

INTIMATE PARTNERS' AWARENESS OF AND RESPONSES
TO SELF-INJURIOUS THOUGHTS AND BEHAVIOURS IN
PEOPLE WITH BORDERLINE PERSONALITY DISORDER: A
MIXED-METHODS DESCRIPTIVE STUDY

TALIA TISSERA

A THESIS SUBMITTED TO THE FACULTY OF GRADUATE
STUDIES IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS

GRADUATE PROGRAM IN PSYCHOLOGY

YORK UNIVERSITY

TORONTO, ONTARIO

August 2024

© Talia Tissera, 2024

Abstract

Intimate relationship dysfunction is characteristic of borderline personality disorder (BPD), and partners' behaviours may exacerbate or ameliorate self-injury in BPD. Therefore, this study investigated partners' awareness of people with BPD's self-injury, how they find out about self-injury, their responses to self-injury, and their self-evaluated helpfulness. To address these aims, 15 people with BPD and their 15 partners reported on the presence or absence of self-injury for 30 days; partners also reported how they found out about self-injury for 30 days and completed semi-structured interviews about a recent response to self-injury and their self-evaluated helpfulness. Partners were aware of 40% of self-injury, and 66.7% found out about self-injury because people with BPD disclosed it. Qualitatively, most partners responded to self-injury by soothing, protecting, and/or problem solving for people with BPD. Most partners observed mixed or negative reactions to their efforts, and perhaps consequently, some felt lost about how helpful they were.

Keywords: Borderline Personality Disorder, Self-Injury, Partners, Disclosure, Qualitative

Acknowledgements

Writing this thesis has made it even clearer to me that I am surrounded by incredibly supportive friends and family. Thank you to my mom and dad for believing in me at every step along this journey and taking care of me as I finally got to the finish line. Thank you to my brother, Shane, for always being generous with his time and a ride – I'd be stranded without him. Thank you to my girlfriend, Corrie. I now know what it's like to write a master's thesis, and she now knows what it's like to live with me while I write one. I truly cannot thank her enough. Thank you to Liz Earle for capturing the experiences of intimate partners of people with BPD with her insightful interviewing skills and sharing the highs and lows of the thesis process with me. Thank you to Hannah Mugford for diligently transcribing the interviews at the centre of this thesis. Thank you to my peers at the TULiP Lab, especially Omega Luxor, Kamyia Goenka, Lindsay Fulham, Sonya Varma and Ashley Siegel, for their contributions to this research and their friendship. Thank you to Dr. Matt Southward, my committee member, for contributing his expertise and eye for detail to this project. And of course, thank you to my supervisor, Dr. Skye Fitzpatrick, who has taught me so much in the relatively short time I have known her, and cheered me on while challenging me to reach higher. So many people have helped me create a thesis project I can be proud of, and for that I am grateful.

Table of Contents

Abstract	ii
Acknowledgements	iii
Table of Contents	iv
List of Tables	vi
List of Figures	vii
Introduction.....	1
Relationship Dysfunction in BPD	2
The Borderline Interpersonal-Affective Systems (BIAS) Model.....	4
Disclosure of SITBs to Intimate Partners.....	5
Intimate Partners' Awareness of SITBs	6
Intimate Partners' Responses to SITBs	8
The Current Study	9
Methods.....	10
Participants	11
Procedures	12
EMA Measures.....	13
Data Analytic Strategy	14
Results.....	18
Aim 1: Intimate Partners' Awareness of Self-Injurious Behaviours	19
Aim 2: How Intimate Partners Find Out About Self-Injurious Behaviours.....	21

Aim 3: Intimate Partners' Responses to SITBs.....	23
Aim 4: Intimate Partners' Evaluations of the Quality of Their Responses to SITBs	31
Discussion.....	39
Intimate Partners' Awareness of Self-Injurious Behaviour in Daily Life.....	40
How Intimate Partners Find Out About Self-Injurious Behaviour in Daily Life.....	42
Intimate Partners' Responses to SITBs.....	43
Intimate Partners' Evaluations of The Effectiveness of Their Responses	46
Clinical Implications	54
Limitations and Future Directions.....	55
Conclusion.....	57
References.....	58
Appendices	72
Appendix A: Demographics.....	72
Appendix B: Semi-Structured Interview Protocol	75

List of Tables

Table 1: Dyadic Agreement on NSSI	20
Table 2: Methods by Which Intimate Partners Found Out about Partners with BPD's Self-Injurious Behaviour	22
Table 3: Intimate Partners' Qualitative Responses to SITBs.....	30
Table 4: Intimate Partners' Evaluations of Their Responses to SITBs	39
Table A 1: Dyadic Demographic Characteristics	72
Table A 2: Individual Demographic Characteristics	73

List of Figures

Figure 1: Visual Example of a Within-Timepoint False Negative at Prompt 2.....	16
Figure 2: Individual and Paired Reports on the Presence or Absence of NSSI	19

Introduction

Borderline personality disorder (BPD) is a severe disorder that affects 2.7% of adults (Tomko et al., 2014). BPD is characterized by persistent and pervasive dysfunction and volatility in affect (e.g., intense anger, chronic emptiness), interpersonal relationships (e.g., cycling between idealizing and devaluing significant others), identity (e.g., abruptly shifting personal values and interests), cognitions (e.g., transient and stress-induced paranoia), and behaviours (e.g., self-injury, reckless driving) (American Psychiatric Association, 2022; Bohus et al., 2021; Linehan, 1993). Suicidal and self-injurious thoughts and behaviours (SITBs) are of particular concern in BPD. For the purposes of this study, self-injurious behaviour encompasses non-suicidal self-injury (NSSI) and suicide attempts, and self-injurious thoughts encompass any cognitions about those behaviours. NSSI involves causing deliberate, self-inflicted damage to one's own body tissue (e.g., cutting, burning, or scratching oneself) without the intent to die (Klonsky, 2007). Suicide attempts involve either deliberately injuring oneself or performing an action with the expectation of injuring oneself (e.g., walking into the road with the intention of being hit by a car), with the intent to die (Nock et al., 2008).

While SITBs are not unique to people with BPD, the co-occurrence of SITBs and BPD is particularly common and severe. An estimated 79% of adults with BPD have attempted suicide and as many as 90% of adults with BPD have a history of NSSI (Goodman et al., 2017), compared to 6% and 22% of the general population, respectively (Lim et al., 2019). Furthermore, suicidal thoughts and NSSI are more severe and chronic in adults with BPD than in adults who self-injure and do not have BPD (Turner et al., 2015). Taken together, this makes BPD among the most lethal psychiatric disorders, with a suicide rate as high as 10% (Black et al., 2004). In addition to being lethal in and of itself, the co-occurrence of NSSI and BPD is associated with

greater emotion dysregulation, loneliness (Glenn & Klonsky, 2013), and mental healthcare utilization (Sansone et al., 2018) than BPD alone. Similarly, the combination of SITBs and BPD is associated with lower quality of life than SITBs without BPD (Kaess et al., 2017). Ultimately, this evidence suggests BPD in combination with SITBs is more severe and lethal than either BPD or SITBs alone. Consequently, it is important to identify factors that contribute to SITBs in people with BPD and how those factors could be targeted to reduce SITBs. People with BPD's intimate partners may be aware of the occurrence of SITBs and their behaviour in these instances may represent unique and important real-world intervention opportunities for reducing people with BPD's SITBs. Therefore, this study investigated the extent to which intimate partners of people with BPD were aware of the self-injurious behaviours of their partners with BPD, and the extent to which intimate partners believed their responses to SITBs were helpful or unhelpful to their partners with BPD.

Relationship Dysfunction in BPD

One potentially important contributor to SITBs in BPD is relationship dysfunction. Broadly, relationship dysfunction is characteristic of BPD (Lazarus et al., 2014), and evidence suggests intimate relationships are especially impaired (Hill et al., 2008). BPD is associated with poorer problem solving in intimate relationships (compared to healthy controls; de Montigny-Malenfant et al., 2013; and those with fewer BPD symptoms; Lavner et al., 2015), more hostility toward intimate partners than non-intimate partners (Lazarus et al., 2018), and higher rates of relational conflict, breakups, violence, and divorce than community samples (Bouchard et al., 2009; de Montigny-Malenfant et al., 2013; Tomko et al., 2014). This impairment may be specific to BPD; while people with BPD and people with antisocial personality disorder experience higher rates of social dysfunction than people without personality disorders, intimate relationship

dysfunction is uniquely severe in people with BPD (Hill et al., 2008). Data suggests that people with BPD also find relationship dysfunction to be particularly distressing. Compared to healthy controls, women with BPD experience more threat to their person and the relationship when talking to a male intimate partner about separating (Miano et al., 2017), and people with more BPD features experience more loss and negative affect in response to intimate partners initiating conflict and other negative interactions (Bhatia et al., 2013). These findings indicate that intimate relationships, more than other relationships, are highly impaired in people with BPD.

Intimate relationship dysfunction may be particularly important in eliciting and maintaining SITBs in BPD. A considerable body of research indicates that intimate relationship dysfunction precedes suicide attempts. In community samples, negative events involving an intimate partner can elicit impulsive suicide attempts within 48 hours (Bagge et al., 2013), and many intimate relationship stressors (e.g., separation, conflict, infidelity, and rejection) are associated with suicide death (Kazan et al., 2016; Overholser et al., 2012). In people with BPD, arguments with intimate partners and other relational stressors precede an estimated 73.7% of first suicide attempts (Brodsky et al., 2006). Over the span of years, relationship dysfunction and interpersonally-oriented experiences (i.e., abandonment) predict suicide threats and attempts in people with BPD (Soloff & Fabio, 2008; Wedig et al., 2013). Intimate relationship dysfunction also motivates NSSI. Among people with BPD, perceived rejection predicts NSSI urges or thoughts in daily life (Hepp et al., 2021), with the intensity of rejection rising in the lead up to NSSI and falling gradually afterward (Snir et al., 2015). Likewise, low interpersonal positivity is associated with NSSI in some people with BPD, and people with BPD perceive day-to-day interactions with intimate partners as distinctly more negative than interactions with others

(Wright et al., 2016). These findings indicate that intimate relationship stressors and perceptions about them (e.g., rejection, abandonment) may be key drivers of SITBs in those with BPD.

Nonetheless, the detrimental effects of relationship dysfunction may be balanced by the ameliorative effects of healthy relationship functioning. Satisfying romantic relationships are associated with lower anger among people with BPD in the short term (Kuhlken et al., 2014), and non-distressing intimate relationships are associated with BPD symptom remittance in the long term (Zanarini et al., 2015). These findings suggest that interactions between people with BPD and their intimate partners can positively or negatively impact BPD symptoms, possibly including SITBs. Therefore, further investigation of intimate partners' behaviours in relation to people with BPD's SITBs could indicate the extent to which intimate partners' behaviours could be targeted or leveraged to reduce SITBs in those with BPD.

The Borderline Interpersonal-Affective Systems (BIAS) Model

Fitzpatrick et al.'s (2021) Borderline Interpersonal-Affective Systems (BIAS) model describes how significant others (e.g., intimate partners, friends and family) contribute to the inadvertent elicitation and reinforcement of SITBs and other self-damaging behaviours in people with BPD. The model suggests that people with BPD are particularly sensitive to potential interpersonal threats, which elicit stronger aversive emotions than non-interpersonal threats (e.g., a math stressor). As is well-supported in the literature, people with BPD may then engage in self-injurious or otherwise self-damaging behaviours to reduce aversive emotions, and the short-term relief produced by that behaviour reinforces it (e.g., Kuehn et al., 2022). Critically, the BIAS model specifies that significant others can also inadvertently elicit and reinforce self-injurious behaviour. The model suggests that, as significant others repeatedly navigate conflict with those with BPD as well as their self-damaging behaviours, they develop negative beliefs about people

with BPD and their distress. These negative beliefs may increase significant others' reactivity to and/or avoidance of potential conflict (e.g., "he's so sensitive, anything could lead to SITBs"), or their engagement in conflict in unskillful ways (e.g., "he is manipulative and is faking his distress"). The resulting communication problems and conflict transact with, and mutually escalate, people with BPD's own difficulties communicating and contributions to conflict. These communication and conflict problems can increase people with BPD's distress and heighten the likelihood of self-injurious behaviour. Additionally, if people with BPD self-injure, significant others may respond by decreasing criticism or increasing care and attention (i.e., accommodation), which may inadvertently reinforce self-injurious behaviour. As such, the BIAS model emphasizes that intimate partners' negative beliefs about BPD, and their resultant responses to conflict and SITBs, can elicit and contribute towards the maintenance of SITBs over time. The BIAS model indicates that involving significant others of those with BPD in SITB interventions may help disrupt the reinforcement of SITBs and other BPD pathology. However, the extent to which the BIAS model could be applied in interventions depends on the validation of the model's underlying assumptions, such as whether intimate partners are aware of SITBs often enough to respond to, and thereby reinforce, them.

Disclosure of SITBs to Intimate Partners

The aforementioned BIAS model suggests that intimate partners' responses to SITBs may play a significant role in their maintenance. However, this presumes that intimate partners are aware of the occurrence of SITBs in those with BPD in the first place. Simply, if intimate partners of people with BPD are not being told about SITBs, or are otherwise unaware of them, intimate partners' responses to SITBs would not be a meaningful target for BPD and SITB interventions, and the BIAS model's assumptions may be inaccurate. In community samples,

50% to 60% of individuals disclose NSSI to someone (Simone & Hamza, 2020), while only 40% to 50% of individuals disclose suicidal thoughts or behaviours to informal supports (Hallford et al., 2023). Individuals may be more likely to disclose NSSI to intimate partners rather than friends as they age (Simone & Hamza, 2020), and family (including intimate partners) receive a greater number of suicide-related disclosures than friends or health professionals (Hallford et al., 2023). These findings suggest that intimate partners are frequently recipients of SITB disclosures, which puts them in the position to respond in ways that might ameliorate or exacerbate SITBs. Nonetheless, it is generally unclear how often intimate partners of people with BPD are aware of their SITBs. Such information is vital to assess whether improving intimate partners' responses to disclosure would be relevant to SITB interventions for BPD.

Intimate Partners' Awareness of SITBs

In addition to it being unclear how often intimate partners of people with BPD are aware of people with BPD's SITBs, it is also unclear whether their perceived awareness is accurate. Simone and Hamza's (2020) review of the disclosure literature found that researchers often conflate NSSI disclosure (i.e., voluntarily revealing NSSI) with NSSI discovery (e.g., another person seeing NSSI scars). This lack of a distinction may obscure potential differences in how helpful conversations about SITBs are when they are initiated voluntarily by people with SITBs or involuntarily by significant others. The lack of research on intimate partners' awareness may be due to the assumption that their awareness of SITBs always or almost always results from people with BPD's voluntary disclosure of SITBs, and therefore, that measuring awareness is not necessary if disclosure is being assessed. However, if intimate partners are observing SITBs more often than people with BPD realize (e.g., due to visible signs of harm or other cues), or perhaps overestimating SITBs (e.g., due to misattribution of cues), then disclosure and awareness

cannot be conflated, and the accuracy of intimate partners' reported awareness of SITBs would need to be measured directly against people with BPD's reports of its actual occurrence.

