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**Borderline Personality Disorder from Both Sides:
Staff and Client Perspectives**

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A thesis submitted in partial fulfilment of the requirements for the degree of
Doctor of Clinical Psychology

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LIST OF ABBREVIATIONS

AMED	The Allied and Complementary Medicine Database
APA	American Psychiatric Association
ASSIA	Applied Social Sciences Index and Abstracts
BPD	Borderline Personality Disorder
BPO	Borderline Personality Organisation
CINAHL	Cumulative Index to Nursing and Allied Health Literature
DSH	Deliberate self-harm
IPA	Interpretative Phenomenological Analysis
MDD	Major Depressive Disorder
MHN	Mental Health Nurse
NHS	National Health Service
NIMHE	National Institute for Mental Health in England
NPO	Neurotic Personality Organisation
OT	Occupational Therapist
PPO	Psychotic Personality Organisation
PTSD	Post-Traumatic Stress Disorder
SW	Social Worker

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DECLARATION

This thesis was carried out under the supervision of Dr. Fiona MacCallum and Dr. Julia Conneely, with Dr. Helen Liebling-Kalifani acting as co-ordinator. The supervision team helped me to design the empirical study, facilitated access to participants, and provided feedback on drafts of chapters. Aside from these collaborations this thesis is exclusively my own work. This thesis has not been submitted for a degree at any other university.

Authorship of any papers arising from this thesis will be shared with the supervisors. The literature review is being prepared for submission to Personality and Mental Health. The empirical paper is being prepared for submission to Personality Disorders: Theory, Research and Treatment. The reflective paper is being prepared for submission to Psychology of Women Section Review.

SUMMARY OF CHAPTERS

The difficulties faced by individuals attracting a diagnosis of Borderline Personality Disorder (BPD) are multiple and varied. Whilst the psychological difficulties characteristic of this diagnosis have a significant impact on these clients' everyday lives, they also contend with others' attitudes and responses to their diagnosis, which has proved both controversial and stigmatising.

Chapter one concentrates on the stigma that surrounds the BPD label by presenting a systematic review of the literature relating to professionals' attitudes and responses to individuals diagnosed with BPD. This highlights the predominantly negative perceptions of this client group, the strength of countertransference experienced by professionals working with this client group, and the ways in which clinicians respond to this.

Chapter two concentrates on the perspectives of clients with BPD by reporting an empirical study investigating the lived experiences of parenting for mothers with BPD. The experiences of six mothers are explored using a phenomenological approach and the themes emerging from their interviews are discussed in detail. The findings are considered in relation to the existing literature and the implications in terms of providing support for mothers with BPD are discussed.

Chapter three continues the theme of motherhood by presenting a reflective paper focussing on the analysis of parenting-related dreams experienced by the author during the course of the research. The personal and professional implications of the dream analysis and research completion are considered.

CHAPTER ONE: LITERATURE REVIEW

Professionals' Attitudes and Responses to People Diagnosed with Borderline Personality Disorder: A Systematic Review of the Literature.

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'Personality and Mental Health'

(see appendix A for Author Guidelines)

1.1. ABSTRACT

The diagnosis of Borderline Personality Disorder (BPD) has come to be associated with significant stigma. As frequent consumers of mental health services this client group readily come into contact with professionals. This review of the literature explores the attitudes that professionals hold towards this group and the impact that these views may have on their responses to these clients. 11 databases were searched for relevant literature published between 1996 and 2012 using terms relating to BPD, attitudes and staff groups. The resulting 19 articles are critically reviewed. Negative attitudes towards clients with BPD dominated. The themes within these attitudes are discussed, and professionals' responses to clients are conceptualised in terms of countertransference. It is recommended that interventions aimed at altering perceptions of this client group are focussed at a systemic level.

Keywords: Borderline Personality; Attitudes; Responses; Professionals; Countertransference

N.B.: The term 'Borderline Personality Disorder' is widely used within the literature and will therefore be used throughout this review. However, it is acknowledged that alternative terms are used by some authors.

1.2. INTRODUCTION

Borderline Personality Disorder (BPD) is characterised by affective dysregulation (including emotional instability, feelings of emptiness and difficulties with anger), interpersonal problems (characterised by unstable, intense relationships and fears of abandonment), atypical behaviours (such as self-damaging impulsivity and suicidal gestures), and cognitive disturbance (including unstable identity and paranoia or dissociative symptoms) (American Psychiatric Association, 2000). Individuals with BPD frequently utilise mental health services with estimates suggesting they account for 11% of outpatients and 19% of inpatients (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). They often present to services at times of crisis, typically in extreme distress and potentially engaging in self-destructive behaviours (O'Brien & Flöte, 1997).

Since its development, the diagnosis of BPD has proved both controversial and stigmatising. Its validity has been questioned, as has the utility of a diagnostic category that encompasses such a heterogeneous group (Horn, Johnstone, & Brooke, 2007). Those assigned this label have often found themselves pigeonholed into a new descriptive category containing terms such as 'manipulative', 'attention seeking', and 'treatment resistant' (Aviram, Brodsky, & Stanley, 2006). Historically, individuals with personality disorders have been treated "at the margins", prioritised below other client groups and excluded from some services altogether (National Institute for Mental Health in England (NIMHE), 2003, page 5). The stigma associated with BPD and the historical perception of the disorder may influence clinicians at both a conscious and unconscious level, resulting in the development of negative views of these clients (Aviram et al., 2006). These perceptions may

influence the way in which professionals respond to this client group and thus have a significant impact on the care that clients receive.

Clients diagnosed with BPD perceive that professionals hold preconceived negative ideas about individuals with their diagnosis (NIMHE, 2003; Nehls, 1999). They describe feeling blamed for their diagnosis and feel that it has become a label that comes with a set of judgements about how difficult they may be to work with or to treat (Nehls, 1999). They perceive the support available to people with their diagnosis to be intentionally limited by professionals who do not seek to understand the root cause of their behaviours and who make them feel undeserving of care (Fallon, 2003; Nehls, 1999).

Westwood and Baker (2010) reviewed eight articles (published between 1993 and 2008) investigating the attitudes of mental health nurses (MHNs), working in psychiatric inpatient settings, towards BPD. They concluded that MHNs held negative attitudes towards clients with BPD and that these influenced the care they provided for this client group. MHNs had a tendency to distance themselves from, and reject, these clients, who they perceived to be dangerous, manipulative and not genuine. MHNs also reported having had more negative experiences with this client group and feeling less optimistic about their clinical outcomes. However, this review did not examine whether these attitudes exist more widely within the other professions that come into contact with clients with BPD, and whether they apply outside of inpatient services.

1.3. AIMS OF CURRENT REVIEW

In light of the above, this review aims to critically evaluate the empirical evidence relating to professionals' attitudes and responses to individuals diagnosed with BPD, considering professionals from a wider range of disciplines and settings than those included in Westwood and Baker's (2010) review. It is hoped that this will highlight the nature of attitudes towards this client group and the impact that these attitudes may have on how professionals behave with, and respond to, these individuals.

1.4. SEARCH STRATEGY

Literature searching was conducted between October 2011 and January 2012. The following databases were searched for relevant articles published in English in peer reviewed journals between 1996 and 2012: ASSIA, PsycArticles, PsycINFO, Social Services Abstracts, Sociological Abstracts, AMED, Embase, Medline, Web of Knowledge, CINAHL, and Scopus (see appendix B for a map of the search strategy). Abstract searches were conducted using the terms "borderline personalit*", (attitude* OR belief* OR opinion* OR perception* OR view OR views OR reaction* OR response* OR countertransference OR "therapeutic relationship*") and (staff OR clinician* OR profession* OR *therapist* OR nurse* OR worker* OR practitioner* OR psychiatrist* OR psychologist*).

Results were scrutinised for articles relevant to the review. Excluded articles included intervention papers, non-empirical papers, papers focussing on client accounts, papers where attitudes or responses to clients were not the focus, and papers included in Westwood and Baker's (2010) review. Cited reference and lead

author searches were completed for identified articles as were reference list checks. Keywords provided in these articles were reviewed to identify additional potential search terms. Table one contains the 19 articles included in the review.

1.5. SYNOPSIS OF INCLUDED STUDIES

The 19 articles reviewed included 13 quantitative studies, five qualitative studies and one study using mixed methods. Sample sizes ranged from six to 706. Studies were conducted in a variety of countries (seven in Australia/New Zealand; six in USA; five in Europe; one in Israel). Professionals taking part in the studies included mental health and physical health staff, and members of the police. Five studies included clinicians working exclusively within inpatient settings, two studies focussed on outpatient/community settings, and the remaining studies included professionals from a mixture of settings or did not clearly state the types of services studied.

Table 1: Articles Included in Literature Review

Author(s)	Country	Sample	Setting	Method	Main findings
Bergman & Eckerdal (2000)	Sweden	29 Nurses, Physicians, Counsellors, Psychologists	Inpatient & outpatient	Qualitative	<ul style="list-style-type: none"> • Theme of professional skills emerged encompassing empathy for people with BPD, interest in treating BPD, professional frustration, and the need for common outlook. • Theme of frame of organisation also emerged encompassing ambivalence between professions, need for structure, emotional support for staff, and shared philosophy of caring.
Black et al. (2011)	USA	706 Psychiatrists, Psychiatry residents, SWs*, Staff Nurses, Psychologists, other clinicians	Not reported	Quantitative	<ul style="list-style-type: none"> • Negative attitudes towards clients with BPD persisted amongst clinicians but differed by occupation. • Almost half of clinicians preferred to avoid clients with BPD. • Nurses held the least empathic and caring views towards clients whilst SWs reported the most caring attitudes. • SWs and Psychiatrists reported the highest levels of treatment optimism whilst nurses held the least optimistic attitudes.
Bodner et al. (2011)	Israel	57 Psychiatrists, Psychologists & MHNs*	Inpatient	Quantitative	<ul style="list-style-type: none"> • Psychologists reported significantly less agreement with antagonistic judgements regarding clients with BPD than psychiatrists and MHNs. • MHNs reported significantly less empathy for clients than psychologists and psychiatrists. • Responses to items relating to suicidal tendencies were able to explain variance in professionals' negative emotions towards clients/views regarding difficulties in treatment.

