourably to experiences when they had not felt safe, understood, or equal. Finding a space where it was “not as scary to talk about whatever it is relating to BPD” countered worries about being understood or accepted with a diagnosis which remains heavily stigmatized. In sum, coproduction of peer groups

may be a powerful tool of engagement, supporting the recovery needs of people with a lived experience of BPD.

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## CONFLICT OF INTEREST STATEMENT

Not applicable.

## DATA AVAILABILITY STATEMENT

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

## ETHICS STATEMENT

Ethics approval was gained from the SA Health Central Adelaide Local Health Network Human Research Ethics Committee (approval number: 13317). All participants provided consent prior to participation in the research interview.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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