To the author's knowledge, no studies describe intimate partners' awareness of NSSI, and limited research describes intimate partners' awareness of suicidal thoughts or behaviours, albeit not in people with BPD. In mixed-gender couples, only 23% of people know about their intimate partner's past suicide attempts and only 14% agree with their intimate partners that future suicidal behaviour is possible, despite 77% knowing about their intimate partner's past suicidal thoughts (May et al., 2019). In clinical populations, awareness of suicidal thoughts and behaviours may be higher. For example, among significant others of suicidal older adults in inpatient or outpatient mental healthcare, 81.6% of significant others are aware of their loved ones' suicidal thoughts while 18.4% are not (Heisel et al., 2011). Similarly, adult psychiatric inpatients with depression have moderate to high agreement with their intimate partners and other informants on stressful life events leading up to a suicide attempt, including interpersonal stressors or divorce (Dejong & Overholser, 2009). Nonetheless, there is always a possibility for significant others to over-estimate suicidal thoughts or behaviours. Among older adults who do not endorse suicidal thoughts, 41% of significant others believe they are suicidal (Heisel et al., 2011), which suggests a risk of significant others falsely detecting suicidal thoughts or, perhaps, a case of inpatients denying suicidal thoughts that their significant others accurately assess. While significant others of individuals in clinical populations are moderately aware of suicidal thoughts and behaviours, it remains unclear whether intimate partners of people with BPD follow the same pattern.

Furthermore, the current literature focuses on intimate partners' awareness of *if* SITBs occur, and not their awareness of *when* or *how often* SITBs occur in daily life. Assessing

awareness of self-injurious behaviours in daily life may be especially important because such behaviours are often chronic in those with BPD (Chapman et al., 2005). Intimate partners who are aware of self-injurious behaviours in the aggregate may still miss individual self-injurious behaviours, which limits their ability to respond in a timely manner. Therefore, measuring the rate of intimate partners' awareness in daily life can help determine whether intimate partners are aware enough of self-injurious behaviour to meaningfully be involved in interventions aimed at reducing them in people with BPD or if intimate partners' awareness might need to be increased first. Similarly, understanding *how* intimate partners find out about self-injurious behaviour could be leveraged to increase the precision and relevance of SITB interventions (e.g., do intimate partners discover signs of injury, receive disclosures from people with BPD, or inquire directly?).

Intimate Partners' Responses to SITBs

If intimate partners are aware of SITBs, or awareness is increased through dyadic interventions, intimate partners' ability to respond effectively to SITBs is vital. Research on non-relatives' responses to SITBs is often limited to the perspectives of youth and young-adult peers (e.g., Fisher et al., 2017; Garcia-Williams & McGee, 2016; Gayfer et al., 2020; Simone et al., 2023). Youth and young adults describe responding to SITBs by providing emotional support (Gayfer et al., 2020; Simone et al., 2023), giving advice about limiting SITBs (Garcia-Williams & McGee, 2016; Gayfer et al., 2020), and encouraging disclosers to talk to a mental health professional or a parent (Garcia-Williams & McGee, 2016; Gayfer et al., 2020). When responding to suicidal thoughts or suicide attempts, significant others are especially concerned with ensuring the physical safety of their loved one (e.g., by getting rid of suicide means or taking a loved one to the hospital; Garcia-Williams & McGee, 2016; Marshall et al., 2023).

However, intimate partners occupy a different social role than friends and relatives, and it is unclear whether their responses to SITBs would differ as a result.

The research on intimate partners' responses to SITBs is often filtered through the experiences of people disclosing SITBs. This research suggests that subjectively helpful or positive responses to SITB disclosures involve emotional validation, non-judgmental listening, expressing concern and support, and engaging in problem solving such as getting rid of suicide means (Love et al., 2021a; Maple et al., 2020; Metts et al., 2022). Meanwhile, subjectively unhelpful responses are often judgemental, angry, dismissive, blaming, and rooted in the misunderstanding that SITBs are attention-seeking or selfish (Love et al., 2021a; Maple et al., 2020; Metts et al., 2022). While these findings are likely unsurprising, they only indicate how people who self-injure perceive responses, not how well their intimate partners can recognize and implement responses that would be well-received. Therefore, it is important to determine how intimate partners describe their responses to SITBs, and how they conceptualize the impact of those responses on their partners with BPD.

The Current Study

The BIAS model and growing evidence support momentary intimate relationship functioning as a maintenance factor of SITBs in BPD. Despite the implication that intimate partners may play a role in eliciting or maintaining SITBs, it is unclear whether they are aware of when SITBs occur, how they come to be aware, and how they respond to them. Therefore, the current study aims to describe intimate partners' awareness of and responses to their partner with BPD's SITBs, with the intention of understanding whether intimate partners' awareness and responses could be leveraged in SITB interventions. Specifically, it is unclear how often intimate partners are aware of their partner with BPD's SITBs. Therefore, the first aim of this study is to

describe the accuracy of intimate partners' daily estimates of their partner with BPD's SITBs. Additionally, researchers have yet to describe how intimate partners of people with BPD find out about SITBs, which could provide important context for how intimate partners respond to SITBs. Likewise, distinguishing between voluntary disclosure and other methods of finding out about self-injury would clarify whether disclosure adequately explains awareness, or if awareness would need to be measured directly. Therefore, the second aim of this study is to describe the common methods through which intimate partners find out about SITBs in daily life. Furthermore, there is a lack of research on how intimate partners respond to their partner with BPD's SITBs. Understanding intimate partners' reactions in the moments following SITBs, and their perceptions of the impact of their responses, would contribute to the understanding of how intimate partners might reinforce or disrupt the engagement of subsequent SITBs. Therefore, the third aim of this study is to describe how intimate partners respond to SITBs in the moments following their occurrence, and the fourth and final aim of this study is to describe intimate partners' evaluations of the impact of their responses to SITBs on their partners with BPD.

Methods

This mixed-methods study involves a qualitative analysis of semi-structured interviews with intimate partners of people with BPD alongside a descriptive analysis of ecological momentary assessment (EMA) data pertaining to the interviewees and their partners with BPD. Both the interview and EMA data were collected as part of a parent study of couples' communication over time wherein at least one partner has BPD and recent SITBs. Only a subset of the intimate partners from the parent study participated in qualitative interviews. Therefore, only the EMA data of interview participants and their partners with BPD were examined.

Participants

Participants included 15 adult couples (18 years and older) living in Canada or the United States. Most participants were in monogamous relationships between a woman with BPD and a man without BPD (67%). Dyads had been in a relationship for one to seventeen years ($M = 6.61$, $SD = 4.9$), 73% were living together, and 40% were married. Intimate partners had a mean age of 31.4 ($SD = 8.68$, range: 21-48), were predominantly white and/or European (80%), heterosexual (87%), and male (73%). Partners with BPD had a mean age of 29.8 ($SD = 7.18$, range = 22-45); were predominantly white and/or European (60%), and female (73%), with a greater diversity of sexual identities (e.g., 47% heterosexual, 33% bisexual, etc.). The complete summary of demographic data can be found in Tables A1 and A2 of the appendix. Dyads were recruited through online flyers posted on BPD-related websites, private mental health clinics, Kijiji, Instagram, and other social media platforms. Given the over-representation of (presumably cisgender) women in BPD research (Silberschmidt et al., 2015), flyers were also posted on social media pages and websites catering to LGBTQ+ populations and men's groups, in an attempt to recruit people who are under-represented in the BPD literature.

Participants with BPD were considered eligible if they met full (five of nine symptoms) or subthreshold (four of nine symptoms) *DSM-5* criteria for BPD (American Psychiatric Association, 2022) and had experienced SITBs or communicated to their intimate partner about SITBs at least once in the past two weeks. Partners with BPD could report communicating about SITBs directly (e.g., saying "I'm going to hurt/kill myself") or indirectly (e.g., saying "I'll show you how much this hurts" or locking oneself in the bathroom with a razor, and reporting that these words and/or behaviours conveyed their intent to self-injure). BPD diagnostic criteria was assessed through clinical interviews using the BPD module of the Structured Clinical Interview

for the *DSM-5* (SCID-5-PD; First et al., 2015). In cases where both members of a dyad met BPD criteria, the participant with more frequent SITBs was designated as the “partner with BPD” as opposed to the “intimate partner”. Dyads were considered ineligible if either member was unable or unwilling to complete daily EMA surveys and correspond via email, was under 18 years old, did not live in Canada or the United States, reported the inability to read and/or write in English, or had a major cognitive, intellectual or medical impairment that would prevent them from being able to participate in the study.

Procedures

EMA Procedures

EMA procedures used Metricwire software and mobile phone applications. Partners with BPD and intimate partners received training on how to complete the EMA and were randomly prompted to complete EMA on the Metricwire app on their personal smartphones. Prompts occurred randomly every 2 or more hours, for a total of 5 times per day, between 9am and 10pm, for 30 consecutive days. When participants did not respond, reminders were sent 15 and 45 minutes after the prompt.

EMA questions probed each partner’s cognitions, emotions, and behaviours “since the last assessment”, with a focus on SITBs. Intimate partners who did not interact with their partner with BPD since the last assessment were not shown any study-relevant questions. Intimate partners who reported that their partner with BPD engaged in SITBs were then asked how they knew that SITBs occurred.

Participants entered the study at different points, and EMA was completed between April 2022 and January 2023. The EMA data in this study is from a parent study that did not begin sending prompts to each member of a dyad at the same time (i.e., syncing prompts within dyads)

until November of 2022. Before this point, participants' prompts were randomized within dyads, with up to 3 hours difference between when one partner and another received a given prompt. The implications of this are explained in the data analytic strategy.

Qualitative Interview Procedures

After completing the EMA portion of the study, intimate partners were invited via email to take part in a 1-hour semi-structured interview about their experience of their partner with BPD's SITBs. Interviews took place between May 2022 and February 2023. Interviews focused on the most recent SITBs that intimate partners were aware of (see interview protocol in Appendix B). While the interview explored intimate partners' thoughts, emotions, and behaviours pertaining to partners with BPD's SITBs, this study's analyses focused on intimate partners' behavioural responses to SITBs and their evaluations of the quality of their responses to SITBs. The interviewer used a series of closed and open-ended questions to elicit information from intimate partners about their experience of the moment-to-moment interactions involving SITBs. To clarify intimate partners' statements and elicit further information, the interviewer asked unscripted follow-up questions using intimate partners' words and gave intimate partners opportunities to voice anything that had not been probed in the interview. Interviews were audio and video recorded and transcribed.

EMA Measures

SITBs and Intimate Partners' Awareness of Them

Partners with BPD were asked whether they engaged in NSSI with the yes or no question "Did you purposely hurt yourself without wanting to die (i.e., non-suicidal self-injury, or NSSI)?" Likewise, intimate partners were asked about their partner with BPD's NSSI with the corresponding question (i.e., "Did they [your partner] purposely hurt themselves without wanting

to die...”) to assess their awareness of NSSI. Similarly, partners with BPD were asked about suicide attempts with the yes or no question “Since the last assessment, did you try to kill yourself (i.e., a suicide attempt)?” and their intimate partners were asked the same question, but with reference to the partner with BPD’s actions.

If intimate partners reported that their partner with BPD engaged in NSSI or a suicide attempt, they were also asked how they knew that the behaviour occurred and could endorse as many options as applied: “They told me on their own”, “I asked and they answered”, “I saw them do it”, “I saw the injury afterwards”, or “other”. Selecting “other” allowed participants to give an open-ended response.

Intimate Partners’ Responses to SITBs

When intimate partners reported that their partner with BPD engaged in NSSI, they were prompted to answer an open-ended follow-up question: “After you found out that they engaged in non-suicidal self-injury, what did you do or say? Please describe your reaction in detail.” Likewise, if intimate partners reported that their partner with BPD attempted suicide, they could answer the same follow-up question about what they did or said after finding out that their partner “tried to kill themselves.”

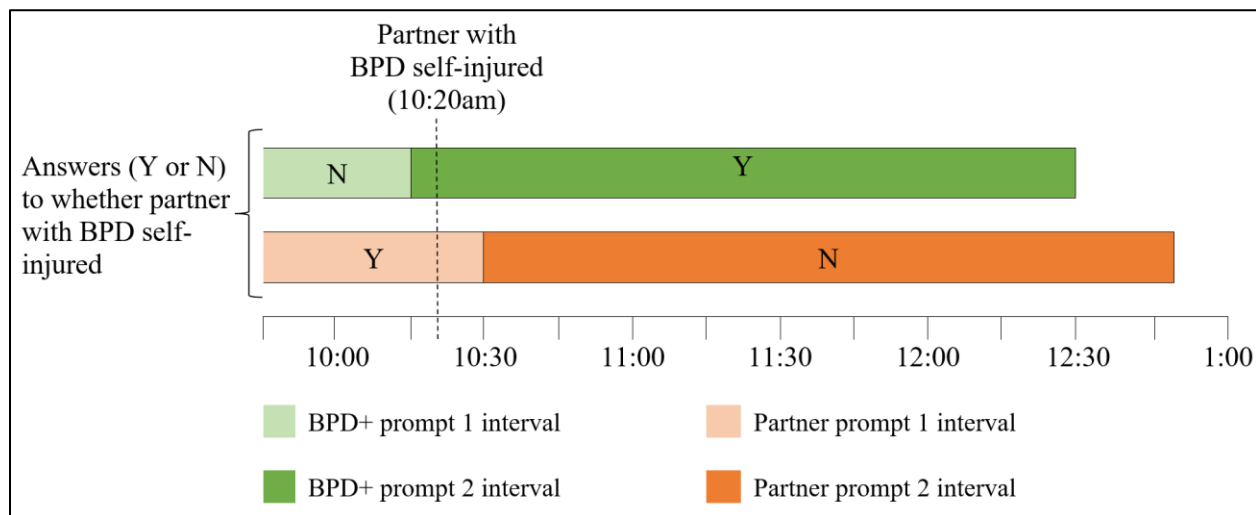
Data Analytic Strategy

A combination of qualitative and quantitative data were analyzed in an effort to maximize convergent validity while minimizing measurement artifacts – a process known as triangulation (Teddlie & Tashakkori, 2009). While qualitative interviews are retrospective, EMA surveys benefit from their precision and capturing of momentary experience. Likewise, closed EMA questions constrain participants’ range of answers, and, unlike qualitative interviews, do not allow participants to offer insights beyond those preconceived by the researcher. Thus,

mixed-methods triangulation benefits from the strengths of each method while minimizing their weaknesses.

Aim 1, which is to describe intimate partners' awareness of SITBs, was assessed with EMA data by calculating the agreement between partners with BPD and intimate partners about the occurrence of SITBs. To this end, percent agreement and prevalence-adjusted and bias-adjusted kappa scores (PABAK; Byrt et al., 1993) were calculated.

As mentioned in the EMA procedures, several dyads participated in the study before both members of a dyad began receiving EMA prompts at the same time. Consequently, attempting to pair dyads' individual assessments post-hoc could have led to false-negatives and under-estimation of intimate partners' awareness as each partner's assessment could refer to a different time interval (see the example in Figure 1). Therefore, dyads' data were paired at the day-level instead of the assessment-level. Positive agreement, or agreement on the presence of NSSI, referred to days in which if both partners responded to EMA and reported NSSI occurring in at least one of their assessments. Negative agreement, or agreement on the absence of NSSI, referred to days in which both partners responded to EMA and reported that NSSI had not occurred in every assessment. As a result, the PABAK score reflects dyads' agreement about whether NSSI occurred at least once on a given day.

Figure 1***Visual Example of a Within-Timepoint False Negative at Prompt 2***

Note. BPD+ prompt 1 interval = the partner with BPD’s prompt 1 interval, with questionnaires answered at 10:15am. Partner prompt 1 interval = the intimate partner’s prompt 1 interval, with questionnaires answered at 10:30am. In this scenario, the dyad is in agreement, but due to differences in when each member of the dyad responded to prompt 1, within-timepoint agreement would be miscategorized as a false-positive at prompt 1 (N/Y) and a false negative at prompt 2 (Y/N). Given that the exact timing of self-injurious behaviour was not recorded in this study, this scenario could not be confirmed or disconfirmed from the EMA data.

Aim 2, which is to describe how intimate partners found out about self-injurious behaviour, was addressed with the frequencies of intimate partners’ answers to the EMA item “How did you know they [your partner] engaged in non-suicidal self-injury?” and their interview responses about discovering either NSSI or a suicide attempt.