Bourke & Greyner (2010)	Australia	20 Clinical Psychologists	Outpatient	Qualitative	<ul style="list-style-type: none"> • Emotional responses were significantly more negative towards clients with BPD than those with MDD*. • Clients with BPD were experienced as more withdrawing and those with MDD as more attentive. • Psychologists felt less satisfied in their role with clients with BPD despite a desire to help them.
Brody & Farber (1996)	USA	336 Clinical Psychology students & licensed practitioners	Inpatient & outpatient	Quantitative	<ul style="list-style-type: none"> • Clients with BPD* evoked the greatest degree of anger and irritation and the least degree of liking, empathy, and nurturance when compared to clients with Depression and Schizophrenia. • Less experienced clinicians were more likely to regret their responses in therapy or feel their emotional reactions to clients were too strong.
Deans & Meocevic (2006)	Australia	47 MHNs	Inpatient & community	Quantitative	<ul style="list-style-type: none"> • A proportion of MHNs experienced negative emotional reactions and attitudes towards clients with BPD. • The most frequently agreed with statements regarding clients with BPD were that they are manipulative and that they emotionally blackmail people.
El-Adl & Hassan (2009)	UK	185 Psychiatrists, MHNs, SWs, OTs*, Psychologists	Inpatient & community	Quantitative	<ul style="list-style-type: none"> • Working with clients with BPD was experienced as challenging and not enjoyable, but only rated as stressful by 25% of respondents. • The majority of staff agreed that training in working with this client group was needed.

Giannouli et al. (2009)	Greece	69 MHNs	Inpatient	Quantitative	<ul style="list-style-type: none"> • MHNs working in psychiatric hospitals did not have less knowledge/experience and more negative attitudes to BPD than those in psychiatric clinics within general hospitals. • 86% of MHNs found managing clients with BPD difficult, 65% saw them as more difficult than other clients, and 71% believed care provided for them was inadequate.
Holmqvist (2000)	Sweden	124 MHNs, Psychiatric Aides, SWs, Psychologists	Inpatient (long-term)	Quantitative	<ul style="list-style-type: none"> • Diagnostic groups (BPO; PPO*; NPO*) could be separated based on the feelings they evoked in staff. • Clients with BPO evoked fewer relaxed feelings but more feelings of manipulation than those with PPO, those with NPO evoked feelings of sympathy/helpfulness, and those with PPO evoked feelings of insufficiency/disappointment.
Krawitz & Batcheler (2006)	New Zealand	29 MHNs, Psychologists, & Psychiatrists	Community, inpatient & crisis	Quantitative	<ul style="list-style-type: none"> • In the previous year 85% of clinicians had practiced in a manner that they felt was not likely to be in the client's best interests but protected themselves from medico-legal repercussions, with some doing so frequently. • Results suggested a clinically significant gap between clinicians' views on best practice and their actual practice when working with clients with BPD.
Leedy (1997)	USA	98 SWs	Not reported	Quantitative	<ul style="list-style-type: none"> • In comparison to clients with PTSD*, clients with BPD were seen as more likely to overdose for attention, be annoying in treatment, pose management problems, and less likely to improve, complete treatment, and be desirable clients.

Little et al. (2010)	Australia	210 police, 120 health & welfare staff, 51 inpatient mental health staff (primarily MHNs)	Inpatient & community	Quantitative	<ul style="list-style-type: none"> • Non-mental health staff held more negative perceptions of clients with BPD than those working in mental health services. • Members of the police were more likely to view clients as nuisances and mental health staff were more likely to be fascinated by them.
McIntyre & Schwartz (1998)	USA	155 Psychotherapists	Not reported	Quantitative	<ul style="list-style-type: none"> • In comparison to clients with MDD, those with BPD were perceived to be more dominant and hostile. • Clients with MDD were seen as more submissive and friendly, and evoked more nurturance and caring in therapists than those with BPD. • The degree of countertransference experienced decreased with clinicians' years of experience.
Nehls (2000)	USA	17 Case Managers	Community	Qualitative	<ul style="list-style-type: none"> • Case managers described monitoring themselves in terms of expressing concern and setting boundaries. • Managers focussed on themselves to retain control of relationships with clients with BPD.
O'Brien & Flöte (1997)	Australia	6 MHNs	Inpatient	Qualitative	<ul style="list-style-type: none"> • MHNs were interviewed regarding their experiences of caring for the same client (who had a diagnosis of BPD). • Experiences of providing care involved: being unsure; being in conflict; struggling to make sense of patient's experience; being traumatised.

Servais & Saunders (2007)	USA	306 Clinical Psychologists	Private practice, inpatient, community, others.	Quantitative	<ul style="list-style-type: none"> • When rating a person with Borderline features, 39% of psychologists thought they were ineffective, 8% incomprehensible, 22% dangerous, 1% unworthy, 42% undesirable to be with, and 60% dissimilar to themselves. • Results suggest that disidentification is a dynamic that operates between psychologists and these clients.
Treloar (2009)	Aus/New Zealand	140 Nurses, Psychologists, SWs, OTs, Psychiatrists & Medics	Mental health & emergency medicine	Qualitative	<ul style="list-style-type: none"> • Clients with BPD generated an uncomfortable personal response in clinicians, including feelings of frustration and inadequacy. • Specific characteristics of BPD were thought to contribute to negative responses including clients being ‘manipulative’, ‘time consuming’, and ‘chaotic’.
Treloar & Lewis (2008)	Aus/New Zealand	140 nurses, Psychologists, SWs, OTs, Psychiatrists & Medics	Mental health & emergency medicine	Quantitative	<ul style="list-style-type: none"> • Mental health practitioners held significantly more positive attitudes to DSH* in clients with BPD than emergency medical staff. • Allied health professionals held more positive attitudes than nursing and medical professionals.
Wilkins & Warner (2000)	UK	36 staff (‘varied disciplines’)	Inpatient	Mixed methods	<ul style="list-style-type: none"> • Trauma/attachment difficulties were considered a central influence on therapeutic relationships with women with BPD. • The ways clients related to staff were perceived to replay early attachments/abuse • The ways staff members related to clients were perceived to re-enact past abuse and involve detachment from clients.

*MHN = Mental Health Nurse; SW = Social Worker; OT = Occupational Therapist; MDD = Major Depressive Disorder; BPO = Borderline Personality Organisation; PPO = Psychotic Personality Organisation; NPO = Neurotic Personality Organisation; PTSD = Post-Traumatic Stress Disorder; DSH = Deliberate Self-Harm

1.6. REVIEW OF THE EVIDENCE

1.6.1. Attitudes and Responses to Clients with BPD

1.6.1.1. Aggression and Abuse

One of the most commonly cited themes within the papers reviewed was a perception of clients with BPD as aggressive (angry, dangerous and antagonistic) (Bergman & Eckerdal, 2000; Bourke & Greyner, 2010; Servais & Saunders, 2007; Wilkins & Warner, 2000). Similarly, when reporting their own emotional responses to clients with BPD, hostile feelings were readily cited by professionals (anger, irritation, frustration, aggression) (Bergman & Eckerdal, 2000; Brody & Farber, 1996; Holmqvist, 2000; McIntyre & Schwartz, 1998; O'Brien & Flöte, 1997; Treloar, 2009a). Wilkins and Warner (2000) in particular discuss clinicians' perceptions that the inpatient environment serves to re-enact clients' traumatic histories resulting in staff, at times, feeling like abusers of clients. However, whether a similar dynamic occurs within outpatient services is unknown.

1.6.1.2. Manipulation

Another commonly cited theme was professionals' perceptions of clients with BPD as manipulative. Staff described clients as emotionally blackmailing and felt that they 'played games' (Black, Pfohl, Blum, McCormick, Allen, North, et al., 2011; Deans & Meocevic, 2006; Little, Trauer, Rouhan, & Haines, 2010; Nehls, 2000; Treloar, 2009a). As a result, professionals were somewhat mistrusting of these clients and felt the need to be on guard around them for fear of betrayal or manipulation (McIntyre & Schwartz, 1998; O'Brien & Flöte, 1997). For example, nurses within O'Brien and Flöte's (1997) study described frequently questioning

clients' motives and honesty, and felt that this defensiveness impaired their relationships with clients.

1.6.1.3. Fear

In some of the articles clients with BPD were described as fragile and afraid (Bergman & Eckerdal, 2000; Wilkins & Warner, 2000). Within their descriptions of their own emotional responses to this client group, professionals frequently highlighted feeling afraid. They feared for the patients (e.g. that they may commit suicide), feared for themselves professionally (e.g. the legal consequences if a patient were to commit suicide), feared for themselves emotionally (e.g. the impact of witnessing self-harm/suicide attempts and hearing clients' stories of past traumatic experiences), and feared the type of clinician-client relationships they may become involved in (e.g. 'intense', overwhelming relationships, or situations where they re-enact the role of the abuser in a client's life) (Bergman & Eckerdal, 2000; Bourke & Greyner, 2010; Deans & Meocevic, 2006; Nehls, 2000; O'Brien & Flöte, 1997; Wilkins & Warner, 2000). O'Brien and Flöte (1997) identified the theme of 'personal and professional threat' within their participants' accounts of working with one particular client. These professionals appeared to weigh up the costs and benefits for themselves of engaging fully with this client and in particular viewed their professional position as frequently under threat.

1.6.1.4. Vulnerability and Helplessness

Some papers reported professionals to view clients with BPD as childlike and dependent (thus in need of care and security), and low in self-esteem (Bergman & Eckerdal, 2000; Black et al., 2011; Bourke & Greyner, 2010; Wilkins & Warner,

2000). When working with this group, clinicians reported pessimism about clients' futures and feelings of helplessness, powerlessness, inadequacy and incompetence as they questioned their ability to help these clients and whether their efforts were making any difference (Bourke & Greyner, 2010; O'Brien & Flöte, 1997; Treloar, 2009a; Wilkins & Warner, 2000). This resulted in professionals feeling overwhelmed, confused and dissatisfied (Bergman & Eckerdal, 2000; Bourke & Greyner, 2010; Deans & Meocevic, 2006; El-Adl & Hassan, 2009; Giannouli, Perogamvros, Berk, Svigos, & Vaslamatzis, 2009; Holmqvist, 2000; O'Brien & Flöte, 1997; Servais & Saunders, 2007; Treloar, 2009a). These feelings may be exacerbated by the sense of responsibility for these clients that staff members reported and their feeling that these clients have no one else to turn to. Whilst this evoked sadness and self-blame for some clinicians (Bergman & Eckerdal, 2000; Wilkins & Warner, 2000), others clearly viewed these clients as responsible for their own actions (Deans & Meocevic, 2006; Little et al., 2010). These conflicting findings may represent respondents' tendencies to provide more empathic responses when being interviewed face-to-face (in the former two studies) as opposed to completing anonymous measures (in the latter two studies).

1.6.1.5. Instability

Some clinicians held an overall view of clients with BPD as unstable, describing them as constantly in crisis, chaotic, and flitting between emotional states (Treloar, 2009a; Bourke & Greyner, 2010). Similarly, professionals reported distinct contrasts within their own emotional responses to these clients. Whilst, as mentioned previously, hostile feelings were readily cited, empathic feelings were also highlighted, such as warmth, compassion, attraction, fascination, closeness,

admiration, and nurturing/parental feelings (Bergman & Eckerdal, 2000; Brody & Farber, 1996; O'Brien & Flöte, 1997; Servais & Saunders, 2007). Finding it difficult to control their own emotions when with these clients and experiencing fluctuations between contrasting emotional states were also reported as clinicians found themselves shifting between positions of hope and hopelessness, feeling that they understood very much and then nothing at all (Bergman & Eckerdal, 2000; Bourke & Greyner, 2010).

In line with the conflicts professionals reported within their emotional responses to clients with BPD, they described feeling torn between different ways of responding. Clients aroused parental feelings in some staff members resulting in a tendency to treat them like children (Bergman & Eckerdal, 2000). However, this was in conflict with the belief that clients are responsible for themselves (Deans & Meocevic, 2006; Little et al., 2010). Similarly, professionals struggled to know how much concern they should express for clients, for example in response to risk-taking behaviours, as, despite caring about clients' well-being, they did not wish to overreact (Nehls, 2000). The pressure felt by case managers within Nehls' (2000) study was evident in their descriptions of trying to accurately judge the level of risk posed by clients with BPD.

1.6.1.6. Withdrawal

In some instances, clients with BPD were considered to be rejecting of clinicians (critical, detached, and defensive) and to withdraw from them (Bourke & Greyner, 2010; Wilkins & Warner, 2000). Similarly, many of the professionals' perceptions of, and emotional responses to, this client group led to a temptation and tendency to withdraw from these clients in order to protect themselves from both the

negative feelings experienced when working with these clients and the burden of responsibility felt due to the risks these clients often pose (Bergman & Eckerdal, 2000; Bourke & Greyner, 2010; Krawitz & Batcheler, 2006; McIntyre & Schwartz, 1998; Nehls, 2000; O'Brien & Flöte, 1997; Servais & Saunders, 2007; Wilkins & Warner, 2000).

Staff members distanced themselves from these clients physically, by avoiding contact with them (Bergman & Eckerdal, 2000; Bourke & Greyner, 2010; Nehls, 2000), psychologically by mentally positioning clients as different to themselves (Servais & Saunders, 2007), and emotionally by detaching themselves from clients and desensitising themselves to clients' traumatic histories (McIntyre & Schwartz, 1998; Wilkins & Warner, 2000). Professionals appeared aware of this withdrawal and often felt caught in a conflict between developing caring relationships with clients but suffering as a result (e.g. through vicarious traumatisation or legal consequences) versus keeping their distance, which may protect themselves but would not provide therapeutic relationships to clients (O'Brien & Flöte, 1997).

1.6.1.7. Specificity to BPD

It may be argued that some professionals hold similar attitudes towards other client groups, hence these views are not unique to BPD. A number of papers compared professionals' attitudes towards BPD with those towards other mental health difficulties. In comparison to clients with depression, professionals reported more negative views of, and feelings evoked by, clients with BPD and felt less positive and confident in working with them (Bourke & Greyner, 2010; Brody &

Farber, 1996; McIntyre & Schwarz, 1998; Servais & Saunders, 2007). Given the high levels of comorbidity between BPD and depression, it is notable that perceptions of the two remain distinct.

Clients with BPD also evoked more negative responses than clients with PTSD, and were perceived as more likely to pose management problems and less likely to engage in, and respond to, treatment than these clients (Leedy, 1997). When compared with clients with Schizophrenia, those with BPD elicited less anxiety and fewer feelings of hopelessness. However, they were also seen as providing a lesser sense of challenge and more boredom, and considered to be more dangerous, less worthy, and less desirable to be with than people with Schizophrenia (Brody & Farber, 1996; Servais & Saunders, 2007).

When compared to clients with other personality difficulties, those with BPD were found to elicit fewer relaxed feelings and more aggressive feelings than clients with psychotic personality traits and more overwhelmed and embarrassed feelings than clients with neurotic personality traits (Holmqvist, 2000). In comparison to non-clinical populations, psychologists rated people with BPD as less effective, understandable, and desirable and more dangerous, but also more worthy than members of the public (Servais & Saunders, 2007). However, the definitions of 'effective' and 'worthy' were not specified.

1.6.2. Factors Influencing Attitudes

1.6.2.1. Level of Experience

Black et al. (2011) found that having worked with more clients with BPD in the last year was indicative of more positive attitudes towards this client group. However, in this study, attitudes (across a number of disciplines) did not improve with years of experience. Therapists with more experience have been found to be less affected by the emotional reactions evoked by clients with BPD (Brody & Farber, 1996; McIntyre & Schwartz, 1998). This may be due to the fact that therapists are encouraged to reflect on their reactions to clients during their training and may also have embarked on their own therapy. Professionals from other disciplines are less likely to have had this experience. Treloar and Lewis (2008) found no significant differences in attitudes to deliberate self-harm in clients with BPD according to the number of years experience staff members had in working with this client group. These limited and somewhat mixed findings make the impact of experience on attitudes unclear.

1.6.2.2. Professional Group

Four of the articles reviewed directly compared the responses of different staff groups. Mental health practitioners were found to hold more positive attitudes towards clients with BPD than members of the police force, health and welfare staff, and staff working in emergency medicine (Little et al., 2010; Treloar & Lewis, 2008). This may be reflective of the fact that emergency medicine staff and the police are more likely to encounter these clients in crisis situations, for example when a client has harmed themselves or broken the law, thus giving them a potentially biased perception. Their contact is also typically short-term, meaning that

they may not develop a relationship with clients or witness clients' development over time as mental health professionals often do.

Within mental health services, allied health professionals held more positive and empathic attitudes towards clients with BPD than nursing and medical professionals (Black et al., 2011; Bodner, Cohen-Fridel, & Iancu, 2011; Treloar & Lewis, 2008). Nurses' attitudes appeared to be the least caring and this staff group held the least optimism regarding treatment of clients with BPD (Black et al., 2011; Bodner et al., 2011). This may be due to the fact that many of the studies focused on inpatient nurses who typically spend large proportions of time with clients in an acute environment. Consequently, their contact is significantly more intensive and potentially overwhelming than that of professionals from other disciplines who see clients as outpatients (Bodner et al., 2011; Wilkins & Warner, 2000).

1.6.2.3. Clinical Setting

Only one study specifically compared the attitudes of clinicians within different settings. Giannouli et al. (2009) evaluated the attitudes of nurses working in psychiatric hospitals and in psychiatric units of general hospitals. Their findings revealed no significant differences between the experience, attitudes and knowledge of these two staff groups in relation to clients with BPD. However, staff working in psychiatric hospitals acknowledged that the diagnosis was not readily used within their services. Although the studies reviewed here were conducted in various settings, insufficient information was provided to allow for between-study comparisons.

1.7. METHODOLOGICAL LIMITATIONS OF PAPERS REVIEWED

A number of the studies reviewed here acknowledged having small sample sizes and low response rates (Black et al., 2011; Bodner et al., 2011; Deans & Meocevic, 2006; Krawitz & Batcheler, 2006; O'Brien & Flöte, 1997). The findings of these studies may not be transferable to wider populations and may have been biased by the nature of those who chose to participate. Due to the limited research in this area, studies from across the world were included in the review. Consequently, professionals' attitudes may have been subject to differing cultural views of BPD and staff members may have been working within distinctly different services in countries with varying medico-legal systems. However, this review highlights negative attitudes and responses to clients with BPD to be a worldwide problem.