Aim 3, which is to describe how intimate partners respond to SITBs, was addressed qualitatively with semi-structured interview data and the open-ended EMA item “What did you do or say [after finding out your partner self-injured]?” Aim 4, which was to describe how

intimate partners evaluated how their responses to SITBs impacted their partners with BPD, was also addressed qualitatively, but solely with the semi-structured interview data. These qualitative analyses were guided by Generic Descriptive-Interpretive Qualitative Research (GDI-QR; Elliott & Timulak, 2021). GDI-QR is a “generic” approach to the systematic analysis of open-ended data for the purpose of describing and interpreting that data. GDI-QR involves the following steps: (1) pre-analysis, (2) understanding and translating, (3) categorizing, and (4) integrating the findings.

In pre-analysis, the domains of investigation were defined (i.e., research aim 3, or intimate partners’ responses to SITBs and research aim 4, or intimate partners’ evaluations of the impact of their responses on their partners with BPD) as a preliminary guide to data analysis. However, it was expected that these domains could and would change upon analysis. Additionally, the data was organized into “meaning units” (i.e., sentences or short paragraphs that convey participants’ experiences) for ease of analysis. In pre-analysis, GDI-QR requires transparency of researchers’ prior expectations and theoretical underpinnings. Thus, it is noted that this author approached intimate partners’ responses to SITBs through the lens of the BIAS model (Fitzpatrick et al., 2021), and took memos about the potential influence of this lens throughout the analytic process. While intimate partners’ responses to SITBs are discussed in relation to the BIAS model throughout this study, the model was not used to create an *a priori* theme structure, lest this interfere with describing responses to SITBs that do not reflect the BIAS model.

In the understanding and translating step, two modes of analysis were chosen: summarizing meaning units and explicating implicit meaning. While summarizing meaning units condenses semantic meaning (e.g., a story about going to a restaurant could be labelled

pleasurable activities), explicating implicit meaning is more interpretative, and expands on participants' statements by adding context from other meaning units (e.g. The following meaning unit is labelled *refraining from old behaviours* after adding the context in square brackets: "It came to a time where I was either gonna lose my job because I was leaving so much [to help manage my partner with BPD's SITBs], or just let them deal with it [SITBs].").

The third step of GDI-QR, developing categories, involves grouping and naming clusters of shared meaning into a hierarchical structure. GDI-QR does not include prescriptive distinctions between categories, themes, or codes; the names of clusters of shared meaning can be labelled at the discretion of the researcher. In this study, domains were used to structure the data, while themes communicate the findings within the data. Primary themes describe the broadest findings and were often separated further into secondary or tertiary themes. The category development step is iterative, and categories were audited for redundancy and fit by this author and her supervisor. Furthermore, the proportion of participants included in each theme is described to increase the transparency of the analysis and provide additional context. These proportions do not imply representativeness within the population of intimate partners of people with BPD. Rather, they indicate representativeness within the sample of intimate partners who contributed to this analysis. In the final step, integrating the findings, themes were described narratively and depicted in Tables 3 and 4.

Results

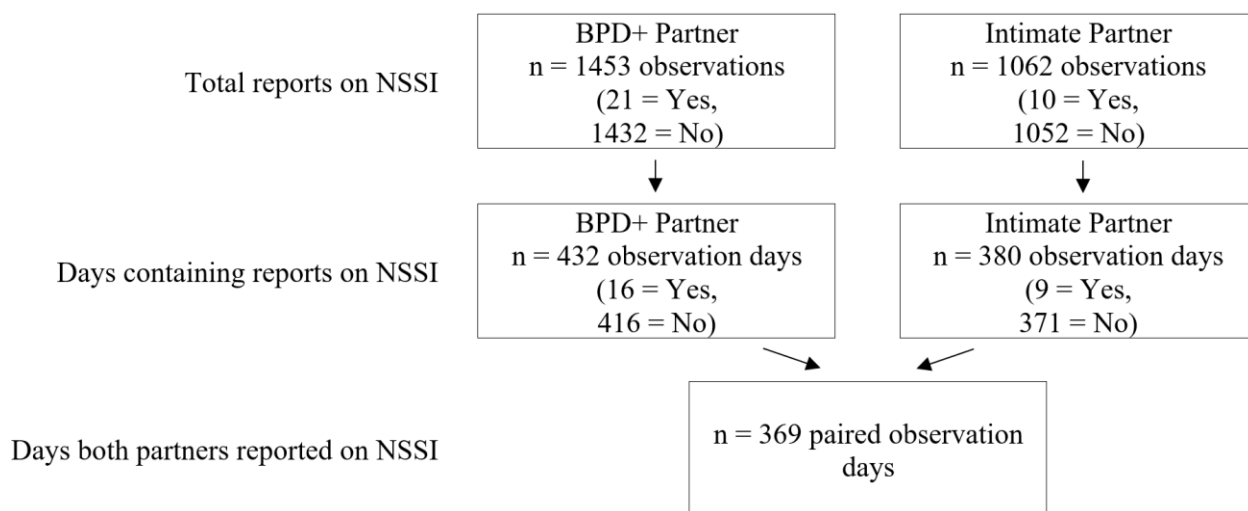
Among the 15 dyads in this study, partners with BPD completed an average of 71.7% of EMA surveys, and intimate partners completed an average of 56.3% of EMA surveys.

Aim 1: Intimate Partners' Awareness of Self-Injurious Behaviours

No partners with BPD reported a suicide attempt, nor did their intimate partners endorse observing a suicide attempt. Four partners with BPD reported engaging in NSSI over the month-long EMA study component. Partners with BPD reported NSSI one or more times a day in 16 instances. According to partners with BPD, all but one of these instances of NSSI occurred during a period where partners interacted with each other. There were 369 instances in which both members of a dyad reported on the presence or absence of NSSI on the same day. When restricting the analysis to days in which both partners reported on the presence or absence of NSSI, the prevalence of NSSI was 4.1% (i.e., 15/369).

Figure 2

Individual and Paired Reports on the Presence or Absence of NSSI



Note. Partners with BPD (BPD+ Partner) provided self-reports on whether they engaged in NSSI. Intimate partners provided observer-reports on whether their partner with BPD engaged in NSSI. “Observation days” refer to instances where a participant made at least one report on the presence or absence of NSSI on a given day.

The sensitivity of intimate partners' observer reports was 0.400, indicating that, when partners with BPD reported engaging in NSSI on a given day, intimate partners were aware of the behaviour 40% of the time (i.e., intimate partners agreed that NSSI had occurred in 6 of 15 cases). The specificity of intimate partners' observer reports was 0.992, indicating that, when partners with BPD reported that NSSI had not occurred on a given day, intimate partners agreed 99.2% of the time (i.e., intimate partners agreed that NSSI had not occurred in 351 out of 354 cases). The positive predictive value was 0.667, indicating that, in the 9 cases that intimate partners believed their partner with BPD had engaged in NSSI, they were correct 66.7% of the time (i.e., 6 out of 9 times). The negative predictive value was 0.975, indicating that, in the 360 cases that intimate partners believed their partner with BPD had not engaged in NSSI, they were correct 351 times, or 97.5% of the time. Given the high dyadic agreement about the absence of NSSI, the PABAK was high, at 0.935.

Table 1

Dyadic Agreement on NSSI

		Partners with BPD	
		NSSI % (<i>n</i>)	No NSSI % (<i>n</i>)
Intimate Partners	NSSI % (<i>n</i>)	1.63% (6)	0.81% (3)
	No NSSI % (<i>n</i>)	2.44% (9)	95.1% (351)

Note. Frequencies indicate the number of paired observations.

Aim 2: How Intimate Partners Find Out About Self-Injurious Behaviours

To determine how intimate partners found out about suicide attempts or NSSI, the subset of intimate partners' EMA responses ($n = 4$ intimate partners, $n = 10$ responses) and interview data ($n = 9$ intimate partners) pertaining to this topic were analyzed. Only one intimate partner reported finding out about a suicide attempt during their interview, and no intimate partners reported finding out about suicide during the EMA component of the study. In the EMA component, intimate partners could endorse multiple ways of finding out about NSSI. One intimate partner found out about NSSI several times, either by asking their partner with BPD if they had engaged in NSSI, seeing or hearing their partner with BPD engage in NSSI, and/or seeing the injury afterwards. Another intimate partner also reported seeing the injury afterwards in one instance. Another intimate partner described two instances of inferring that NSSI had occurred "based on past experiences," such as their partner voicing suicidal thoughts or going into the bathroom while in crisis. Only one of four intimate partners (25%) found out about NSSI because their partner with BPD disclosed it to them without being asked. However, in the interview component, 55.6% of intimate partners found out about self-injurious behaviours due to disclosure. The EMA and interview findings are compiled in Table 2.

Table 2***Methods by Which Intimate Partners Found Out about Partners with BPD's Self-Injurious******Behaviour***

Method	Number and percent of intimate partners, by data source					
	Interview (<i>n</i> = 9)		EMA ^a (<i>n</i> = 4)		All Sources ^{ab} (<i>n</i> = 9)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Asking	1	11.1	1	25.0	1	11.1
Being present during behaviour	2	22.2	1	25.0	3	33.3
Disclosure	5	55.6	1	25.0	6	66.7
Inferring ^c	0	0	1	25.0	1	11.1
Seeing the injury afterwards	1	11.1	2	50	2	22.2

Note. *n* = number of intimate partners who endorsed a method of finding out about self-injurious behaviour. Every intimate partner who reported that their partner with BPD self-injured in their EMA also discussed their partner with BPD self-injuring in the semi-structured interview. The remaining six participants from the full sample of intimate partners (*N* = 15) did not report self-injurious behaviours in the EMA, and discussed other interactions involving SITBs in their interview (i.e., responding to recent self-injurious thoughts or a history of self-injurious behaviour that predated the relationship).

^a Totals do not sum to 100% because participants could report multiple ways of finding out about self-injurious behaviour.

^b This category represents the total number of participants who endorsed a given method of finding out about self-injurious behaviour. Instances where participants reported finding out about self-injurious behaviour in the same way in the interview and the EMA are not double counted. Hence, some values in this column are smaller than the sum of the previous columns.

^c Using only indirect evidence to infer that self-injurious behaviour had occurred.

Aim 3: Intimate Partners' Responses to SITBs

Using the interview data ($n = 15$ intimate partners) and an open-ended EMA item about intimate partners' responses to SITBs ($n = 3$ intimate partners; $n = 9$ responses), themes were developed to describe intimate partners' behavioural responses in the moments that followed their partner with BPD's SITBs or SITB disclosure. Four themes described intimate partners' actions: *Soothing*, *Protection Mode*, *Problem Solving*, and *Opting Out*, and one theme described their attempts at inhibiting their own behavioural responses: *Staying Steady*. Themes are italicized throughout this paper, with primary themes in title case and secondary or tertiary themes in lowercase. Quotes have been edited for clarity and all third-person personal pronouns have been changed to "they/them/theirs" for further de-identification.

Soothing

Eleven of the fifteen intimate partners described comforting and *Soothing* their partners with BPD after they had self-injured or disclosed self-injurious thoughts. Seven of those eleven intimate partners described *acknowledging their partner with BPD's pain* by expressing sympathy, empathy, or concern. For example, intimate partners recounted asking their partners with BPD if they were okay and saying things like, "I'm really sorry to hear that," or like, "that sounds really painful." Some intimate partners explicitly described their words as validations (e.g., "I try to do a little bit of like, you know, gentle validation and like, expressing some concern.")

Seven of eleven intimate partners responded to SITBs by *Soothing* through *reassurance* in some form. They provided reassurance of their *love and the stability of the relationship*, with one intimate partner explaining, "my behaviour is more like showing them 'hey, I'm here. I'm not going anywhere, I'm not gonna leave you.'" Four of eleven intimate partners provided

reassurance by *apologizing and promising to change* whatever they believed had caused or contributed to the SITBs. One intimate partner commented that, before their partner with BPD engaged in NSSI, “Things were falling apart and I told [partner with BPD] that I needed a break [...] Afterwards, you know, I was the opposite, telling them that it could be okay, that we can do this, you know, ‘it’s not that big a deal, blah blah blah’. So, it was- yeah, they changed my talking completely by doing that [self-injuring].” Intimate partners also provided reassurance by *softening the pain* of their partners with BPD by saying things like, “it’s okay, the cuts are superficial, they’ll heal,” or tried to *absolve blame* by telling them that SITBs were not their fault.

Four of eleven intimate partners described *Soothing* their partners with BPD by being *physically affectionate* and holding their hand or offering a hug. Finally, three of eleven intimate partners described trying to help their partner with BPD by engaging in *pleasurable activities*, with one intimate partner saying that they, “took them out for some, you know, steak. Try to calm them down, you know, spend the time-a day with them.” Intimate partners tried *Soothing* their partners with BPD by showing extra care after SITBs through reassurance, sympathy and validation, physical affection, and pleasurable activities.

Protection Mode

Ten out of fifteen intimate partners described taking steps to protect their partner with BPD’s physical safety. One intimate partner said, “my mind just goes into like, um, protection mode. Like, I have to do something, I have to be with them, I have to talk them out of it. [...] I guess my mind goes into ‘I have to keep them here.’” Five of the ten intimate partners who described *Protection Mode* behaviours said that they stopped what they were doing and *rushed to help* their partner with BPD, even if this meant leaving work or other responsibilities. Some

intimate partners rushed to help their partners with BPD due to what they perceived as a serious suicide attempt or injury, with one intimate partner reporting that they, “just kind of went on autopilot. I didn’t say anything then, I just like took them [to the hospital].” Other intimate partners described coming to their partner with BPD’s aid more habitually. For example, when suicidal thoughts arose for their partner with BPD, one intimate partner explained “I needed to come home all the time to help deal with this. And again, this is my responsibility.”

Six out of ten intimate partners recounted engaging in *Protection Mode* by tending to their partner with BPD’s immediate *physical safety* by ensuring self-injury means were disposed of, tending to injuries, or enlisting help from family and friends or medical professionals. For example, one intimate partner described their initial response to learning that their partner with BPD had engaged in NSSI: “I said, ‘oh,’ and then I grabbed some antiseptic and I put it on their arm.” Another intimate partner described asking a “mutual best friend to go spend the night there, or hang out with them for the night,” because they “wanted to make sure [their partner with BPD] was physically okay.”

Four out of ten intimate partners engaged in *Protection Mode* by trying to *discourage self-injurious behaviour*, saying things like, “you don’t need to do that,” or, “it’s not okay to just hurt yourself,” or, “you could fall back into the habit, and it could get out of hand.” Essentially, intimate partners who *discouraged self-injurious behaviour* tried to frame self-injurious behaviour as harmful and unacceptable, either before, during, or after a self-injurious behaviour occurred. Overall, intimate partners tried to protect their partners with BPD from the physical harms of self-injurious behaviour by immediately coming to their partner with BPD’s aid, trying to convince partners with BPD not to self-injure, providing physical aftercare or getting help, and/or getting rid of SITBs means.

Problem Solving

Eight out of fifteen intimate partners described working with their partners with BPD to understand what had happened, how they might support them, and/or what might reduce or prevent future SITBs and strong negative emotions. Unlike *discouraging self-injurious behaviour* in the last theme, *Problem Solving* involves encouraging behaviours that would actively prevent future SITBs. Only two of the intimate partners who reported *Problem Solving* were among those who reported *discouraging self-injurious behaviour*. Four of the eight intimate partners who engaged in *Problem Solving* described *trying to understand the problem* by gathering information about their partner with BPD's actions and motivations. For example, one intimate partner said they, "tried to break it down, like, you know, 'what made you wanna do this?'" Three of eight intimate partners directly *asked how to help* by saying things like, "what can I do to help you, in this moment?" or asking whether their partner with BPD needed anything.