Findings may have been further biased by the settings in which studies were conducted. For example, Holmqvist (2000) focussed on 'treatment homes' for clients with severe, long-term difficulties, Black et al. (2011) conducted their research within academic research centres, and Servais and Saunders' (2007) participants primarily worked in private practice, thus making the experiences of these clinicians potentially distinct from one another in terms of the severity of client difficulties and the types of relationship clinicians are likely to have had with clients. The majority of the studies employed cross-sectional designs, thus attitudes may have been specific to those time-points. However, two studies did use longitudinal approaches and report findings concurrent with the other studies (Bodner et al., 2011; Holmqvist, 2000).

Due to the lack of appropriate standardised measures available for assessing attitudes towards mental health difficulties, the majority of studies reviewed here developed their own scales. Consequently, the reliability and validity of these had not been assessed and direct between-study comparisons are not possible. Furthermore, some measures used language that may have been ambiguous. For example, clinicians' interpretations of feeling 'relaxed' with a client, or of a client's 'effectiveness', may differ. Overall, measures that incorporated both professionals' cognitive and emotional responses to clients with BPD appeared most appropriate (e.g. Bodner et al., 2011).

Whilst most of the studies reviewed asked professionals about clients with BPD in general, a minority asked about specific clients that clinicians had worked with (Bourke & Greyner, 2010; Holmqvist, 2000; O'Brien & Flöte, 1997; Wilkins & Warner, 2000). Focussing on known as opposed to hypothetical clients may have affected professionals' reports. Only two studies provided participants with a description of a client with BPD (Brody & Farber, 1996; McIntyre & Schwartz, 1998). The remaining studies relied on professionals having a clear and accurate perception of the diagnosis. Whilst the majority of the studies reviewed used the term BPD, three studies referred to clients with 'Borderline Personality Organisation' (Brody & Farber, 1996; Holmqvist, 2000) or 'borderline features' (Servais & Saunders, 2007). Consequently, it is possible that these studies may have been referring to clients with slightly different presentations.

1.8. DISCUSSION

The current review synthesises and evaluates the empirical evidence relating to professionals' attitudes towards individuals diagnosed with BPD and considers the impact that these attitudes may have on the care of these clients. The review has highlighted the frequency with which professionals' own emotional responses to clients with BPD mirror their perceptions of this client group. For example, whilst clients are perceived as aggressive, unstable and vulnerable, professionals also navigate an emotional journey encompassing these feelings when working with this client group. In this respect, staff members may be considered to experience clients' projected emotions in the countertransference. Similarly, professionals' responses within their relationships with clients with BPD appear to mimic clients' responses. For example, the approach/avoidance patterns of responding identified in these clients appear to be replicated in clinicians' responses, such that they feel both a desire to nurture and engage with these clients but also a need to withdraw from them. This suggests that the countertransference is being played out within staff members' relationships with clients.

In their classic paper, Maltzberger and Buie (1974) posit that therapists experience 'countertransference hate' in working with suicidal patients, particularly those who they describe as 'borderline'. They suggest that this results in clinicians feeling a mixture of malice and aversion towards the patient. Whilst the malice component may be less conscious and instead experienced as a sense of fear, the aversive component is often experienced consciously creating a temptation to abandon the patient. Both fear and withdrawal from clients with BPD emerged as themes within the literature reviewed. In light of Bodner et al.'s (2011) finding that

professionals' responses to items relating to suicidal tendencies were able to explain variance in their negative emotions towards clients with BPD, it appears possible that the self-destructive components of BPD may have a particularly strong bearing on professionals' attitudes and responses. Further research is needed in order to test this hypothesis.

1.8.1. Clinical Implications

The attitudes and responses of professionals described here are likely to impact upon these clients' experiences of services. It appears that, when working with clients with BPD, professionals feel the need to focus on protecting themselves, despite the fact that this may mean acting in a manner that they do not believe to be in the clients' best interests (Krawitz & Batcheler, 2006; O'Brien & Flöte, 1997). Some of the typical responses to these clients may serve to exacerbate their difficulties. For example, clinicians' tendencies to withdraw may reinforce clients' fears of abandonment, thus causing them to engage in added efforts to avoid abandonment, which deter staff members further still. The perceptions of clients with BPD discussed here appear inherent within many services thus raising the issue of whether services contribute to the stigma associated with this diagnosis.

It is also evident that the emotional demands placed on staff working with this client group may have been underestimated. The personal and professional threats described by clinicians are suggestive of high levels of stress associated with providing clinical care to clients with BPD. Clinicians appear dissatisfied with available systems of care and feel there to be insufficient education, protection, and containment for themselves within these systems (Wilkins & Warner, 2000).

Some professionals felt that services were inadequate and unable to meet clients' needs (Bergman & Eckerdal, 2000; Giannouli et al., 2009; Treloar, 2009a). Suggested reasons for this were differing professional opinions on how to intervene with this client group, both between disciplines (e.g. use of medication versus therapy) and between individuals (e.g. punitive versus nurturing response styles), a lack of staff education in relation to BPD, and a shortage of services available (Bergman & Eckerdal, 2000; Giannouli et al., 2009; O'Brien & Flöte, 1997; Treloar, 2009a). Consequently, it is evident that intervention is needed in order to create services that provide optimum support for both clients and professionals. A number of the studies reviewed call for interventions to alter staff perceptions of clients with BPD (e.g. Black et al., 2011; Deans & Meocevic, 2006; Treloar & Lewis, 2008). However, it appears likely that attitudes need to be addressed at a systemic level in addition to the provision of further supervision and support for professionals. The discussion presented here suggests that support for clinicians focussing on issues of countertransference may be most helpful. This is consistent with Treloar's (2009b) findings that a psychoanalytic focussed education program had a longer lasting effect on clinicians' attitudes towards BPD than a cognitive-behavioural focussed group.

1.8.2. Directions for Future Research

Further comparisons between mental health professionals working within different clinical settings may shed light on aspects of the environment that exacerbate negative attitudes and response styles. Investigations into the impact of the self-destructive aspect of BPD on professionals' attitudes are warranted, and research comparing reactions to clients whose presentations do/do not include this

aspect of the diagnosis may prove informative. Finally, despite considerable negativity within professionals' reported attitudes towards clients with BPD, clinicians continue to choose to work with this population. Whilst Bergman and Eckerdal's (2000) study sheds some light on potential reasons for this (e.g. empathy, fascination, hope, excitement), further investigation may provide valuable information to inform future interventions aimed at altering perceptions of this client group.

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CHAPTER TWO: EMPIRICAL PAPER

Parenting Experiences of Mothers with Borderline Personality Disorder

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2.1 ABSTRACT

The difficulties experienced by women with Borderline Personality Disorder (BPD) have been suggested to make parenting more challenging. However, qualitative research investigating the experiences of parenting for these women is lacking. The current study uses a phenomenological approach to investigate the first-hand lived experiences of parenting for mothers with mental health difficulties consistent with a diagnosis of BPD. This paper reports the findings of interviews with six mothers (of children under the age of 18) who have mental health difficulties consistent with a diagnosis of BPD, about their experiences of parenting. Interviews were analysed using Interpretative Phenomenological Analysis, which revealed six super-ordinate themes: Parenting Struggles, Positive Impact of Motherhood, Judgement, Identity, Relationships with Children, and Impact on Children. The findings highlight both the positive and negative impact of parenting on maternal mental health and vice versa. Particular attention is paid to aspects of parenting experiences that appear unique to BPD and how some of the diagnostic features of BPD may be manifested in motherhood. The implications of the findings in terms of providing support for mothers with BPD are discussed.

Keywords: Borderline Personality; Mothers; Parenting; Phenomenology.

2.2 INTRODUCTION

2.2.1 Borderline Personality Disorder and Parenting.

Borderline Personality Disorder (BPD) is characterised by pervasive emotional, cognitive and behavioural patterns that cause significant impairment and distress (American Psychiatric Association (APA), 2000). Individuals attracting this diagnosis typically have difficulties in emotional regulation, unstable interpersonal relationships, fears of abandonment, identity disturbance, impulsivity, recurrent suicidal behaviour, chronic feelings of emptiness, difficulties with anger, and transient paranoia, delusions or dissociative symptoms (APA, 2000). BPD is predominantly experienced by women and often diagnosed in early adulthood (National Institute for Health and Clinical Excellence, 2009). Consequently a significant number of women with the disorder are likely to also be mothers (Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2012).

It has been suggested that some of the difficulties experienced by women with BPD may make parenting particularly challenging for them (Lamont, 2006). The emotional instability that is characteristic of this group of women may make it difficult for them to feel emotionally available for their children, their difficulties with interpersonal relationships and attachment may extend to their relationships with their children, and their already unstable sense of self may be tested by the additional role of motherhood (Kiel, Gratz, Moore, Latzman, & Tull, 2011; Lamont, 2006). Stepp et al. (2012) suggest that mothers with BPD oscillate between over-involvement and under-involvement in parenting their children, although no empirical evidence for this exists to date (Macfie, 2012). Those domains of functioning that people with BPD struggle within are similar to the developmental tasks of childhood and adolescence (attachment, self-development, self-regulation),

potentially making raising a child through these stages more difficult (Macfie, 2009). In addition to this, individuals diagnosed with BPD often report adverse upbringings in invalidating environments (Heard & Linehan, 1993). Consequently, their struggles in parenting may be exacerbated by their own traumatic childhood memories or “ghosts in the nursery” (Lamont, 2006; Newman & Stevenson, 2005).

2.2.2 Children of Mothers with BPD.

Infants of mothers diagnosed with BPD have been rated as less attentive, interested, and eager to interact, more likely to be categorised as disorganised in their attachment, and have been observed to smile and vocalise less than those of mothers with no mental health difficulties (Crandell, Patrick, & Hobson, 2003; Hobson, Patrick, Crandell, Garcia-Perez, & Lee, 2005; Newman, Stevenson, Bergman, & Boyce, 2007; White, Flanagan, Martin, & Silverman, 2011). In later life children of mothers with BPD may experience more parent-child role-reversal, more negative relationship expectations with their parents, greater fears of abandonment, and feel over protected by their mothers (Barnow, Spitzer, Grabe, Kessler, & Freyberger, 2006; Macfie & Swan, 2009). Overall there exists a higher prevalence of psychological difficulties and diagnoses in the children of mothers with BPD in comparison to mothers with other mental health difficulties and controls, and these children are more likely to report low self-esteem and poorer emotional regulation (Barnow et al., 2006; Macfie & Swan, 2009; Weiss, Zerkowitz, Feldman, Vogel, Heyman, & Paris, 1996). Whilst the difficulties experienced by children of mothers with BPD have been evidenced, the links between these and mothers’ parenting have not yet been fully explored.

2.2.3 Interactions between Mothers with BPD and their Children.

Observations of mothers with BPD interacting with their infants have reported them to be more intrusive and less sensitive (Crandell et al., 2003; Danon, Rosenblum, Heroux, Tarnopolski, & Annick, 2001; Hobson et al., 2005; Kiel et al., 2011; Newman et al., 2007) and to exhibit disrupted affective communication with their infants and more frightened/disorientated behaviour in response to their infants than depressed or control mothers (Hobson, Patrick, Hobson, Crandell, Bronfman, & Lyons-Ruth, 2009). They have also been found to smile, touch their infants, and play games with their children less than mothers with Major Depressive Disorder (MDD) and control mothers (White et al., 2011). However, significantly less attention has been paid to the way in which these findings translate into everyday parenting and how they affect mothers' experiences of parenting.

2.2.4 Parenting Experiences.

Despite the growing literature documenting the impact of maternal BPD on their children, few studies report the experience of parenting for these mothers. Newman et al. (2007) asked mothers with BPD to complete questionnaire measures regarding their parenting and found them to feel less satisfied and competent in parenting, experience more difficulties and distress in coping with parenting, and feel more disappointment and less satisfaction in their interactions with their children in comparison to mothers without mental health difficulties. Schacht (2004) found mothers with BPD (of children aged 10-18 years) to report feeling inadequate, uncertain and guilty in relation to their parenting and to question how effective their parenting was. Mothers also felt that their mental health had impacted negatively on

their parenting and placed increased responsibility on their children. Nevertheless, feelings of fulfilment in relation to parenting were also identified.

Although research focussing on BPD is limited, qualitative studies exploring the parenting experiences of mothers with other mental health difficulties have been conducted. These typically focus on diagnoses such as Schizophrenia, Bipolar Disorder and MDD. These parents report concerns regarding custody, stigmatisation, and difficulties with services. They talk of their children as a positive resource that boosts their self-esteem, keeps them going and makes them feel fulfilled as a woman but also of the difficulties they face in parenting during relapses of their illness and their worries about the effect that they may be having on their children (Ackerson, 2003; Bassett, Lampe, & Lloyd, 1999; Diaz-Caneja & Johnson, 2004; Montgomery, Tompkins, Forchuk, & French, 2006; Mowbray, Oyserman, & Scott, 1995; Nicholson, Sweeney, & Geller, 1998; Sands, 1995). However, as BPD is distinct from these diagnoses it is not possible to generalise from these findings and hence the experiences of mothers with BPD remain unclear.

2.2.5 Aims of the Current Study.

Whilst it is likely that the mental health difficulties experienced by mothers with BPD impact upon their experiences of parenting, studies investigating maternal perceptions remain virtually non-existent and, to the author's knowledge, phenomenological explorations are yet to be conducted. Consequently it is not clear what these mothers perceive the key issues in parenting to be for them, or what support may be helpful to them. The current study investigated the lived experiences of parenting for mothers with mental health difficulties consistent with a diagnosis of BPD using a phenomenological approach and considered the following questions:

- What are these mothers' experiences of parenting?
- What difficulties with parenting do these mothers experience and are certain stages of their children's development particularly difficult for them?
- What impact do these mothers think that parenting may have on their mental health and that their mental health may have on their parenting?
- What are the views of these mothers regarding services and support that have been, or may be, helpful to them in relation to their parenting?

2.3 METHODOLOGY

2.3.1 Ethics

Ethical approval was granted by Coventry University, Birmingham East North and Solihull NHS Research Ethics Committee, and the Research and Development Committees for Coventry and Warwickshire NHS Partnership Trust and Birmingham and Solihull NHS Mental Health Foundation Trust (appendix C).

2.3.2 Recruitment and Participants.

The current study employed an interpretative phenomenological approach, which places emphasis on the quality of interview data as opposed to the quantity. However, as a guide, it has been suggested that studies taking this approach involve up to ten participants (Reid, Flowers, & Larkin, 2005; Smith, Flowers, & Larkin, 2009). Consequently the current study aimed to recruit up to this number of participants. A cover letter, a participant information sheet, and a 'consent to be contacted' form (appendices D and E) were distributed to appropriate clients currently under the care of mental health services within the two NHS Trusts for which ethical approval had been obtained. A total of eight mothers returned the

‘consent to be contacted’ form. These women were then contacted by telephone by the investigator who provided them with further information regarding the study, assessed whether or not they met the inclusion criteria for the project, and gave them the opportunity to ask questions and consider their participation. Two women were excluded from the study due to not being currently under the care of a mental health service or their children having been removed from their care. Six women met the inclusion criteria and agreed to participate. The inclusion criteria were:

- Mental health difficulties consistent with a diagnosis of BPD (co-morbid mental health difficulties were accepted).
- The mother of at least one child aged between 12 months and 18 years.
- Aged 18 or over.
- Fluent in English.
- Able to provide informed consent for themselves.
- Currently living with and parenting at least one of their children.
- Under the care of a mental health service at the time of the interview.

Participating mothers were aged between 26 and 46 (mean=33.3 years). All participants were White British and unemployed at the time of the interview. Levels of education ranged from holding minimal qualifications to currently studying at degree level. All of the women were married or in a relationship but only three of them were living with their partners at the time of the interview. All of the women had been told by a mental health professional that they had difficulties consistent with a diagnosis of BPD, ranging from 15 years ago to within the last year. Five of the women had been given comorbid mental health diagnoses including Bipolar Disorder, Depression, Anxiety, Post-Traumatic Stress Disorder and Eating

Disorders. All mothers had received some form of intervention for their mental health difficulties. These included Dialectical Behaviour Therapy, individual and group therapy, day hospital, Crisis/Community Mental Health Teams and Mind, medication, and inpatient admission. Participating mothers had between one and three children each (mean=2.0), with children aged between 18 months and 17 years (mean=11.6 years). Seven of the children were male and five were female. All of the children except one were living with their mothers at the time of the interviews.

2.3.3 Procedure.

Following ethical approval and recruitment, a mental health professional responsible for each participant's care was informed of their involvement in the study (appendix F). The six participants were each interviewed individually, by the chief investigator, in their own homes or at a health service facility, according to their personal preference. Informed, written consent was obtained from each participant immediately prior to their interview (appendix E) and participants' right to withdraw without their clinical care being affected was made explicit. Interviews lasted between 50 and 110 minutes and were audio-recorded. Interviews were transcribed verbatim by the chief investigator and anonymised for confidentiality.

2.3.4 Measure.

A semi-structured interview was administered to all participants using an interview guide (appendix G). The interview guide was designed by the chief investigator and supervision team and consisted of a number of pre-determined areas and potential questions that could be asked within each area. Questions were phrased to elicit open-ended responses from participants, with the interviewer probing where necessary. Care was taken to avoid leading questions and for the interview not to be

embarrassing or upsetting to participants. Inspiration for the interview guide was taken from the Parent Development Interview (Aber, Slade, Berger, Bresgi, & Kaplan, 1985) and the Working Model of the Child Interview (Zeanah & Benoit, 1995). The proposed interview guide was piloted prior to the start of the study in order to assess the suitability of the questions. Following this, additional prompts were added to the interview. Further amendments were made as necessary based on initial participants' responses to questions.

2.3.5 Design.

The study sought to understand the lived experiences of mothers with difficulties consistent with a diagnosis of BPD and therefore employed a qualitative, phenomenological approach to ascertain their perceptions and experiences of motherhood and the meaning they made of these.

2.3.6 Data Analysis.

Interview transcripts were analysed using Interpretative Phenomenological Analysis (IPA) (Smith, 1996), an approach that aims to capture and explore experiences and the meanings of these to participants. An interpretative account of this is then provided with an acceptance that this is a subjective process engaged in by the researcher. The analytic process involved the noting of emergent themes and connections between these themes within each of the mother's accounts, followed by looking for patterns across the mothers' experiences and identifying themes for the group as a whole. Appendix H outlines the analytic process employed in greater detail and includes a sample piece of analysed transcription.

2.3.7 Reliability and Validity.

Qualitative phenomenological research is invariably subject to the influences of the researcher. The investigator of the current study has approached the research as a non-parent and recognises that this may have affected the interpretative analysis. Having worked within mental health services, the investigator acknowledges that she may hold a biased view of what constitute typical parenting and parental attitudes. The interviewer attempted to identify, and minimise where possible, her impact on the interview process by noting her thoughts and feelings prior to, and following, each interview and reflecting on these. The subjectivity of the interpretative analysis was reduced through verification of the emergent themes within a proportion of the data by an independent researcher and the use of supervision during the analysis.