Some intimate partners described *Problem Solving* to avoid self-injurious thoughts turning into action, and others engaged in *Problem Solving* after self-injurious behaviours to improve future outcomes. Six of eight intimate partners described *finding solutions* as, "trying to basically help them and come up with solutions the way I knew how," or, "longer-term strategizing and problem solving." Intimate partners described solutions as behavioural alternatives to self-injurious behaviours, or, "things they can do instead of doing that." The process of finding solutions was often described as collaborative and iterative, with one intimate partner saying, "we make adjustments and make sure it doesn't happen again." While the specifics of these solutions remain unclear, some intimate partners describe strategies to mitigate distress and negative emotions. For example, one intimate partner asked their partner with BPD,

“what could we do for the emotions?” and another described trying to, “take their mind out of, like, this feeling of hopelessness and more onto, like, things they might do, like possible paths to take,” (i.e., using distraction). Only one intimate partner reported encouraging their partner with BPD to seek professional mental health support. Intimate partners who engaged in *Problem Solving* tried to collaborate with their partners with BPD to reduce self-injurious behaviour. They discussed what led to SITBs or intense emotions, how they could support their partners with BPD, and/or tried to find solutions that did not involve self-injurious behaviour.

Staying Steady

In addition to specific communications and actions, intimate partners also described their attempts at modulating their own behaviour with their partners with BPD. Seven out of fifteen intimate partners described maintaining a calm demeanor and holding back certain reactions when responding to SITBs, with one intimate partner stating, “I try to stay as steady as possible,” in instances when their partner with BPD said they might kill themselves. While intimate partners often described negative emotional responses to SITBs, such as anxiety and frustration, five of the seven who endorsed *Staying Steady* described making a concerted effort to *limit the expression of these emotions* and the resulting urges. Some intimate partners described limiting their own emotional reactivity as a necessary part of helping their partner with BPD, with one saying, “You just can’t be angry at them. You just can’t. It’s just the-I think that’s the worst reaction you can have.” Intimate partners tried to present a calmer demeanor, with one explaining, “I would compose myself in a way that [is] more, like, inviting,” and “I trying [sic] talking to them in [...] a calm voice.” Four out of seven intimate partners *chose their words carefully* when responding to SITBs, with one intimate partner commenting that, “it really is a situation of having to, like, qualify, quantify, measure something before mentioning it. And that

sort of censoring is really stressful.” Another intimate partner mentioned being selective with their words to make sure they did not “put fuel on the fire.” Several intimate partners attempted to limit their emotional and verbal reactivity while responding to SITBs, though the success of their attempts is uncertain.

Opting Out

With only four of fifteen intimate partners engaging in this behaviour, *Opting Out* was an uncommon response to SITBs. These intimate partners described *walking away* and/or *refraining from old behaviours* that they previously engaged in when responding to SITBs. Two of four intimate partners endorsed *walking away*, with one intimate partner explaining that they often left the room when the frustration and stress of watching their partner with BPD hitting themselves became overwhelming. They and other intimate partners weighed the risks and benefits of engaging with their partner with BPD’s SITBs and chose to disengage. They explained that, “if they had a knife or something, I would not walk away,” but that it was otherwise not worth intervening when they felt so overwhelmed and unable to stop their partner with BPD from harming themselves. Similarly, another intimate partner described no longer rushing home when their partner with BPD had suicidal thoughts (i.e., *refraining from old behaviours*), explaining, “it came to a time where I was either gonna lose my job because I was leaving so much, or just let them deal with it [suicidal thoughts] and then hope for the best when I came home.” Two other intimate partners described *refraining from old behaviours* such as insisting “I do love you, I do care about you,” as they had done, “for many many years in the beginning.” Importantly, intimate partners who *Opted Out* did not ignore their partners with BPD; they engaged in *Problem Solving*, *Soothing*, or *Protection Mode* behaviours in addition to *Opting Out*. For example, the intimate partner who stopped offering *reassurance* (i.e., *Soothing*)

still described validating their partner with BPD's emotions. Ultimately, some intimate partners tried to minimize how much they intervened during SITBs or became too overwhelmed to continue intervening.

Table 3***Intimate Partners' Qualitative Responses to SITBs***

Primary Theme (<i>n</i>)	Secondary/Tertiary Theme (<i>n</i>)
Soothing (11/15)	Reassurance (7) <ul style="list-style-type: none"> • Love and stability of the relationship (5) • Apologizing and promising to change (4) • Softening the pain (3)^a • Absolving blame (2)
	Acknowledging the pain (7) ^a
	Physical affection (4) ^a
	Pleasurable activities (3)
	Protection Mode (10/15)
Problem Solving (8/15)	Rushing to help (5)
	Discouraging self-injurious behaviour (5) ^a
	Trying to understand the problem (4) ^a
Opting Out (4/15)	Asking how to help (3) ^a
	Finding solutions (6)
	Walking away (2)
Staying Steady (7/15)	Refraining from old behaviours (3)
	Limiting emotional expression (5)
	Choosing words carefully (4)

Note. Bracketed numbers indicate the proportion of intimate partners who described a behaviour.

^a Reported in EMA as well as interviews

Aim 4: Intimate Partners' Evaluations of the Quality of Their Responses to SITBs

The qualitative analysis of how intimate partners evaluated their responses to SITBs is based solely on their interviews ($n = 15$ intimate partners). The analysis was organized into two domains: *Observations* and *Self-Evaluations*, which each included several themes (see Table 4). The *Observations* domain encapsulates the perceived reactions that partners with BPD had to intimate partners' attempts at helping them. The *Self-Evaluations* domain contains themes describing intimate partners' beliefs about how helpful they are and their experience of trying to evaluate their helpfulness. *Observations* and *Self-Evaluations* are distinguished from each other because few intimate partners explicitly based their self-evaluations on whether partners with BPD reacted positively or negatively to intimate partners' actions. Likewise, intimate partners did not consistently attribute their partner with BPD's reactions to what they (the intimate partner) had just said or done. For example, one intimate partner noticed their partner with BPD's withdrawal, saying, "I do remember talking about it [their suicide attempt], they didn't want to talk about it on the way home, of course. They didn't-they usually don't," but did not attribute the withdrawal to their attempts at talking about the suicide attempt. What intimate partners noticed about their partners with BPD' reactions interacted with- but was distinct from- how partners evaluated their helpfulness.

Observations

After intimate partners responded to SITBs, fourteen of fifteen described *Observations* of particular reactions from their partners with BPD. The one intimate partner who did not describe how their partner with BPD reacted when they responded to SITBs explained that they avoided discussing SITBs altogether. *Observations* are described in two themes: *Positive Reactions* and *Negative Reactions*. Many intimate partners described a mix of positive and negative reactions

(i.e., seven out of fourteen), with five intimate partners describing only *Negative Reactions*, and two describing only *Positive Reactions*. Intimate partners rarely explicitly categorized reactions as positive or negative; such categorization was performed by the author to emphasize the contrasting valence of partners with BPD's reactions.

Positive Reactions. Nine of fourteen intimate partners described *Positive Reactions* from their partners with BPD after they responded to SITBs. Five of these nine intimate partners observed an *improved mood* in their partners with BPD, and described them calming down, feeling reassured, or feeling less distressed. This improvement in emotional well-being was often described imprecisely, with one partner commenting, "changing my behaviour to, you know, be more responsive and more present is- helps them, emotionally." Five out of nine intimate partners described their partners with BPD becoming *more responsive* and less fixated on their distress and SITBs. One intimate partner said that, after their partner with BPD let them clean their wound, "they're fairly reasonable and self-aware." Some intimate partners observed an increase in responsiveness and a decrease in distress at the same time. For example, one intimate partner noted that whenever they *Soothed* their partner with BPD, "they listen and calm down. They, like, will start to be more, what do you call it, responsive... They start to talk." Finally, three intimate partners noticed *reduced self-injurious thoughts and behaviours*, with one intimate partner explaining that offering reassurance to their partner with BPD "decreases the risk of self-injury cause genuinely, they just want to know, like, I truly care about them." Overall, intimate partners observed their behaviours leading to short-term improvements in partners with BPD's mood, SITBs, and their responsiveness to intimate partners' support.

Negative Reactions. Twelve of fourteen intimate partners perceived *Negative Reactions* from their partners with BPD after they responded to SITBs. Eight out of twelve intimate

partners observed *worsened mood* in the form of their partner with BPD's *lingering distress* or *guilt*. Six of those intimate partners described *lingering distress*, wherein their partners with BPD remained distressed or became more distressed after the dyad had an interaction involving SITBs. One intimate partner described how they would "get like ninety-nine plus messages within like, twenty minutes," whenever they responded to their partner with BPD's text messages about suicidal thoughts. Another intimate partner commented that even when they felt like they were helping their partner manage SITBs, "they were pretty distressed still." Three intimate partners observed *guilt*, though they did not always believe they caused it. As one intimate partner explained, "I believe that them doing, you know, self-harming behaviour, I believe they would have typically feel [sic] very embarrassed, maybe even ashamed the following day, or days. I can tell that it's not-they're not happy about it. I can tell they feel guilty because we often deal with the ramifications after."

Just as some intimate partners observed their partners with BPD becoming more responsive and engaged when they responded to SITBs, six out of twelve intimate partners described their partners with BPD being unreceptive to their efforts (i.e., *decreased responsiveness*). Among these six intimate partners, four described partners with BPD getting *angry* with them. One intimate partner explained, "I'm doing everything that I could to really just be there and to be supportive and, you know, help them get through this difficulty. And a lot of the time they get angry at me." Similarly, four of six intimate partners described their partners with BPD dismissing their help or *withdrawing* from conversations. One intimate partner described their partner with BPD saying, "It's not a big deal," "It's not your fault," and, "don't freak out about it or anything," when they tried to convince them not to self-injure. Another partner explained, "I kept trying, trying, trying [to problem solve about SITBs], and they got

mad, and they told me they didn't wanna talk again." While this partner described anger leading to withdrawal, many intimate partners who noticed withdrawal did not report seeing anger.

Four intimate partners reported observing *continued self-injurious thoughts and behaviours* after they responded to SITBs. One intimate partner reported that their partner with BPD made more allusions to killing themselves, with statements such as, "I'll make sure this is a Christmas nobody forgets." Another intimate partner reported both an increase and a decrease in self-injurious behaviour. They commented, "I wonder sometimes if [walking away] stops the behaviour too. Because the stimulus is gone, right?" and in another instance commented, "my walking away, I think, didn't stop what was happening. If anything, it got a little bit worse but then it kind of petered itself out." This confusion over whether intimate partners' responses are helpful or not will be discussed in the *Self-Evaluations* domain. Ultimately, many intimate partners reported that, after they responded to SITBs, partners with BPD's negative emotions and self-injurious thoughts lingered or increased.

Self-Evaluations

Thirteen out of fifteen intimate partners explicitly described their perceptions of the effectiveness of their responses to SITBs, or their experience of trying to determine how helpful they were. Intimate partners' experiences rarely fit into just one theme, and they described believing they were *Making a Positive Impact* in some moments, then *Feeling Lost* in others, and *Relinquishing Responsibility* when they felt they had miscalculated how much they could help, or what being helpful could look like.

Making a Positive Impact. Five out of fifteen intimate partners explicitly described their responses to SITBs *Making a Positive Impact* on their partner with BPD. These intimate partners attributed the *Positive Reactions* of their partners with BPD to things that they had said or done.

These intimate partners mentioned things like, “it did feel like what I had said kinda landed for them,” or, “whenever I do that, it’s, like, a good response.” These intimate partners found that validating their partners with BPD, reassuring them, or talking openly about SITBs led to *Positive Reactions*. Of course, some intimate partners who described engaging in the same behaviours did not express that they believed their behaviours had been helpful. Nonetheless, intimate partners who commented on potentially being unhelpful were unsure whether this was the case, and therefore, their experiences are described in the *Feeling Lost* theme.

Feeling Lost. Even when intimate partners described their partners with BPD calming down or becoming more responsive in the moment, they sometimes felt lost and unsure of whether they were really helping their partners with BPD. Of the thirteen intimate partners who described the perceived effectiveness of their responses to SITBs, seven described *Feeling Lost*. More specifically, six of seven partners described not understanding what they were doing wrong and *not knowing how to fix things*. These intimate partners often felt angry at themselves, saying things like, “what is it that I’m doing wrong? And then I get angry about that because I can’t identify the thing that could actually help us move forward.” Intimate partners also described feeling worried, with one partner saying, “the worry, I guess, leads to a lot of questions without super easy answers about like how I should be responding.” These intimate partners seemed to believe that there could be a “right” way to respond to SITBs, and that they were failing their partners with BPD by not knowing those responses. While these intimate partners blamed themselves, at least in part, for their partner with BPD’s distress and SITBs, they could rarely articulate what they had done wrong.

Four of seven intimate partners discussed *not knowing what partners with BPD think*, rather than assuming their actions were helpful or unhelpful. These partners said things like, “I

don't know, and that's only for them to explain – what would help, what am I doing to make it worse? Better? I don't know, right?" Others were more doubtful of their helpfulness. For example, one partner explained that their partner with BPD's SITBs remained high for long periods of time, and that, "they get better eventually, so I don't know if it's- they say that I help, but I mean there's not really anything I can do to just make everything better immediately." Nonetheless, three of the seven partners who described *Feeling Lost* still expressed *hope that they were being helpful*. One partner said, "I'm not in their mind, so I'm not sure what they think about it [responses to SITBs]. Or, like, yeah, they never told me, but I want to think that it does help." Overall, partners felt lost when they felt ineffective and unsure of how to improve the effectiveness of their responses. Nonetheless, even when intimate partners could not tell if they were effective, some still hoped they were.

Relinquishing Responsibility. Eight of thirteen intimate partners challenged the notion that their moment-to-moment responses to SITBs could stop SITBs, or that stopping SITBs immediately should be their goal. Specifically, these intimate partners believed their partners with BPD were too distressed to be effectively engaged with in the moments following SITBs, that they could not control whether partners with BPD self-injured, and/or believed that some of the ways that they once tried to help their partners with BPD actually perpetuated SITBs. Of these eight intimate partners, four expressed that their partners with BPD were too distressed to be receptive to their support in the moments following SITBs (i.e., *intervening in the moment is ineffective*). There were several reasons that intervening was perceived to be ineffective. Some intimate partners thought their words were misinterpreted when their partners with BPD were distressed. For example, one intimate partner commented that their partner with BPD's distress, "gets louder than everything in the room. And then, you know, it doesn't matter what I say, it

becomes part of that.” Other intimate partners felt that their partners with BPD were not misinterpreting their statements per se, so much as having trouble processing them. As one intimate partner explained, “when they’re mid panic attack, they don’t really respond at all.” The notion that partners with BPD were going to be distressed no matter what intimate partners did appeared to make some intimate partners feel helpless or frustrated at their partners with BPD or themselves.

Five intimate partners described trying to accept that they were not the “arbiters” of their partners with BPD’s SITBs (i.e., *I do not decide whether my partner self-injures*). One intimate partner explained, “I kinda had to start with just accepting that their self-harm isn’t something I, like, cause, and it’s not something that I can really prevent either.” This belief was not easy for intimate partners to accept, and they did so to varying degrees. As one intimate partner put it, “I have to talk myself into remembering that I can’t make someone do that [self-injure]. But there’s still that feeling of like [...] if I hadn’t acted like an idiot too, it wouldn’t have happened, right?” Intimate partners with firmer acceptance of their limited influence on SITBs still reported that they struggled with watching their partners with BPD suffer, with one intimate partner saying, “I’m sad for them, I wish I could say something or push a button to help them, but I’ve realized that I can’t.” Furthermore, three intimate partners described having the retrospective insight that *not all help is helpful*, because trying to accommodate their partner with BPD at the first sign of a SITB could perpetuate SITBs rather than prevent them. One partner commented, “I think the more I gave into it and just doing it [rushing home to help], the more that it [an SITB] was likely to happen.” Another partner said, “I’m tired and my partner sometimes appreciates this, but, like, sometimes really doesn’t. And I don’t think I’m helping their, like, capacity long-term. I think I might just be setting myself up for more of this kind of task, without actually having the kind of

benefit that I want to have.” Importantly, these intimate partners did not stop trying to support their partners with BPD, and instead, tried to engage in behaviours they believed would make more of a difference. For example, one intimate partner described, “being there for the feelings they’re experiencing,” instead of trying to *Problem Solve* immediately. Ultimately, the intimate partners who endorsed *Relinquishing Responsibility* described not being able to influence SITBs in the short or long term as much as they would like, but many tried to accept this limitation and work within it.