2.4 RESULTS

Six super-ordinate themes that captured the mothers' experiences of parenting emerged from the IPA analysis. These were made up of a total of 21 subordinate themes. The super-ordinate themes and subordinate themes are outlined in table two. Each of the themes will now be explored in more detail, using verbatim quotes from participants' interviews to illustrate each theme. Pseudonyms have been used throughout and transcript line numbers appear in brackets following quotes.

2.4.1 Super-ordinate Theme 1: Parenting Struggles

This theme represents the difficulties that the mothers experienced in parenting. This was discussed by all participants and contains the subordinate themes Practical Struggles, Emotional Struggles, Reduced Parenting Capacity, and Support.

Table 2: Super-ordinate and Subordinate Themes.

Super-ordinate Themes	Subordinate Themes
Theme 1: Parenting Struggles	Day-to-Day Struggles
	Emotional Struggles
	Reduced Parenting Capacity
	Support
Theme 2: Positive Impact of Motherhood	Coping
	Motivation
	Staying Alive
Theme 3: Judgement	Feeling Judged
	Other Mothers
	Self-Evaluation
	Getting it Right
Theme 4: Identity	Identity as a Mother
	Identity beyond Motherhood
Theme 5: Relationships with Children	Differences between Children
	Role-Reversal
	Children's Appraisals
	Hiding Mental Health
Theme 6: Impact on Children	Fear
	Mixed Impact
	Guilt

Subordinate Theme 1: Day-to-Day Struggles

All of the mothers described practical aspects of parenting that were difficult for them. Claire struggled to get out of bed: “...*some mornings I just couldn't get up and he'd come in the room and say “you alright mum? I'm going to school now”, I was just dazed out my tree on medication and alcohol...*” (375-378) and Anne felt aware of what might help her but unable to implement it: “...*if I can get into a routine, that makes it a bit easier, but I struggle to get into the routine...or if I can get into a routine I struggle to keep it going...*” (614-616). Other mothers echoed Anne's difficulties in sticking to a routine despite believing this may help them.

The majority of the mothers reported parenting to be easier and more enjoyable for them when their children were infants. Holly found it less challenging to look after her children as infants: “*I quite like, like little babies cos they're just really easy to look after I think. I mean I know they can't tell you what the matter is but you haven't exactly gotta be a genius to figure it out*” (437-439) and Kate emphasised that her children have become harder to look after as they have grown older “*I thought it was quite easy to start with, but not so much now...*” (160) and also described the current time as the hardest stage of parenting for her. Verity described the hope she felt when her child was born “*I loved it when she was a baby...it gave me a bit of hope, you know, like here's someone who's gonna love me regardless, someone who's always gonna be there...someone you know's not gonna let you down...*” (575-581). Reflected in Verity's quote is her desire not to be abandoned and her belief that her child will not do so.

All of the women reported being, or feeling, somewhat absent in their children's lives either through physical separations, others parenting their children on their behalf, or feeling as though they had missed out on parenting. Anne

described both positive and negative aspects of being separated from her children in the past “*while they were away life was probably a bit easier. It was very sad, um, obviously cos I was constantly thinking about them...*” (430-432). Claire describes how her mental health difficulties resulted in her feeling absent from her son’s life “[son] ended up going to a lot of, [ex-husband] had to look after him a lot ... I feel like I almost missed a year of, you know, of not really being his mum” (663-667).

All of the women described difficulties with the children’s fathers, particularly when they were no longer in relationships with them. Verity described finding the sporadic involvement from her daughter’s father difficult: “*...he’s only sort of really been in the picture for the last few years and she (daughter) does see him but it’s...there’s no real routine to it*” (160-162). She also emphasised the impact that difficulties between herself and her daughter’s father had on her relationship with her daughter: “*...it’s hard cos one minute we (father and self) do and then we don’t (get on)...he’s very um, controlling and very, you know everything has to be his way or he goes mad so that’s caused tension between me and her (daughter)*” (168-171). Although the mothers did not talk in depth about their relationships with their children’s fathers, the interpersonal difficulties often reported by people with BPD were evident within some of these relationships. These quotes reflect the difficulties that instability in their relationships with their children’s fathers posed for the mothers in relation to parenting. These difficulties also highlight the impact of the social and environmental situation these mothers may find themselves parenting within, on their experience of parenting.

Subordinate Theme 2: Emotional Struggles

All of the mothers reported negative emotions in response to parenting such as finding it stressful, exhausting, frustrating and overwhelming. Holly describes her

emotional experience of struggling to get her children to sleep “...he was waking her up and she was crying and then he'd settle down but she'd be crying...I was so tired and just you know, pi**ed off really...” (481-487). Claire's response to her son in this extract illustrates her anxiety around parenting tasks: “...he doesn't think through...but then when you say to him “did you not think to tell me that you've got no clean shirts for school” you know and there's me panicking, and “well I thought you'd know mum”...and I'm like “for god's sake man”...” (127-131).

Subordinate Theme 3: Reduced Parenting Capacity

The mothers discussed the impact that they felt their mental health had had on their parenting and the ways in which they felt that their capacity to parent was reduced by their mental health difficulties. In response to being asked what the most difficult or painful thing about being a parent was Holly responded “when you haven't got any capacity in your head to deal with your own s**t going on and they're just like relentless...it's just a bit much, it's like when you're overwhelmed by life generally anyway” (335-341). Rachel describes her lack of mental capacity to focus on her children “I can be talking to them but it just doesn't go in 'cos my head's just full of rocking horse c**p ...and it just doesn't go in....” (791-796). This suggests that, for these mothers, a desire to engage in parenting is not always enough as their mental health may prevent them from having the capacity to do so.

Some of the mothers emphasised the difference between their capacity to parent whilst they were mentally well and whilst they were unwell “...if I was well and could cope it didn't matter what [son] was doing because mentally and physically I was able to know...but if I was going through a bad stage or I'm drunk or something, doesn't matter how well or bad [son]'s doing I'm not gonna be able to” (Claire, 1466-1474). In this sense the women appeared to see themselves as two

different mothers, the “well” and capable mother and the “unwell” mother who lacks the capacity to parent her children. This is in line with the tendency to split things in to ‘all good’ or ‘all bad’ that is characteristic of BPD (Kernberg, 1984).

Interestingly, one of the mothers also highlighted the fact that periods of poor mental health were not necessarily synonymous with poor parenting “*when I had Anorexia, I might have been six stone but I was a brilliant mum...I was physically very, very unwell obviously but as a functioning person, I was like super-woman*” (Claire, 1439-1444). However, this experience was a rarity as other mothers did not tend to associate periods of poor mental health with coping with parenting.

Subordinate Theme 4: Support

Each of the women was asked about any support that they had received for parenting or that they felt would be helpful to them. In general the mothers had not found formal parenting services helpful and felt that these were not tailored to mothers with mental health difficulties. “*I suppose ‘cos there’s nothing specifically for like with mental health...it’s kind of like they’re telling you all this stuff and it’s not like you don’t know any of it*” (Holly, 830-834). This extract suggests that these mothers are aware of ‘ideal’ parenting strategies but find these difficult to implement due to their mental health difficulties. The mothers generally favoured support from family and friends instead “*you’ve just gotta have support off people who care as much about your child as you do*” (Claire, 1319-1323).

A number of the women emphasised their desire for support to be non-judgmental. Whilst the women desired support for their parenting, some of them were also fearful of the consequences of requesting this “*it would’ve helped to be able to ring someone up and ask for advice...but someone that you know isn’t gonna judge you, and there’s no worry that, you know, you’re gonna lose your kids or*

something, 'cos that's the biggest worry I think...that if you ask for help...it's a sign of weakness, or a sign that...you can't cope or something" (Verity, 890-897).

2.4.2 Super-ordinate Theme 2: Positive Impact of Motherhood

This theme symbolises the positive ways in which being a mother had impacted on the participants' lives. This was discussed by all six women and contains the subordinate themes Coping, Motivation, and Staying Alive.

Subordinate Theme 1: Coping

Some of the mothers described the happiness and pride that their children brought them and how this helped them to cope with life *"...I don't have a lot of fun time with them 'cos good moods and being healthy for me don't happen that often, and when they do and when the kids are in a good frame of mind it's brilliant and that makes me happy" (Rachel, 247-253). "...that's probably the thing that gives me the most joy, just the fact that he's mine and that he's, I'm proud of him...that keeps me going..." (Claire, 359-363).*

Subordinate Theme 2: Motivation

Some of the women were motivated to engage in life for the sake of their children *"...however depressed I am, however in another place my head is, that's one thing that always brings me back, is just thinking about [son]...whatever I've done I think you've got to, got to, got to, sort yourself out, not for yourself, not for your parents, not for anything, but for [son]..." (Claire, 642-648).* In response to being asked whether she thought her mental health had been affected by the fact that she's a mother Holly stated *"probably...in a way it's like, it makes things better because...it's really important...if you've just got some bulls**t job...it'd be much easier to just f**k it all off and just not give a s**t about anything, but it's kind of*

like because it is just me...they do kind of need me..." (738-750). In these examples the responsibility of being a mother drove Claire and Holly to engage more both with life, and in parenting their children. In this respect motherhood appears to hold a motivational factor for these women that other aspects of life do not.

Subordinate Theme 3: Staying Alive

Four of the six mothers felt that being a mother had stopped them from committing suicide "*...I couldn't even think of life without them, if it wasn't for my boys I wouldn't even be alive today. I'm sure I would've just packed in by now...*" (Rachel, 384-387). "*Because I have her it sort of gives me an excuse to sort of say well I have to be ok for her and I can't go and you know kill myself or go and self-harm or anything*" (Verity, 814-817). These two examples suggest that motherhood has prevented the women from committing suicide due to both their children making them want to live and the responsibility to their children preventing them from leaving them. One of the mothers also described the resentment that she felt towards motherhood for forcing her to engage in life when a part of her did not wish to "*...this sounds awful, but sometimes I think 'but if you weren't here I could just get on with shutting my doors and nailing all the windows shut and I could just rot to death in here and it would be...' sometimes that's what I wanna do*" (Claire, 1163-1167). Within this quote Claire acknowledges her own sense of ambivalence towards staying alive, highlighting the fact that this may not always be considered to be a 'positive impact of motherhood' by this group of women.

2.4.3 Super-ordinate Theme 3: Judgement

This theme highlights feelings of judgement described by the mothers. This was reported by all six women and contains the subordinate themes Feeling Judged, Other Mothers, Self-Evaluation, and Getting it Right.

Subordinate Theme 1: Feeling Judged

Most of the mothers reported feeling judged by others for their parenting and feeling that others believed them to be a bad mother due to their mental health difficulties “...because they hear a word ‘mental illness’ they think automatically I’m a bad mum...I’m just tarred with being a like crap mother, and I’m not crap, I mean I do, my parenting skills are crap when I’m ill yeah, you know, that I can understand, but it doesn’t make me a bad parent” (Anne, 547-552). They also felt that others did not understand their mental health difficulties and may blame them for their children’s behaviour “...I worry then that, or he’ll get into some sort of police trouble over something and then they’ll kind of look at the state of me and all the rest of it and go “well, look at the state of his mum, is this to be expected?, ‘cos she’s obviously not very stable or she’s not well’...” (Claire, 630-633). The mothers were concerned not only about being judged to be a bad parent but also about the potential impact this could have on the way others view their children.

Subordinate Theme 2: Other Mothers

Participants had a tendency to compare themselves to other mothers “you see people with their kids...and they just seem to know, they seem to have a way with them, if that makes sense, it seems they know how to relate to them, they know how to talk to them, they know how to play with them, and I don’t feel like I know how to do that” (Verity, 244-248). They also reported feeling categorically different to other mothers “I found it difficult taking him to stuff like that (playgroups). Just ‘cos of the anxiety it’d give me thinking I’d have to have a conversation with other mothers that I’ve got nothing in common with” (Claire, 318-320). For each of these mothers, the beliefs and feelings they describe led to them isolating themselves from other mothers, who may have been a potential source of support for them.

Subordinate Theme 3: Self-Evaluation

Although some of the women reported feeling judged and criticised by others, they were their own biggest critics. Rachel talks about things that she felt she should have done but had not “...*I continually berate myself for all the things that I don't do with them and that I am rubbish at with them and that I haven't done that I should have done...that's one stick I beat myself with*” (777-783), whilst Kate talks about things that she had done but believed she should not have “*I shouldn't be doing that (self-harm) really when I've got the kids, should I really?*” (404).

Whilst self-criticism may be present for many new mothers who do not have mental health difficulties, the women in this study amplified this self-criticism further still with some of them judging themselves to be bad mothers “...*I've sort of made myself believe that I'm a bad mum and I'm never gonna be able to do anything right...*” (Verity, 526-528) and blaming themselves for their children's difficulties “*I think because of how I am, like I know that [child]'s quite emotionally unstable...but because like there's skills that I maybe haven't got in the same way as other people...I can't really impart that wisdom because I don't have it*” (Holly, 600-605).

Subordinate Theme 4: Getting it Right

The majority of the mothers appeared to believe that there was a “right” way to parent. Rachel discussed her regrets about things that she felt she had done “wrong” in the past and the things she wishes that she had done differently: “...*I'd try a lot harder to be a better mum...being in their lives more, being physically around more often, having more input, being more involved in their daily lives really...*” (718-722). Meanwhile, Verity talked about her fears of getting things “wrong” in the future “*no one gives you an instruction manual you know, when you have a child, so you don't really have a clue what you're doing and if you're doing it right, it's only*

when you do it really wrong that you realise you've done it really wrong and then it's too late" (879-883). These examples suggest that the mothers were not confident in their parenting abilities and had a tendency to question their parenting. These references to 'right' and 'wrong' ways to parent are again reflective of the tendency for splitting recognised in this client group (Kernberg, 1984).

2.4.4 Super-ordinate Theme 4: Identity

This theme symbolises the women's sense of identity. This was touched upon by all six participants and contains the subordinate themes Identity as a Mother and Identity beyond Motherhood.

Subordinate Theme 1: Identity as a Mother

Some of the women described how they viewed themselves as mothers (e.g. *"unconventional"* (Claire, 280); *"semi-functional"* (Rachel, 303)) and all six women commented on things that they valued in parenting their children *"...I've always made sure that if he comes out with comments about something or he has an opinion that I sort of say to him well "where's that come from?, where have you made that decision from?""* (Claire, 165-170).

Four of the mothers discussed the conflicts in parenting style that they had experienced with partners *"I feel that we used to clash on a lot of things, he (ex-husband) was very sort of straight down the line and very much well you know 'if you do something wrong you'll have your Xbox taken off you' and I was never like that"* (Claire, 176-80). Similarly to Claire, a number of the mothers had strong views on how they wanted to parent their children, despite not always feeling like they were able to do this. Again this reflects the parenting conflicts that occurred within the mothers' relationships with their partners.

Some of the women also made reference to their own upbringings and expressed a desire to parent their children differently to how they had been parented: *“it sort of makes you see how, it makes me see how my childhood was, ‘cos mine was quite wrong...you have your own child and you think god how could anyone treat their kids in this sort of way, I could never imagine doing”* (Verity, 327-336). In this sense the mothers own adverse childhood experiences served as motivation for them to try to parent as well as they were able to.

Subordinate Theme 2: Identity beyond Motherhood

Some of the women talked about trying to retain a sense of self beyond being a mother *“...I still wasn’t maternal or anything you know, I didn’t dress like a mum, you know, I was still very much me. Um, still a party animal you know, rock clubs on a Friday night with [son’s father] and stuff”* (Claire, 806-809), and their enjoyment of time to themselves without their children *“...it’s sort of nice to have a break, it’s sort of nice to be like me again...”* (Verity, 358-360). These are feelings that are common to many mothers, regardless of their mental health status (Maushart, 1999).

One mother in particular voiced how restricted she felt by motherhood *“...it’s quite restricting...like when you’re on your own with kids you can’t go anywhere or do anything...”* (Holly, 345-346). Holly subsequently felt somewhat resentful towards motherhood for preventing her from doing other things *“...I’ve been doing this like voluntary work...and then over the summer holiday I had to stop...I can’t really pay in someone to look after him...then I found out I was pregnant so it was like well f**k that idea basically...it’ll be like ten years or something by the time that this next one is at school for me to actually have a job and then I’ll probably be like unemployable anyway for a decade of no job...”* (588-596).

2.4.5 Super-ordinate Theme 5: Relationships with Children

This theme reflects the way the mothers viewed their children and their relationships with their children. This was raised by all six mothers and contains the subordinate themes Differences between Children, Role-Reversal, Children's Appraisals, and Hiding Mental Health.

Subordinate Theme 1: Differences between Children

Each of the four mothers who had more than one child described different perceptions of, and relationships with, their children. Typically, there was one child that they had particular difficulty with "*[youngest child] is very strong-willed, stubborn...he knows what he wants and he'll do what he wants...we don't have a close relationship [youngest son] and myself*" (Rachel, 177-181) and one child that they were closer to or viewed more positively "...we've always been really, really close, we have a very special relationship because we've always, always been together...and we've always had a special connection. He's a very, very smart kid..." (Rachel, 119-123). As seen in Rachel's descriptions the mothers expressed both positive (pride, love, a desire to protect) and negative (anger, frustration) feelings towards their children and had also observed both similarities and differences between their children and themselves. Again this is reflective of the characteristic splitting often observed within this client group (Kernberg, 1984).

Subordinate Theme 2: Role-Reversal

Evident within the mothers' descriptions of their relationships with their children were instances in which the roles of mother and child appeared to have been reversed "...sometimes it's like he's the adult and I'm the child and I don't like that...it's like 'hang on you're 14'...he is very grown up, and in some ways it's good but in some ways I just think hang on, no, I'm his mum" (Claire, 210-221) or where

the child had taken on a role much older than their years “...*I think there’s a lot of pressure on him ‘cos he’s only 6...he helps out with housework and stuff quite a lot, like he does most of the washing (Holly, 185-187).* In these examples both Claire and Holly seem aware of the role-reversal and Claire in particular feels frustrated by this. In relation to the previous subordinate theme, role-reversal did not occur specifically with children that mothers felt close to or distanced from.

Subordinate Theme 3: Children’s Appraisals

Five of the six women expressed concerns about their children holding negative opinions of them. Rachel describes her reaction to a poem that her son wrote about her “...*he wrote about the drug overdoses and never, not being surprised at the ambulances being called anymore, not flinching anymore ‘cos it happened so often, mum not being around, mum not being there to support him and mum not remembering things, him having to tell me ten times and me still forgetting things, and the frustration of it all, and, yeah it was horrid*” (281-287). Others expressed fears about how their children may view them in the future “*I’m worried she’ll grow up to hate me*” (Verity, 281), “...*I’d hate for him to see things going on and for him to make the wrong decision about me and think that I’m a loser or I do things on purpose, you know, and I think no it’s not like that*” (Claire, 405-408). These concerns appeared to elicit both feelings of guilt about their children’s experiences of them and fears of being rejected by their children.