Table 4***Intimate Partners' Evaluations of Their Responses to SITBs***

Domain: Observations ($n = 14/15$)	
Primary Theme (n)	Secondary/Tertiary Theme (n)
Positive reactions (9/14)	Improved mood (5) Reduced SITBs (3) Increased responsiveness (5)
Negative reactions (12/14)	Worsened Mood <ul style="list-style-type: none"> • Lingering distress (6) • Guilt (3) Decreased Responsiveness <ul style="list-style-type: none"> • Withdrawal (4) • Anger toward intimate partner (4) Continued SITBs (4)
Domain: Self-Evaluations ($n = 13/15$)	
Primary Theme (n)	Secondary/Tertiary Theme (n)
Making A Positive Impact (5)	N/A
Feeling lost (7)	Not knowing how to fix things (6) Not knowing what partners with BPD think (4) Hoping I help (3)
Relinquishing Responsibility (8)	Intervening in the moment is ineffective (4) I do not decide whether my partner self-injures (5) Not all help is helpful (3)

Note. Bracketed numbers indicate the proportion of intimate partners who described a behaviour.

Discussion

People with BPD often disclose SITBs and seek support from their intimate partners (Simone & Hamza, 2020; Turner et al., 2016), which may put intimate partners in a unique

position to intervene to prevent current or future SITBs. To this end, dyadic SITB interventions have been developed for couples in which one partner has BPD and SITBs (e.g., DeBeer et al., 2019; Fitzpatrick et al., 2022). However, the extent to which intimate partners could meaningfully reduce their partner with BPD's SITB depends on whether they are aware of SITBs often enough to intervene. Likewise, there is little to no research indicating how intimate partners learn about self-injurious behaviours, how they respond to SITBs, and the impact of their responses. Therefore, the current study aimed to describe intimate partners' awareness of and responses to the SITBs of their partners with BPD. Intimate partners accurately reported an absence of self-injurious behaviour throughout most of the study, but in the rare instance that self-injurious behaviour did occur (according to partners with BPD), intimate partners were aware of it less than half the time. When they were aware, most intimate partners found out about self-injurious behaviour because their partner with BPD disclosed it. Qualitatively, in their semi-structured interviews and open-ended EMA items, intimate partners often described taking an active and engaged approach to responding to SITBs (e.g., going into *Protection Mode*). Despite this, intimate partners' *Observations* of their effect on partners with BPD were highly variable, with a mix of positive and negative reactions. Intimate partners' *Self-Evaluations* of their helpfulness were not solely based on how partners with BPD reacted, with many intimate partners *Feeling Lost* regardless of the reaction they received.

Intimate Partners' Awareness of Self-Injurious Behaviour in Daily Life

The first aim of this study was to determine how often intimate partners were aware of their partner with BPD's self-injurious behaviour. However, due to the absence of suicide attempts and the low prevalence of NSSI in this study, the data has limited utility in addressing the study's first aim. The PABAK statistic measures observed agreement (Chen et al., 2009), or

how often dyads agree, regardless of whether they agree that NSSI occurred or agree that it did not. Given that the prevalence of NSSI (i.e., days in which people with BPD reported engaging in NSSI) was only 4%, the high PABAK score of 0.935 is largely the product of high agreement about the absence of NSSI. The PABAK score suggests that intimate partners rarely overestimated their partner with BPD's NSSI. However, eleven of the fifteen partners with BPD did not engage in NSSI during the EMA component of the study, meaning that most intimate partners would achieve high agreement by always assuming NSSI had not occurred. In a sample with higher rates of NSSI, where intimate partners could not easily assume that NSSI was absent, it is possible that false positives would be more frequent.

The sensitivity score, which describes intimate partners' awareness of the presence of NSSI, is based on the data of only four dyads, with most data coming from two dyads with relatively high rates of NSSI. Therefore, the sensitivity score should be interpreted with caution. While the data on the presence of NSSI is too limited to indicate intimate partners' true awareness of NSSI, the data suggests that intimate partners were aware of NSSI 40% of the time. If awareness is as low as the data suggests, it may be a consequence of people with BPD hiding their NSSI from their intimate partners. People with BPD often experience intense shame (Buchman-Wildbaum et al., 2021), which could contribute to non-disclosure (Metts et al., 2022). People with BPD may also refrain from disclosing suicidal thoughts if they have had unsupportive disclosure experiences in the past or fear that the disclosure will effect their relationship (Frey et al., 2018; Fulginiti et al., 2016). Considering that relationships involving one partner with BPD can be prone to conflict (Navarro-Gómez et al., 2017), and intimate partners can feel unsure of how to support their partner with BPD (Kay et al., 2018), some people with BPD may find disclosure conversations with intimate partners unhelpful or

invalidating. However, further research is needed before asserting that intimate partners do indeed have low awareness of partners with BPD's NSSI.

How Intimate Partners Find Out About Self-Injurious Behaviour in Daily Life

The second aim of this study was to describe how intimate partners find out about their partner with BPD's self-injurious behaviour. The low rate of NSSI in the EMA component of this study meant that intimate partners had few opportunities to become aware of NSSI in daily life. In their interviews, in which intimate partners discussed their most recent experience responding to SITBs, most intimate partners found out about self-injurious behaviours after their partner with BPD disclosed it to them. By contrast, awareness of self-injurious behaviour was due to disclosure only once in the EMA component of the study.

One interpretation of the higher rate of disclosure in interviews than EMA is that people who self-injure less frequently (i.e., before the interviews and not during the 30 days of EMA) may consider self-injurious behaviour to be a more serious or notable behaviour, and therefore something worth disclosing to intimate partners. This assertion is supported by the disclosure literature, which shows that people who disclose SITBs believe the behaviour is consequential, while those who do not disclose SITBs believe the disclosure would be irrelevant to others (Mirichlis et al., 2022, 2023).

Alternatively, the rate of methods other than disclosure (e.g., asking whether self-injurious behaviour occurred) may be prevalent in EMA because people with BPD who self-injure more often may have hypervigilant intimate partners who find signs of self-injurious behaviour before it is disclosed. This explanation aligns with research indicating that people who self-injure more frequently report that their significant others are more emotionally overinvolved (i.e., prone to exaggerated, protective, and intrusive behaviours; Hack & Martin, 2018).

Qualitative studies suggest that these intimate partners likely experience increased burden as a result of monitoring and anticipating their partner with BPD's self-injurious behaviour (Ek Dahl et al., 2011; Giffin, 2008; Kay et al., 2018).

Critically, the rate of self-injurious behaviour was so infrequent in the EMA that the relatively lower rate of disclosure may be due to chance. Therefore, more research is needed to determine how often intimate partners find out about self-injurious behaviour in the absence of disclosure. If, as these findings suggest, awareness of self-injurious behaviour is not adequately explained by disclosure, then future research should not rely on disclosure as an indicator of intimate partners' awareness of self-injurious behaviour. Measuring intimate partners' awareness directly will likely achieve more accurate awareness rates than solely relying on individuals with BPD's reports of disclosure.

Intimate Partners' Responses to SITBs

The third aim of this study was to describe intimate partners' behavioural responses to their partner with BPD's SITBs. In most cases, intimate partners took an attentive and involved approach to responding to SITBs, as exemplified in most *Protection Mode* behaviours, and some *Problem Solving* and *Soothing* behaviours (e.g., providing *physical affection*). In other instances, intimate partners tried to take a less involved approach when responding to SITBs, or attempted to act in a calm fashion, by *Staying Steady* and *Opting Out* of what they considered to be overinvolved responses to SITBs. While intimate partners were sometimes unsure of how helpful their responses to SITBs were (as indicated in the aim 4 theme, *Feeling Lost*), most still responded to SITBs with the primary goal of helping their partners with BPD. Several factors likely influenced intimate partners' beliefs about what would be most helpful, and therefore the actions they engaged in.

Intimate partners' responses to SITBs may be explained, in part, by whether they believed self-injurious behaviour was imminent and/or highly damaging. For example, intimate partners may have engaged in immediate and intense *Problem Solving* and *Protection-Mode* behaviours if they believed their partner with BPD's life was in danger. Some intimate partners described *rushing to help* in response to their partner with BPD's suicidal thoughts, or after discovering a recent suicide attempt. By contrast, some intimate partners may have focused on *Soothing* their partners with BPD or *Problem Solving* about emotions if they believed emotional pain was most salient and that the immediate physical or medical risk of self-injurious behaviour was low. Some evidence from vignette studies suggests a relationship between the perceived risk and severity of SITBs and people's responses to them. Laypeople's assertions that they would engage in helping behaviours is associated with their belief that the person in the vignette has suicidal intent (Nielsen & Townsend, 2018). Likewise, when the self-injurious behaviour in a vignette is more physically damaging (i.e., cutting or burning as opposed to hitting or scratching oneself), laypeople are more likely to endorse seeking help for the person in the vignette, rather than talking to them about their feelings (Bresin et al., 2013).

Intimate partners' beliefs about the function of SITBs and their partners with BPD may also help explain their responses to SITBs. For example, even if intimate partners believed that their partners with BPD were at high risk of self-injuring, if they believed SITBs served a mood-improvement function, they may have focused on bringing their partners with BPD's emotions down (e.g., by *Soothing* partners with BPD or *Problem Solving* about emotions). This strategy is supported by other qualitative research, in which both disclosers and disclosure recipients express the belief that being attentive and caring can lessen self-injurious behaviour (Love et al., 2021b; Simone et al., 2023). By contrast, if intimate partners believed that SITBs served

interpersonal functions, such as getting attention or solving interpersonal problems, they may have been more inclined towards *Opting Out* to avoid providing that attention. Other research supports the notion that laypeople are more likely to reject or ignore individuals who they believe to be engaging in SITBS for interpersonal motivations (Fisher et al., 2017; Nielsen & Townsend, 2018).

Intimate partners' beliefs about partners with BPD's capacity for managing their emotions and SITBs may also explain their responses to SITBs. If intimate partners believed their partners with BPD had little control over their emotions and SITBs, they may have taken a less collaborative and more involved approach to their responses, regardless of whether they were *Soothing*, *Problem Solving*, or going into *Protection Mode*. For example, intimate partners may have tried *finding solutions* without their partner with BPD's input or taken care by *getting rid of self-injury means* for them. Additionally, some intimate partners expressed the belief that their partners with BPD could do more to avoid SITBs, which may explain why they *discouraged self-injurious behaviour*. Beliefs about *Relinquishing Responsibility* may also explain some responses to SITBs, and is therefore explored in the aim 4 discussion section.

Ultimately, intimate partners' responses to SITBs may be explained, in large part, by how dangerous they believe SITBs to be, what they believe could stop future SITBs, and how much control they believe partners with BPD have over their emotions and SITBs. Given that intimate partners were likely not responding to SITBs for the first time, their risk assessments and beliefs about SITBs and BPD were likely influenced by their previous experiences responding to SITBs. For example, some intimate partners expressed the belief that SITBs were high-risk because of previous instances of repeated NSSI or suicide attempts. Therefore, intimate partners' responses

to SITBs may be explained by their cumulative experiences and beliefs as well as the context of any given SITB.

Intimate Partners' Evaluations of The Effectiveness of Their Responses

Observations

The fourth aim of this study was to describe intimate partners' evaluations of their responses to SITBs. One component of this analysis included intimate partners' *Observations* of how their partners with BPD reacted to their attempts at helping them manage SITBs. Despite intimate partners putting considerable effort into responding to partners with BPD's SITBs, intimate partners observed mixed if not slightly negative reactions. Given that many intimate partners were hoping to improve partners with BPD's mood and SITBs in the short term, the heterogeneity in partners with BPD's reactions indicates that some intimate partners may struggle to reliably produce the reactions they desire. While this study cannot determine whether intimate partners' observations align with the actual reactions of partners with BPD, it is notable that disclosure research yields similarly mixed results (i.e., 56% of people who disclose suicidal thoughts feel supported by their significant others' responses; Metts et al., 2022). Moreover, intimate partners' perspectives on whether their efforts were positively or negatively received presumably impact how they choose to respond to future SITBs, and are therefore important contributions to the literature regardless of their accuracy.

Some of the positive and negative reactions intimate partners received reflect literature on the preferences of people with BPD and others who disclose SITBs. For example, some intimate partners observed *Positive Reactions* after *Soothing* their partners with BPD, and across studies, individuals who disclose SITBs consider emotional support and non-judgemental listening to be helpful (Love et al., 2021a; Metts et al., 2022; Simone et al., 2023). Intimate partners' attempts at

validating partners with BPD or *acknowledging [their] pain* has the potential to reduce intense emotions (Herr et al., 2015; Kuo et al., 2022), and encourage people with SITBs to seek support from their intimate partners in the future (Love et al., 2021a). People who receive validating responses from intimate partners when they disclose suicidality can feel more satisfied with their relationship, and in some instances, less suicidal (Love et al., 2021b).

Likewise, some responses to SITBs were often poorly received, both in this study and in the disclosure literature. Specifically, some intimate partners who were regularly *discouraging self-injurious behaviour* reported that their partners with BPD were regularly unreceptive to such arguments. Partners with BPD may have found statements like “it’s not okay to just hurt yourself” invalidating and stigmatizing. Such responses could trivialize SITBs by suggesting that people with BPD would stop self-injuring if they only understood how socially unacceptable it is. The subset of intimate partners who responded this way may not have realized the demoralizing and isolating effect of stigma on people with BPD and those with SITBs (Corrigan et al., 2016; van Schie et al., 2024; Veysey, 2014).

Despite these trends in which responses to SITBs might elicit positive or negative reactions from partners with BPD, this study does not indicate a one-to-one relation between a type of response and the valence of a partner with BPD’s reaction. There are several potential reasons for this. Firstly, intimate partners who engaged in the same type of response to SITBs may have implemented the strategy differently. For example, some intimate partners described *Problem Solving* immediately upon learning of their partner with BPD’s SITBs, while others engaged in *Soothing* before *Problem Solving*. While the first strategy often led to partners with BPD *withdrawing* or expressing *anger toward intimate partners*, the second strategy led to *increased responsiveness* which facilitated communication about *Problem Solving*. The

difference between partners with BPD's reactions may be explained by the importance of balancing change strategies with acceptance strategies, as advised in Dialectical Behaviour Therapy (a frontline BPD intervention; Linehan, 1993). Linehan (1993) suggests that being overly change-focused can lead people to shut down, while acceptance and validation can make people more receptive to subsequent change efforts and help them learn to validate themselves.

Another potential reason for the heterogeneity in people with BPD's reactions is that intimate partners were each responding to different people and in different contexts. What one person considers validating might be invalidating to another (Dixon-Gordon et al., 2015). Therefore, some *Positive Reactions* may be explained by intimate partners' efforts to refine their responses to SITBs over time. Intimate partners in this study had responded to their partner with BPD's SITBs on multiple occasions and those who described *Making a Positive Impact* described having a sense of what their partner with BPD had appreciated in the past, and what they considered genuine. Additionally, the heterogeneity in people with BPD's reactions may be the result of mood lability and sensitivity to potential interpersonal threats (Koenigsberg et al., 2002; Lazarus et al., 2014). Even when intimate partners believe that they are delivering a reliably effective response to SITBs, small contextual difference may have a large impact on people with BPD's emotions. Moreover, intimate partners cannot be expected to immediately and completely resolve the distress and SITBs of their partners with BPD. Negative emotions can take hours to return to baseline after people with BPD experience SITBs (Houben et al., 2017; Snir et al., 2015). Therefore, reactions like *lingering distress* may not reflect a change in an intimate partner's response to SITBs so much as the expected course of emotional distress.

The positive and negative reactions intimate partners perceived partially reflects research on the effects of well-received responses to SITBs. Responses that researchers and people with

SITBs consider helpful or validating may buffer against negative outcomes like depression and indirectly reduce suicide risk (Love et al., 2021b; Park & Ammerman, 2020). Likewise, responses that are perceived as unhelpful or invalidating may increase disclosure regret, discourage future disclosures, increase depression, and heighten suicide risk (Love et al., 2021a, 2021b; Park & Ammerman, 2020). However, some research suggests that the valence of reactions does not predict their effects. For example, the perceived helpfulness of a suicide disclosure may not impact future help-seeking for better or worse (Ammerman et al., 2021), and increased social support may increase next-day non-suicidal SITBs (Turner et al., 2016). Therefore, the valence of partners with BPD's reactions may not indicate whether intimate partners' responses to SITBs will reduce distress or SITBs in the long-term. Indeed, the short-term positive effect that some responses have on partners with BPD may reinforce them over time (Fitzpatrick et al., 2021). For example, while intimate partners who *apologize and promise to change* may receive *Positive Reactions*, and intimate partners who *walk away* may receive *Negative Reactions*, if some SITBs function by resolving relationship distress, *walking away* may disrupt the cycle of SITBs and *apologizing and promising to change* might reinforce it. Regardless of the degree to which partners with BPD's reactions reflect the long-term impact of intimate partners' responses to SITBs, they help describe intimate partners' experience of responding to SITBs and may help explain intimate partners' *Self-Evaluations*.

Self-evaluations

While intimate partners' *Observations* could be classified as positive or negative reactions from partners with BPD, their beliefs about the helpfulness of their responses to SITBs were not as clearly positive or negative. The immediate reactions of partners with BPD did appear to inform intimate partners' *Self-Evaluations*, especially when they described *Making an*

Impact, though intimate partners also considered the long-term impact of their responses to SITBs. Several intimate partners described *Feeling Lost* about their effectiveness and/or questioning the limits of their influence on SITBs and *Relinquishing Responsibility*.

Feeling Lost. There are several potential reasons that intimate partners may have described *Feeling Lost* while responding to SITBs. Firstly, significant others often find it difficult to find information on how to help people with BPD or to access support for their own mental health concerns (Dunne & Rogers, 2013; Giffin, 2008; Lawn & McMahon, 2015). Intimate partners may simply be unsure of what a helpful response to SITBs would look like, or how to evaluate their effect on partners with BPD. When intimate partners did look to their partner with BPD's reactions as indicators of their effectiveness, they sometimes received conflicting information. For example, one intimate partner explained that their partner with BPD says their response is helpful, yet they (the partner with BPD) remain distressed and continue to self-injure in the coming days (i.e., "they say that I help but I mean there's not really anything I can do to just make everything better immediately.") As one person with BPD explained in Moltu et al.'s (2023) qualitative study, "what I want does not go together with what is actually good for me". Despite intimate partners' presumably limited knowledge about adaptive and maladaptive responses to SITBs, they seem to be aware that they may be doing something that could be positively received and also inadvertently reinforcing of SITBs over time.

Problematic communication patterns may also lead to confusion. For example, partners with BPD may have felt such intense emotions during SITB discussions with their intimate partners that they expressed themselves in inaccurate and hurtful ways (i.e., inaccurate expression, such as expressing anger when one feels hurt; Fruzzetti & Worrall, 2010). Inaccurate expression would make it difficult for intimate partners to understand the true feelings of their

partners with BPD, thus heightening their confusion. Conflict avoidance could also contribute to intimate partners feeling lost. Some intimate partners did not talk to their partners with BPD about how helpful their responses to SITBs were, with one intimate partner commenting on their helpfulness by saying, “they never told me, but I want to think that it does help.” Just as some intimate partners responded to SITBs by choosing their words carefully and *Staying Steady* to avoid upsetting partners with BPD, some may have feared that talking about SITBs after a crisis might cause another one. Overall, intimate partners may have felt lost when trying to evaluate the effectiveness of their responses to SITBs, due in part to their lack of knowledge about how to support partners with BPD, and in part to a lack of communication or problematic communication patterns in their relationship.

Intimate partners often expressed considerable burden when describing feeling lost. In fact, feeling lost appeared to reflect more than a lack of knowledge about how to respond to self injury. Especially among intimate partners who expressed *not knowing how to fix things*, feeling lost may be the result of taking responsibility for, and trying to change, something that is not fully in their control (i.e., the SITBs and distress of their partners with BPD). In support of this, other research indicates that intimate partners find responding to SITBs especially stressful and confusing due to the perceived unpredictability of their partner with BPD’s reactions (Greer & Cohen, 2018). Perhaps as a result, the intimate partners in this study felt worried and sad for their partners with BPD, and felt anger and guilt toward themselves. This feeling aligns with research showing that significant others of adults with BPD feel more burden, grief, and disempowerment than significant others of people with other severe mental illnesses (Bailey & Grenyer, 2013). Intimate partners and other biologically unrelated caregivers of people with BPD also experience more anxiety, depression, and other psychological symptoms than the general population, though

it is unclear whether this is causally related to the stresses of their relationship (Scheirs & Bok, 2007). Ultimately, intimate partners' difficulty assessing their helpfulness has a negative impact on their mental health and limits their ability to support their partners with BPD. This highlights the importance of improving intimate partners' responses to SITBs, or at least their acceptance regarding the unpredictability of the effectiveness of their responses, in service of meeting the needs of both people with BPD and their intimate partners.

Relinquishing Responsibility. The beliefs and experiences in the theme of *Relinquishing Responsibility* are not well-represented in the literature, which often presents significant others feeling overly responsible for the well-being of people with BPD, lacking information about the disorder, and being emotionally overinvolved (Bailey & Grenyer, 2015; Dunne & Rogers, 2013; Giffin, 2008). By contrast, many intimate partners who described *Relinquishing Responsibility* tried not to blame themselves for their partner with BPD's SITBs and made astute observations about the potential for their heightened engagement to reinforce SITBs.

Intimate partners' acknowledgement of their limited control over partners with BPD's SITBs may help them engage in fewer overinvolved responses to SITBs and feel less guilt and self-blame, thus leading to a lower subjective sense of burden. Nonetheless, intimate partners' acknowledgement of their limited control over SITBs did not always translate into actions. For example, most intimate partners who believed that *[they] do not decide whether [their] partner self-injures* still tried *Staying Steady* to avoid upsetting their partners with BPD, and most intimate partners who believed that *intervening in the moment is ineffective* still intervened in the moment.

There were some exceptions, where intimate partners engaged in behaviours that aligned with their beliefs about *Relinquishing Responsibility*. For example, some intimate partners tried

not to reinforce SITBs through excessive reassurance, and instead chose to *Opt Out*, or empower partners with BPD to communicate what they needed. In all other instances, intimate partners may have struggled to act in accordance with their beliefs about *Relinquishing Responsibility* for a few reasons. Firstly, some intimate partners were ambivalent about *Relinquishing Responsibility*, and may have believed that a highly involved response to SITBs was the best way to maintain relationship satisfaction or avoid their partner with BPD hurting themselves. Giffin (2008) describes a similar conflict, in which mothers of people with BPD recognized that being overly supportive might reinforce SITBs, yet “feared the consequences of backing off” too much to change their behaviour. Additionally, intimate partners may have struggled to behave skillfully due to the distress and emotional reactivity that can arise when responding to SITBs. Not only is finding out about SITBs distressing in its own right (Giffin, 2008), intimate partners in this study described having negative thoughts about self-injurious behaviour (e.g., believing it is “attention-seeking”), which may have heightened their own emotional reactivity (Fitzpatrick et al., 2021). Therefore, while intimate partners expressed beliefs about *Relinquishing Responsibility* and tried not to blame themselves or respond reactively to SITBs, their accounts also suggest that successfully acting on those beliefs was difficult.

Notably, intimate partners’ descriptions of *Relinquishing Responsibility* sometimes indicated a sense of helplessness or resignation rather than acceptance of their limited influence over SITBs. A sense of helplessness was most prominent in intimate partners’ statements about their belief that *intervening in the moment is ineffective*. These intimate partners often made absolutist statements about the futility of their responses to SITBs, such as, “it doesn’t matter what I say.” That perceived futility may make some intimate partners disengage from helping their partners with BPD manage SITBs, though further research is needed to distinguish between

adaptive and maladaptive beliefs about *Relinquishing Responsibility*, and the subsequent behaviours that follow from them.

Clinical Implications

Intimate partners in this study were highly involved in their partner with BPD's management of SITBs, yet many lacked the knowledge or skill to improve SITB outcomes and alleviate their feelings of burden and confusion. Therefore, people with BPD and their intimate partners could both benefit from intimate partners being involved in SITB interventions. While some intimate partners appeared to be hypervigilant about SITBs, roughly half of intimate partners only became aware of SITBs when their partner with BPD disclosed it to them. Given this frequency of disclosure, disclosure conversations may present a key opportunity for intimate partners to disrupt SITBs. If so, these findings stress the importance of encouraging partners with BPD to disclose SITBs and helping intimate partners provide responses to SITBs that encourage future disclosures.

This study's qualitative analyses can offer clinicians insights into intimate partners' behavioural responses to SITBs and their perceptions of how helpful their responses are. This broad overview of patterns in intimate partners' experiences and behaviours, coupled with careful case formulation of dyads' specific interpersonal patterns, may help clinicians provide interventions that improve SITB outcomes while serving the needs of both people with BPD and their intimate partners. For example, given that several intimate partners observed mixed reactions to their attempts at helping their partners with BPD, or described *Feeling Lost* about how helpful they were, some dyads may benefit from developing communication skills that demystify each partner's emotions and their experience of interactions involving SITBs.

Furthermore, while intimate partners' emotional experience of responding to SITBs was not the focus of this study, their experience of stress and burden permeated their experience of implementing and evaluating their responses to SITBs. This highlights the need for interventions that address intimate partners' mental health needs, and not just their ability to support their partners with BPD. Indeed, clinicians are advised to attend carefully to the extent to which intimate partners' involvement actually helps reduce SITBs or not and, even if it does, whether it does so at the expense of intimate partners' well-being. In such an instance, intimate partners may benefit from being protected from stepping into roles that overemphasize their responsibility for people with BPD's SITBs.

Limitations and Future Directions

This study provides a largely qualitative overview of how intimate partners respond to the SITBs of their partners with BPD in the short-term. This study does not address intimate partners' proactive strategies for reducing their partner with BPD's SITBs, nor responses to SITBs that occurred days later. Furthermore, most interviewees in this study were white, male, heterosexual, and monogamous, and it is unclear whether their experiences reflect those of intimate partners with different demographics. Therefore, research into the experiences of queer, non-monogamous and racialized intimate partners of people with BPD is warranted.

The results of this study may have been impacted by a selection effect, given that dyads needed to be comfortable enough discussing their relationship and SITBs to do so in this study. Given the stigma associated with BPD and SITBs (Long, 2018; Veysey, 2014), it is unclear whether intimate partners who would elect to participate in an hour-long interview about their partner with BPD's SITBs are representative of most intimate partners. It is possible, for example, that intimate partners who find SITBs too shameful to discuss may be as unlikely to

participate in this study as they are to validate their partner with BPD's SITBs. Therefore, the results may be most representative of dyads with some level of comfort discussing SITBs and their relationship.

Furthermore, most partners with BPD in this study exhibited a low base rate of self-injurious behaviour. Intimate partners of people who self-injure more frequently may respond differently to SITBs than the participants in this study or display higher or lower awareness of self-injurious behaviour in daily life. Indeed, this study's PABAK for dyadic agreement about NSSI was high because NSSI was so infrequent that most dyads consistently agreed that NSSI had not occurred. From a public health perspective, research on intimate partners' awareness of SITBs in higher-risk individuals with BPD is vital.

Despite the low occurrence and variation of the rate of SITBs in this study, when SITBs did occur, intimate partners described a variety of responses to them. This appears to be caused not only by differences in intimate partners' responding skills and intentions, but contextual differences, such as the perceived symptoms and needs of partners with BPD. BPD is a highly heterogeneous disorder, and an intimate partner's response to SITBs may be effective in one context and not another. Future research should employ idiographic quantitative methodology to describe heterogeneous relations between SITBs, intimate partners' awareness and responses, and other transactions between people with BPD and their intimate partners.

While the EMA items and interview questions in this study were designed to elicit intimate partners' moment-to-moment experience of responding to a recent SITB, the EMA data was limited, and intimate partners sometimes had trouble recalling details about the SITBs they were describing. Therefore, this study is largely retrospective and influenced by intimate partners' recall. It is both a strength and a limitation that this study may be most indicative of

what intimate partners find salient about their responses to SITBs in the long-term. Future studies should investigate people with BPD's perspectives on their intimate partners' responses to SITBs to highlight where intimate partners are most or least aligned with the people they are trying to help. Furthermore, to account for interpersonal processes that dyads may not be aware of, observational studies of dyads communicating about SITBs are warranted. To increase the ecological validity of this research and make stronger assertions about intimate partners' effect on SITBs, dyadic EMA studies with larger sample sizes and higher rates of SITBs are critical.

Conclusion

Intimate partners appeared motivated to help their partners with BPD manage SITBs, even if they were not aware of every instance of its occurrence. Despite their efforts, intimate partners' responses to SITBs produced a mix of positive and negative reactions from their partners with BPD and had the potential to either ameliorate or exacerbate SITBs. While some intimate partners were aware of how their behaviours could reinforce SITBs, many were unsure of what a helpful or unhelpful response to SITBs should entail, and experienced considerable worry and distress as a result. This study emphasizes the importance of providing mental health supports for intimate partners, including dyadic interventions that have the potential to improve SITB outcomes for people with BPD while addressing intimate partners' often-overlooked burden and distress.

References

- American Psychiatric Association. (2022). Borderline Personality Disorder. In *Diagnostic and statistical manual of mental disorders: Vol. text rev.* (5th ed.). American Psychiatric Association.
- Ammerman, B. A., Wilcox, K. T., O'Loughlin, C. M., & McCloskey, M. S. (2021). Characterizing the choice to disclose nonsuicidal self-injury. *Journal of Clinical Psychology, 77*(3), 683–700. <https://doi.org/10.1002/jclp.23045>
- Bagge, C. L., Glenn, C. R., & Lee, H.-J. (2013). Quantifying the impact of recent negative life events on suicide attempts. *Journal of Abnormal Psychology, 122*(2), 359–368. <https://doi.org/10.1037/a0030371>
- Bailey, R. C., & Grenyer, B. F. S. (2013). Burden and support needs of carers of persons with borderline personality disorder: A systematic review. *Harvard Review of Psychiatry, 21*(5), 248–258. <https://doi.org/10.1097/HRP.0b013e3182a75c2c>
- Bailey, R. C., & Grenyer, B. F. S. (2015). The relationship between expressed emotion and wellbeing for families and carers of a relative with Borderline Personality Disorder. *Personality and Mental Health, 9*(1), 21–32. <https://doi.org/10.1002/pmh.1273>
- Bhatia, V., Davila, J., Eubanks-Carter, C., & Burckell, L. A. (2013). Appraisals of daily romantic relationship experiences in individuals with borderline personality disorder features. *Journal of Family Psychology, 27*(3), 518–524. <https://doi.org/10.1037/a0032870>
- Black, D. W., Blum, N., Pfohl, B., & Hale, N. (2004). Suicidal Behavior in Borderline Personality Disorder: Prevalence, Risk Factors, Prediction, and Prevention. *Journal of Personality Disorders, 18*(3), 226–239.

- Bohus, M., Stoffers-Winterling, J., Sharp, C., Krause-Utz, A., Schmahl, C., & Lieb, K. (2021). Borderline personality disorder. *The Lancet*, *398*(10310), 1528–1540.
[https://doi.org/10.1016/S0140-6736\(21\)00476-1](https://doi.org/10.1016/S0140-6736(21)00476-1)
- Bouchard, S., Sabourin, S., Lussier, Y., & Villeneuve, E. (2009). Relationship quality and stability in couples when one partner suffers from borderline personality disorder. *Journal of Marital and Family Therapy*, *35*(4), 446–455. <https://doi.org/10.1111/j.1752-0606.2009.00151.x>
- Bresin, K., Sand, E., & Gordon, K. H. (2013). Non-Suicidal Self-Injury from the Observer's Perspective: A Vignette Study. *Archives of Suicide Research*, *17*(3), 185–195.
<https://doi.org/10.1080/13811118.2013.805636>
- Brodsky, B. S., Groves, S. A., Oquendo, M. A., Mann, J. J., & Stanley, B. (2006). Interpersonal precipitants and suicide attempts in borderline personality disorder. *Suicide & Life-Threatening Behavior*, *36*(3), 313–322. <https://doi.org/10.1521/suli.2006.36.3.313>
- Buchman-Wildbaum, T., Unoka, Z., Dudas, R., Vizin, G., Demetrovics, Z., & Richman, M. J. (2021). Shame in Borderline Personality Disorder: Meta-Analysis. *Journal of Personality Disorders*, *35*(Suppl A), 149–161. https://doi.org/10.1521/pedi_2021_35_515
- Byrt, T., Bishop, J., & Carlin, J. B. (1993). Bias, prevalence and kappa. *Journal of Clinical Epidemiology*, *46*(5), 423–429. [https://doi.org/10.1016/0895-4356\(93\)90018-V](https://doi.org/10.1016/0895-4356(93)90018-V)
- Chapman, A. L., Specht, M. W., & Cellucci, T. (2005). Borderline Personality Disorder and Deliberate Self-Harm: Does Experiential Avoidance Play a Role? *Suicide and Life-Threatening Behavior*, *35*(4), 388–399. <https://doi.org/10.1521/suli.2005.35.4.388>

- Chen, G., Faris, P., Hemmelgarn, B., Walker, R. L., & Quan, H. (2009). Measuring agreement of administrative data with chart data using prevalence unadjusted and adjusted kappa. *BMC Medical Research Methodology*, *9*(1), 5. <https://doi.org/10.1186/1471-2288-9-5>
- Corrigan, P. W., Bink, A. B., Schmidt, A., Jones, N., & Rüsch, N. (2016). What is the impact of self-stigma? Loss of self-respect and the “why try” effect. *Journal of Mental Health*, *25*(1), 10–15. <https://doi.org/10.3109/09638237.2015.1021902>
- de Montigny-Malenfant, B., Santerre, M.-È., Bouchard, S., Sabourin, S., Lazaridès, A., & Bélanger, C. (2013). Couples’ Negative Interaction Behaviors and Borderline Personality Disorder. *The American Journal of Family Therapy*, *41*(3), 259–271. <https://doi.org/10.1080/01926187.2012.688006>
- DeBeer, B. B., Matthieu, M. M., Kittel, J. A., Degutis, L. C., Clafferty, S., Qualls, N., & Morissette, S. B. (2019). Quality Improvement Evaluation of the Feasibility and Acceptability of Adding a Concerned Significant Other to Safety Planning for Suicide Prevention With Veterans. *Journal of Mental Health Counseling*, *41*(1), 4–20. <https://doi.org/10.17744/mehc.41.1.02>
- Dejong, T. M., & Overholser, J. C. (2009). Assessment of depression and suicidal actions: Agreement between suicide attempters and informant reports. *Suicide & Life-Threatening Behavior*, *39*(1), 38–46. <https://doi.org/10.1521/suli.2009.39.1.38>
- Dixon-Gordon, K. L., Bernecker, S. L., & Christensen, K. (2015). Recent innovations in the field of interpersonal emotion regulation. *Current Opinion in Psychology*, *3*, 36–42. <https://doi.org/10.1016/j.copsyc.2015.02.001>

- Dunne, E., & Rogers, B. (2013). “It’s us that have to deal with it seven days a week”: Carers and borderline personality disorder. *Community Mental Health Journal*, 49(6), 643–648. <https://doi.org/10.1007/s10597-012-9556-4>
- Ekdahl, S., Idvall, E., Samuelsson, M., & Perseus, K.-I. (2011). A Life Tiptoeing: Being a Significant Other to Persons With Borderline Personality Disorder. *Archives of Psychiatric Nursing*, 25(6), e69–e76. <https://doi.org/10.1016/j.apnu.2011.06.005>
- Elliott, R., & Timulak, L. (2021). *Essentials of descriptive-interpretive qualitative research: A generic approach*. <https://doi.org/10.1037/0000224-000>
- First, M. B., Williams, J. B. W., Benjamin, L. S., & Spitzer, R. L. (2015). *User’s Guide for the SCID-5-PD (Structured Clinical Interview for DSM-5 Personality Disorder)*. American Psychiatric Association.
- Fisher, K., Fitzgerald, J., & Tuffin, K. (2017). Peer Responses to Non-Suicidal Self-Injury: Young Women Speak about the Complexity of the Support-Provider Role. *New Zealand Journal of Psychology*. <https://www.semanticscholar.org/paper/Peer-Responses-to-Non-Suicidal-Self-Injury%3A-Young-Fisher-Fitzgerald/159d8b1f2daef46caef806e8720a93a793d227a2>
- Fitzpatrick, S., Liebman, R. E., & Monson, C. M. (2021). The borderline interpersonal-affective systems (BIAS) model: Extending understanding of the interpersonal context of borderline personality disorder. *Clinical Psychology Review*, 84, 101983. <https://doi.org/10.1016/j.cpr.2021.101983>
- Fitzpatrick, S., Liebman, R. E., Varma, S., Norouzian, N., Chafe, D., Traynor, J., Goss, S., Earle, E., Di Bartolomeo, A., Latham, M., Courey, L., & Monson, C. M. (2022). Protocol Development of Sage: A Novel Conjoint Intervention for Suicidal and Self-Injuring

- People With Borderline Personality Disorder and Their Significant Others. *Cognitive and Behavioral Practice*. <https://doi.org/10.1016/j.cbpra.2022.11.002>
- Frey, L. M., Fulginiti, A., Lezine, D., & Cerel, J. (2018). The decision-making process for disclosing suicidal ideation and behavior to family and friends. *Family Relations: An Interdisciplinary Journal of Applied Family Studies*, 67(3), 414–427. <https://doi.org/10.1111/fare.12315>
- Fruzzetti, A. E., & Worrall, J. M. (2010). Accurate Expression and Validating Responses: A Transactional Model for Understanding Individual and Relationship Distress. In K. T. Sullivan & J. Davila (Eds.), *Support Processes in Intimate Relationships* (p. 0). Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780195380170.003.0005>
- Fulginiti, A., Pahwa, R., Frey, L. M., Rice, E., & Brekke, J. S. (2016). What Factors Influence the Decision to Share Suicidal Thoughts? A Multilevel Social Network Analysis of Disclosure Among Individuals with Serious Mental Illness. *Suicide & Life-Threatening Behavior*, 46(4), 398–412. <https://doi.org/10.1111/sltb.12224>
- Garcia-Williams, A. G., & McGee, R. E. (2016). Responding to a suicidal friend or family member: A qualitative study of college students. *Death Studies*, 40(2), 80–87. <https://doi.org/10.1080/07481187.2015.1068246>
- Gayfer, B. L., Mahdy, J. C., & Lewis, S. P. (2020). Peer reactions to non-suicidal self-injury disclosures: A thematic analysis. *Counselling Psychology Quarterly*, 33(1), 79–99. <https://doi.org/10.1080/09515070.2018.1536647>
- Giffin, J. (2008). Family Experience of Borderline Personality Disorder. *Australian and New Zealand Journal of Family Therapy*, 29(3), 133–138. <https://doi.org/10.1375/anft.29.3.133>

- Glenn, C. R., & Klonsky, E. D. (2013). Nonsuicidal Self-Injury Disorder: An Empirical Investigation in Adolescent Psychiatric Patients. *Journal of Clinical Child & Adolescent Psychology, 42*(4), 496–507. <https://doi.org/10.1080/15374416.2013.794699>
- Goodman, M., Tomas, I. A., Temes, C. M., Fitzmaurice, G. M., Aguirre, B. A., & Zanarini, M. C. (2017). Suicide attempts and self-injurious behaviours in adolescent and adult patients with borderline personality disorder. *Personality and Mental Health, 11*(3), 157–163. <https://doi.org/10.1002/pmh.1375>
- Greer, H., & Cohen, J. N. (2018). Partners of individuals with borderline personality disorder: A systematic review of the literature examining their experiences and the supports available to them. *Harvard Review of Psychiatry, 26*(4), 185–200. <https://doi.org/10.1097/HRP.000000000000164>
- Hack, J., & Martin, G. (2018). Expressed Emotion, Shame, and Non-Suicidal Self-Injury. *International Journal of Environmental Research and Public Health, 15*(5), Article 5. <https://doi.org/10.3390/ijerph15050890>
- Hallford, D. J., Rusanov, D., Winestone, B., Kaplan, R., Fuller-Tyszkiewicz, M., & Melvin, G. (2023). Disclosure of suicidal ideation and behaviours: A systematic review and meta-analysis of prevalence. *Clinical Psychology Review, 101*, 1–18. <https://doi.org/10.1016/j.cpr.2023.102272>
- Heisel, M. J., Conwell, Y., Pisani, A. R., & Duberstein, P. R. (2011). Concordance of self- and proxy-reported suicide ideation in depressed adults 50 years of age or older. *The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie, 56*(4), 219–226. <https://doi.org/10.1177/070674371105600405>

- Hepp, J., Carpenter, R. W., Freeman, L. K., Vebares, T. J., & Trull, T. J. (2021). The environmental, interpersonal, and affective context of nonsuicidal self-injury urges in daily life. *Personality Disorders: Theory, Research, and Treatment*, *12*, 29–38. <https://doi.org/10.1037/per0000456>
- Herr, N. R., Jones, A. C., Cohn, D. M., & Weber, D. M. (2015). The impact of validation and invalidation on aggression in individuals with emotion regulation difficulties. *Personality Disorders: Theory, Research, and Treatment*, *6*(4), 310–314. <https://doi.org/10.1037/per0000129>
- Hill, J., Pilkonis, P., Morse, J., Feske, U., Reynolds, S., Hope, H., Charest, C., & Broyden, N. (2008). Social domain dysfunction and disorganization in borderline personality disorder. *Psychological Medicine*, *38*(1), 135–146. <https://doi.org/10.1017/S0033291707001626>
- Houben, M., Claes, L., Vansteelandt, K., Berens, A., Sleuwaegen, E., & Kuppens, P. (2017). The emotion regulation function of nonsuicidal self-injury: A momentary assessment study in inpatients with borderline personality disorder features. *Journal of Abnormal Psychology*, *126*(1), 89–95. <https://doi.org/10.1037/abn0000229>
- Kaess, M., Fischer-Waldschmidt, G., Resch, F., & Koenig, J. (2017). Health related quality of life and psychopathological distress in risk taking and self-harming adolescents with full-syndrome, subthreshold and without borderline personality disorder: Rethinking the clinical cut-off? *Borderline Personality Disorder and Emotion Dysregulation*, *4*(1), 7. <https://doi.org/10.1186/s40479-017-0058-4>
- Kay, M. L., Poggenpoel, M., Myburgh, C. P., & Downing, C. (2018). Experiences of family members who have a relative diagnosed with borderline personality disorder. *Curationis*, *41*(1). <https://doi.org/10.4102/curationis.v41i1.1892>

- Kazan, D., Calear, A. L., & Batterham, P. J. (2016). The impact of intimate partner relationships on suicidal thoughts and behaviours: A systematic review. *Journal of Affective Disorders, 190*, 585–598. <https://doi.org/10.1016/j.jad.2015.11.003>
- Klonsky, E. D. (2007). Non-suicidal self-injury: An introduction. *Journal of Clinical Psychology, 63*(11), 1039–1043. <https://doi.org/10.1002/jclp.20411>
- Koenigsberg, H. W., Harvey, P. D., Mitropoulou, V., Schmeidler, J., New, A. S., Goodman, M., Silverman, J. M., Serby, M., Schopick, F., & Siever, L. J. (2002). Characterizing Affective Instability in Borderline Personality Disorder. *American Journal of Psychiatry, 159*(5), 784–788. <https://doi.org/10.1176/appi.ajp.159.5.784>
- Kuehn, K. S., Dora, J., Harned, M. S., Foster, K. T., Song, F., Smith, M. R., & King, K. M. (2022). A meta-analysis on the affect regulation function of real-time self-injurious thoughts and behaviours. *Nature Human Behaviour, 6*(7), Article 7. <https://doi.org/10.1038/s41562-022-01340-8>
- Kuhlken, K., Robertson, C., Benson, J., & Nelson-Gray, R. (2014). The interaction of borderline personality disorder symptoms and relationship satisfaction in predicting affect. *Personality Disorders: Theory, Research, and Treatment, 5*(1), 20–25. <https://doi.org/10.1037/per0000013>
- Kuo, J. R., Fitzpatrick, S., Ip, J., & Uliaszek, A. (2022). The who and what of validation: An experimental examination of validation and invalidation of specific emotions and the moderating effect of emotion dysregulation. *Borderline Personality Disorder and Emotion Dysregulation, 9*(1), 15. <https://doi.org/10.1186/s40479-022-00185-x>
- Lavner, J. A., Lamkin, J., & Miller, J. D. (2015). Borderline personality disorder symptoms and newlyweds' observed communication, partner characteristics, and longitudinal marital

- outcomes. *Journal of Abnormal Psychology*, 124(4), 975–981.
<https://doi.org/10.1037/abn0000095>
- Lawn, S., & McMahon, J. (2015). Experiences of family carers of people diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, 22(4), 234–243. <https://doi.org/10.1111/jpm.12193>
- Lazarus, S. A., Cheavens, J. S., Festa, F., & Zachary Rosenthal, M. (2014). Interpersonal functioning in borderline personality disorder: A systematic review of behavioral and laboratory-based assessments. *Clinical Psychology Review*, 34(3), 193–205.
<https://doi.org/10.1016/j.cpr.2014.01.007>
- Lazarus, S. A., Scott, L. N., Beeney, J. E., Wright, A. G. C., Stepp, S. D., & Pilkonis, P. A. (2018). Borderline personality disorder symptoms and affective responding to perceptions of rejection and acceptance from romantic versus nonromantic partners. *Personality Disorders*, 9(3), 197–206. <https://doi.org/10.1037/per0000289>
- Lim, K.-S., Wong, C. H., McIntyre, R. S., Wang, J., Zhang, Z., Tran, B. X., Tan, W., Ho, C. S., & Ho, R. C. (2019). Global Lifetime and 12-Month Prevalence of Suicidal Behavior, Deliberate Self-Harm and Non-Suicidal Self-Injury in Children and Adolescents between 1989 and 2018: A Meta-Analysis. *International Journal of Environmental Research and Public Health*, 16(22), Article 22. <https://doi.org/10.3390/ijerph16224581>
- Linehan, M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. Guilford Publications.
- Long, M. (2018). ‘We’re not monsters ... we’re just really sad sometimes:’ hidden self-injury, stigma and help-seeking. *Health Sociology Review*.
<https://www.tandfonline.com/doi/full/10.1080/14461242.2017.1375862>

- Love, H. A., LeFebvre, L. E., & Pederson, J. R. (2021a). Disclosure and nondisclosure of suicidality to romantic partners: Understanding the decision-making process. *Journal of Social and Personal Relationships*, 38(9), 2421–2441.
<https://doi.org/10.1177/02654075211008996>
- Love, H. A., LeFebvre, L. E., & Pederson, J. R. (2021b). Perceptions of romantic partners' responses to disclosures of suicidality. *Personal Relationships*, 28(4), 803–821.
<https://doi.org/10.1111/pere.12389>
- Maple, M., Frey, L. M., McKay, K., Coker, S., & Grey, S. (2020). “Nobody hears a silent cry for help”: Suicide attempt survivors' experiences of disclosing during and after a crisis. *Archives of Suicide Research*, 24(4), 498–516.
<https://doi.org/10.1080/13811118.2019.1658671>
- Marshall, P., Sansom, K., Jagfeld, G., Jones, S., & Lobban, F. (2023). Caring for a friend or family member who has experienced suicidal behaviour: A systematic review and qualitative synthesis. *Psychology and Psychotherapy: Theory, Research and Practice*, 96(2), 426–447. <https://doi.org/10.1111/papt.12449>
- May, A. M., Crenshaw, A. O., Leifker, F., Bryan, C. J., & Baucom, B. R. W. (2019). Knowledge of suicide history, current depressive symptoms, and future suicide risk within couples. *Behaviour Research and Therapy*, 120, 103394.
<https://doi.org/10.1016/j.brat.2019.03.015>
- Metts, A. V., Sears, M., Vargas, J. H., Marafon, T., Couto, D. D., & Niles, A. N. (2022). Perceptions of helpful and unhelpful responses to disclosures of suicidality in a sample of mobile app users. *Archives of Suicide Research*.
<https://doi.org/10.1080/13811118.2022.2152984>

- Miano, A., Dziobek, I., & Roepke, S. (2017). Understanding Interpersonal Dysfunction in Borderline Personality Disorder: A Naturalistic Dyadic Study Reveals Absence of Relationship-Protective Empathic Inaccuracy. *Clinical Psychological Science, 5*(2), 355–366. <https://doi.org/10.1177/2167702616683505>
- Mirichlis, S., Boyes, M., Hasking, P., & Lewis, S. P. (2023). What is important to the decision to disclose nonsuicidal self-injury in formal and social contexts? *Journal of Clinical Psychology, 29*(1), 1–12. <https://doi.org/10.1002/jclp.23503>
- Mirichlis, S., Hasking, P., Lewis, S. P., & Boyes, M. E. (2022). Correlates of disclosure of non-suicidal self-injury amongst Australian university students. *Journal of Public Mental Health, 21*(1), 70–81. <https://doi.org/10.1108/JPMH-07-2021-0089>
- Moltu, C., Kverme, B., Veseth, M., & Natvik, E. (2023). How people diagnosed with borderline personality disorder experience relationships to oneself and to others. A qualitative in-depth study. *International Journal of Qualitative Studies on Health and Well-Being, 18*(1), 2152220. <https://doi.org/10.1080/17482631.2022.2152220>
- Navarro-Gómez, S., Frías, Á., & Palma, C. (2017). Romantic Relationships of People with Borderline Personality: A Narrative Review. *Psychopathology, 50*(3), 175–187. <https://doi.org/10.1159/000474950>
- Nielsen, E., & Townsend, E. (2018). Public Perceptions of Self-Harm: Perceived Motivations of (and Willingness to Help in Response to) Adolescent Self-Harm. *Archives of Suicide Research: Official Journal of the International Academy for Suicide Research, 22*(3), 479–495. <https://doi.org/10.1080/13811118.2017.1358223>

- Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and Suicidal Behavior. *Epidemiologic Reviews*, *30*(1), 133–154.
<https://doi.org/10.1093/epirev/mxn002>
- Overholser, J. C., Braden, A., & Dieter, L. (2012). Understanding suicide risk: Identification of high-risk groups during high-risk times. *Journal of Clinical Psychology*, *68*(3), 349–361.
<https://doi.org/10.1002/jclp.20859>
- Park, Y., & Ammerman, B. A. (2020). How should we respond to non-suicidal self-injury disclosures?: An examination of perceived reactions to disclosure, depression, and suicide risk. *Psychiatry Research*, *293*. <https://doi.org/10.1016/j.psychres.2020.113430>
- Sansone, R. A., Sellbom, M., & Songer, D. A. (2018). Borderline personality disorder and mental health care utilization: The role of self-harm. *Personality Disorders: Theory, Research, and Treatment*, *9*(2), 188–191. <https://doi.org/10.1037/per0000245>
- Scheirs, J. G. M., & Bok, S. (2007). Psychological Distress in Caretakers or Relatives of Patients With Borderline Personality Disorder. *International Journal of Social Psychiatry*, *53*(3), 195–203. <https://doi.org/10.1177/0020764006074554>
- Silberschmidt, A., Lee, S., Zanarini, M., & Schulz, S. C. (2015). Gender Differences in Borderline Personality Disorder: Results From a Multinational, Clinical Trial Sample. *Journal of Personality Disorders*, *29*(6), 828–838.
- Simone, A. C., & Hamza, C. A. (2020). Examining the disclosure of nonsuicidal self-injury to informal and formal sources: A review of the literature. *Clinical Psychology Review*, *82*, 101907. <https://doi.org/10.1016/j.cpr.2020.101907>
- Simone, A. C., Yu, S., & Hamza, C. A. (2023). Understanding experiences of disclosing and receiving disclosures of nonsuicidal self-injury amongst peers in university: A qualitative

- investigation. *Counselling Psychology Quarterly*, 36(4), 615–637.
<https://doi.org/10.1080/09515070.2022.2144807>
- Snir, A., Rafaeli, E., Gadassi, R., Berenson, K., & Downey, G. (2015). Explicit and inferred motives for nonsuicidal self-injurious acts and urges in borderline and avoidant personality disorders. *Personality Disorders*, 6(3), 267–277.
<https://doi.org/10.1037/per0000104>
- Soloff, P. H., & Fabio, A. (2008). Prospective predictors of suicide attempts in borderline personality disorder at one, two, and two-to-five year follow-up. *Journal of Personality Disorders*, 22(2), 123–134. <https://doi.org/10.1521/pedi.2008.22.2.123>
- Teddlie, C., & Tashakkori, A. (2009). *Foundations of Mixed Methods Research: Integrating Quantitative and Qualitative Approaches in the Social and Behavioral Sciences*. SAGE.
- Tomko, R. L., Trull, T. J., Wood, P. K., & Sher, K. J. (2014). Characteristics of Borderline Personality Disorder in a Community Sample: Comorbidity, Treatment Utilization, and General Functioning. *Journal of Personality Disorders*, 28(5), 734–750.
https://doi.org/10.1521/pedi_2012_26_093
- Turner, B. J., Cobb, R. J., Gratz, K. L., & Chapman, A. L. (2016). The role of interpersonal conflict and perceived social support in nonsuicidal self-injury in daily life. *Journal of Abnormal Psychology*, 125(4), 588–598. <https://doi.org/10.1037/abn0000141>
- Turner, B. J., Dixon-Gordon, K. L., Austin, S. B., Rodriguez, M. A., Zachary Rosenthal, M., & Chapman, A. L. (2015). Non-suicidal self-injury with and without borderline personality disorder: Differences in self-injury and diagnostic comorbidity. *Psychiatry Research*, 230(1), 28–35. <https://doi.org/10.1016/j.psychres.2015.07.058>

- van Schie, C. C., Lewis, K., Barr, K. R., Jewell, M., Malcolmson, N., Townsend, M. L., & Grenyer, B. F. S. (2024). Borderline personality disorder and stigma: Lived experience perspectives on helpful and hurtful language. *Personality and Mental Health*, 1–11. <https://doi.org/10.1002/pmh.1609>
- Veysey, S. (2014). People with a borderline personality disorder diagnosis describe discriminatory experiences. *Kōtuitui: New Zealand Journal of Social Sciences Online*, 9(1), 20–35. <https://doi.org/10.1080/1177083X.2013.871303>
- Wedig, M. M., Frankenburg, F. R., Bradford Reich, D., Fitzmaurice, G., & Zanarini, M. C. (2013). Predictors of suicide threats in patients with borderline personality disorder over 16 years of prospective follow-up. *Psychiatry Research*, 208(3), 252–256. <https://doi.org/10.1016/j.psychres.2013.05.009>
- Wright, A. G. C., Hallquist, M. N., Stepp, S. D., Scott, L. N., Beeney, J. E., Lazarus, S. A., & Pilkonis, P. A. (2016). Modeling Heterogeneity in Momentary Interpersonal and Affective Dynamic Processes in Borderline Personality Disorder. *Assessment*, 23(4), 484–495. <https://doi.org/10.1177/1073191116653829>
- Zanarini, M. C., Frankenburg, F. R., Reich, D. B., Wedig, M. M., Conkey, L. C., & Fitzmaurice, G. M. (2015). The course of marriage/sustained cohabitation and parenthood among borderline patients followed prospectively for 16 years. *Journal of Personality Disorders*, 29(1), 62–70. https://doi.org/10.1521/pedi_2014_28_147

Appendix A

Demographics

Table A 1

Dyadic Demographic Characteristics

Dyadic characteristic	<i>M (SD)</i>	<i>Range</i>	<i>n</i>	<i>%</i>
Relationship Length (years)	6.61 (4.93)	1-17		
Marital Status				
Married, cohabitating			6	40.0
Unmarried, cohabitating			5	33.3
Unmarried, not cohabitating			4	26.7
Monogamous				
Yes			14	93.3
No			1	6.7
Primary Earner ^a				
Intimate partner			8	53.3
Partner with BPD			1	6.7
Equal income brackets			3	20.0

Note. $N = 30$ ($n = 15$ intimate partners, $n = 15$ partners with BPD). Due to unanswered questions, not all variables add up to 100%.

^a The frequency of income brackets could not be reported as-is due to the demographics questionnaire failing to account for differences between Canadian and US dollars. A participant was designated the primary earner if their income bracket was higher than their partner's. In three dyads, one or both partners did not report their income. Participants reported their income in the following brackets: 1 = under \$5,000; 2 = \$5,000-\$9,999; 3 = \$10,000-\$14,999; 4 = \$15,000-\$24,999; 5 = \$25,000-\$34,999; 6 = \$35,000-\$49,999; 7 = \$50,000-\$74,999; 8 = \$75,000-\$99,999; 9 = \$100,000-\$249,999; 10 = \$250,000 and over

Table A 2***Individual Demographic Characteristics***

Individual characteristic	Intimate Partners		Partners with BPD		Full Sample	
	<i>M/n</i>	<i>SD/%</i>	<i>M/n</i>	<i>SD/%</i>	<i>M/n</i>	<i>SD/%</i>
Age	31.4	8.68	29.8	7.18	30.6	7.87
Gender ^a						
Cisgender female	3	20.0	11	73.3	14	46.7
Cisgender male	11	73.3	2	13.3	13	43.3
Non-binary	1	6.7	1	6.7	2	6.7
Transgender female	0	0	1	6.7	1	3.3
Race/Ethnicity						
Black/African	0	0	1	6.7	1	3.3
East/Southeast Asian	2	13.3	1	6.7	3	10.0
Hispanic/Latina/o/x	1	6.7	0	0	1	3.3
Indigenous/First Nations/Métis/Inuit	0	0	1	6.7	2	6.7
South Asian	0	0	1	6.7	1	3.3
White/European	12	80.0	9	60.0	21	70.0
Other Asian	0	0	1	6.7	1	3.3
Multi-Racial	0	0	1	6.7	1	3.3
Sexuality						
Bisexual	1	6.7	5	33.3	6	20.0
Gay/Lesbian	0	0	1	6.7	1	3.3
Heterosexual	13	86.7	7	46.7	20	66.7
Pansexual	0	0	1	6.7	1	3.3
Queer	1	6.7	1	6.7	2	6.7
Education						
High school diploma	1	6.7	2	13.3	3	10.0
Some post-secondary	4	26.7	6	40.0	10	33.3
College or trade certification	3	20.0	3	20.0	6	20.0
University degree	6	40.0	3	20.0	9	30.0
Master's/doctoral degree	0	0	1	6.7	1	3.3
Employment status						
Employed	14	93.3	9	60.0	20	66.7
Unemployed	0	0	6	40.0	9	30.0

Current mental health treatment and/or lifetime diagnosis ^b						
Yes	9	60.0	15	100	24	80.0
No	6	40.0	0	0	6	20.0
Has Children						
Yes	4	26.7	5	33.3	9	30.0
No	11	73.3	10	66.7	21	70.0

Note. $N = 30$ ($n = 15$ intimate partners, $n = 15$ partners with BPD). Due to unanswered questions, not all variables add up to 100%.

^a The demographic questionnaire's gender item included the options "trans female" and "female" for women and "trans male" and "male" for men. This wording erroneously communicates that women and men who identify with the sex they were assigned at birth (i.e., cisgender people) are better described as "female" or "male" than their transgender counterparts (i.e., women and men who were assigned a different sex at birth). Therefore, the participants who chose "female" or "male" were given the "cisgender" specifier based on the assumption that women and men who were assigned a different sex at birth chose "trans female" and "trans male" respectively.

^b Participants were coded as "Yes" if they reported currently taking psychiatric medication, currently receiving therapy or attending a mental health support group, or having a past or current mental health diagnosis

Appendix B

Semi-Structured Interview Protocol

1. Has your partner ever told you that they self-injured or attempted suicide, or told you that they might or were thinking about it? Can you describe some examples?

I. Follow Up Q: Have there been times where you have been worried about their safety, that they might hurt themselves or attempt suicide?

I. We ask everyone

2. IF N: Have they ever done anything that suggests that they might self-injure or attempt suicide, even if they didn't? Can you describe some examples?

IF NO to either above, skip to question 11.

3. Think back to the most recent time this occurred. What did they do?

4. I'm interested in the sequence of events from your perspective. What led up to the event in your view? (Did you talk or interact with each other at all before?)

5. If not obvious: How did you find out that they [insert descriptor: e.g., self-injured, attempted suicide, were told about the thoughts]? Did they tell you explicitly, or through their behaviour? Or was there something you did to find out? (If yes, ask to elaborate).

6. When you found out that they [insert descriptor: e.g., self-injured, attempted suicide, were told about the thoughts] on that day/evening, what thoughts went through your mind? What emotions did you experience?

7. What was the very first thing that you did in response?

8. How did they respond to that?

9. After that immediate response/initial reaction, did you do anything else? Did your behaviour toward them change at all? How so?

10. What about in the days or weeks that followed that event, what kinds of thoughts or feelings did you have about it?

11. Are there times when you find that you accidentally upset your partner? What is that like for you?

12. If Y to #11: How does that affect you? How do you think that has impacted your own view of yourself, your partner, and your relationship (if at all)? Do you have a recent example you could share?

13. In general, do you feel that you change your behaviour towards your partner because you're afraid that they might self-injure or attempt suicide? How so?

14. If Y to #13: How do you think that impacts your well-being?

15. If Y to #13: How do you think that impacts your relationship?

16. If Y to #13: How do you think that impacts your partner? Do you think it increases the risk of self-injury or suicide? Decreases it? How so?

17. Even though these experiences that you've had with your partner sound very challenging, there are clearly parts of your relationship that are positive too. Can you tell me about some of the things that you like or love about your partner or relationship?

18. Can you give me an example of a time with your partner where those aspects that you like or love felt very present?

Wrapping up Interview: *“Thank you so much for answering those questions and discussing some of your experiences with today. I really appreciate your openness to sharing all of that with me. Before we end the interview, I just want to double check if there's anything that you think I should know that you haven't mentioned, or that I haven't asked about that you would like to share with me today?”*