Subordinate Theme 4: Hiding Mental Health

The mothers expressed mixed views on whether or not their mental health difficulties should be hidden from their children. Some felt determined to hide all aspects of it from them “...*I do hide it from her quite well, there are things that have impacted on her like being negative and that but she doesn’t see me cry, she doesn’t*

know that I've self-harmed, she doesn't know that I've took overdoses, she doesn't know any of that really" (Verity, 933-937), whilst others preferred to be open with their children about it "...I like to be as honest as I can with them. Obviously there might be a little odd white lie here and there but when it comes to my mental health..." (Anne, 188-193). For the women that had tried to hide their mental health difficulties from their children it was unclear whether this was an attempt to protect their children or due to a fear of being judged negatively by their children.

2.4.6 Super-ordinate Theme 6: Impact on Children

This theme symbolises the impact that the mothers felt that their mental health difficulties had had on their children. Notably, this emerged spontaneously from the interviews of all six participants. This theme contains the subordinate themes Fear, Mixed Impact, and Guilt.

Subordinate Theme 1: Fear

Five of the mothers had recognised aspects of themselves in their children and feared that their children might develop similar psychological difficulties to themselves. Some of the women also verbalised a desire for their children's mental health to be better than their own: *"I don't want her to turn out like me...that's my main worry...I've noticed that [daughter]'s really negative, well not as much as me but you can tell she's got it from me, so it was a bit upsetting to realise that. I thought I don't want her to be like that I want her, you know, to...believe that she can do whatever she wants rather than believe what I believe" (Verity, 268-279).*

Subordinate Theme 2: Mixed Impact

The mothers described the ways in which they felt their mental health difficulties may have impacted on their children, both negatively *"...I don't really know how I'm supposed to...instil good mental health in my children when I'm not*

really a very good example...” (Holly, 284-287) and positively “*other kids...they’re oblivious to the sort of things that my kids aren’t oblivious to if that makes sense?...my kids know what real stress is, cos they’ve seen me...my kids have had to learn how to adapt, which in a way is, can be a positive thing...*” (Anne, 293-308).

Subordinate Theme 3: Guilt

Four of the mothers described feeling guilty about the impact of their mental health difficulties on their children “*...I’ve often thought that I shouldn’t have had them cos they haven’t had a fair crack of it all they haven’t had the best life they could’ve had...*” (Rachel, 381-384). They felt guilt in relation to the things that their children may have witnessed (such as self-harm), or the way that they may have behaved towards their children “*...because I’ve put in my diary that I’m going out at 4 o’clock I can’t possibly leave it ‘til 5...I sometimes feel really bad for that, and just like I’m some sort of control freak...*” (Claire, 431-437).

2.5 DISCUSSION

The present study investigated the lived experiences of parenting for mothers with mental health difficulties consistent with a diagnosis of BPD using a phenomenological approach. Analysis of the mothers’ interviews revealed six super-ordinate themes including: Parenting Struggles, Positive Impact of Motherhood, Judgement, Identity, Relationships with Children, and Impact on Children.

The difficulties the participants had experienced within interpersonal relationships were clearly evident within the interviews through their descriptions of difficulties in their relationships with the children’s fathers. In some cases this had resulted in fathers being somewhat absent from the children’s lives leaving the mothers further isolated and unsupported. This potentially offers an explanation as to

why the mothers did not talk at length about the children's fathers within their spontaneous accounts of parenting. Relationship difficulties were also evident with some of the children themselves. The alternations between idealisation and devaluation that are characteristic of the relationships of individuals with BPD appeared to occur between children, as revealed by the subordinate theme 'Differences between Children'. Mothers with more than one child tended to 'split' their children into ideal and problematic categories. This is in line with suggestions from Lamont (2006) and Macfie (2009) that mothers with BPD may struggle in forming attachment relationships with their children.

Similarly mothers appeared to 'split' themselves into the 'mentally well mother' and the 'mentally unwell mother', seemingly distancing themselves from the latter when mentally well, perhaps as a way of coping with having exhibited what they perceived to be poor parenting skills when unwell. During 'unwell' periods the mothers experienced a lack of capacity to parent in line with Lamont's (2006) suggestion that they may find it difficult to be emotionally available for their children. Despite this, a number of the mothers emphasised how much they valued listening to and being there for their children and how hard they worked to do this when they had the capacity to do so, suggesting their emotional availability may vary dependent upon their mental health. Stepp et al. (2012) suggest oscillations between over-involvement and under-involvement in parenting to be specific to mothers with BPD, as opposed to other mental health difficulties. The current study provides some evidence for fluctuations between parenting states in the forms of the 'well' and the 'unwell' mother. It also suggests a recognised lack of capacity to parent during 'unwell' periods and thus under-involvement in caring for their children at these

times. The findings provide less evidence for self-recognised periods of over-involvement of these mothers in caring for their children.

The frequency of reference to fear within the findings of this study is notable. The mothers feared negative appraisal from services, other mothers and above all their children. They also feared that they may get parenting “wrong”, that their mental health difficulties and subsequent parenting style may be having a negative impact on their children, and that their children may develop mental health difficulties similar to their own. Within these worries appears to be a fear of rejection and potentially abandonment, in the case of their children. The belief that their newborn children would never abandon them may have been common to the mothers and thus account for their primarily positive perceptions of the infancy period. However, as their children have grown, the mothers’ perceptions have altered such that the fears of abandonment inherent within the BPD diagnosis seem to extend to these women’s relationships with their children. It has been suggested that maternal fears of being abandoned by her child may result in role-reversal within the parent-child relationship (Stepp et al., 2012). The emergence of role-reversal as a subordinate theme within the current study provides support for this idea.

The emergence of the ‘Identity’ theme from this analysis is of significance given the known difficulties that women with BPD experience in this area. Many women with BPD experience an unstable self-image or sense of self (APA, 2000). It appears that becoming a mother creates an additional identity for these women; however, it is not entirely clear whether this serves to exacerbate their already unstable sense of self as suggested by Lamont (2006) or facilitates them in confirming their identity by providing them with a maternal role to fulfil.

Whilst raising their children brought back memories of their own childhood for some of the mothers in this study, this was not necessarily as problematic for their parenting as suggested by Lamont (2006) and Newman and Stevenson (2005). For the participants of this study, memories of their own adverse upbringings served as motivation for them to try to parent differently to how they were parented. It should therefore be considered that maternal ‘ghosts in the nursery’ may have both a negative and a positive impact on a mother’s experience of parenting.

Overall, the findings of the current study suggest that mothers had experienced parenting to have both a negative and a positive impact on their mental health. In addition to finding parenting challenging, stressful and emotionally demanding, the ‘Positive Impact of Motherhood’ theme highlights the importance of these mothers’ children in helping them manage their mental health difficulties. This finding is in line with Schacht (2004) who found mothers with BPD to feel fulfilment in relation to parenting in addition to inadequacy, guilt and uncertainty. Similarly Newman et al. (2007) found mothers with BPD to feel less competence and more distress in relation to parenting than mothers without mental health difficulties. However, they also found mothers to feel less satisfaction and more disappointment in their interactions with their children, which was not the case for the mothers interviewed here, who valued time with their children immensely, viewing this as something that ‘kept them going’.

The mothers within the current study also perceived their mental health difficulties to have both a negative and a positive impact on their parenting as, although they worried and felt guilty about the detrimental effect on their children, some of them also saw positives in their children being exposed to their difficulties.

Whilst Schacht (2004) reported mothers to feel that their mental health had impacted negatively on their parenting, the current study is the first to acknowledge some mothers' perceived positive impact on their children.

The current study has reported the in-depth parenting experiences of mothers with BPD thus encapsulating those parts of their experience which are common to other mothers and those that appear unique to mothers with BPD. The loss of identity, self-criticism, and feelings of inadequacy described here may be shared by many mothers, although they appear likely to be experienced more intensely by mothers with mental health difficulties. A number of the themes that emerged in the current study have also been reported by mothers with other mental health difficulties such as feeling stigmatised, their children providing them with motivation to cope, hiding their mental health difficulties from their children, struggling with parenting during relapses of mental illness, and fears regarding the impact of their mental health on their children (e.g. Bassett et al., 1999; Diaz-Caneja & Johnson, 2004; Montgomery et al., 2006; Mowbray et al., 1995). Beyond these, this study has highlighted a number of aspects of parenting experiences that appear unique to BPD. Most notably, fears of abandonment leading to role-reversal in their relationships with their children, and 'splitting' of both themselves, into the 'well' and the 'unwell' mother, and their children, into ideal or problem roles. These findings reflect how some of the diagnostic features of BPD may be manifested in motherhood. Consequently, it is possible that other features that are characteristic of BPD, such as difficulties with anger, impulsivity, and paranoia, may be evident in mother-child relationships but may not be recognised by these mothers themselves.

2.5.1 Clinical Implications

The current study explored mothers' views regarding services and support that had been, or may be, helpful to them in relation to their parenting. The women interviewed here felt that non-judgemental support that was specific to mothers with mental health difficulties would be the most beneficial. One participant in particular reflected a sense that she found typical parenting courses frustrating as she was well aware of the suggested parenting strategies but did not feel able to implement them due to her mental health difficulties. Consequently, parenting groups for mothers with BPD that hold a strong behavioural parenting training focus, as suggested by Zalewski and Lengua (2012), may not prove suitable for some of these women and may result in disengagement. The current findings also reflect issues raised by Fruzzetti (2012) suggesting that parenting interventions for this client group need to take into account the impact of the mother's general social environment on her parenting. This idea is supported here by the participants' accounts of having limited social support and difficulties with their children's fathers.

2.5.2 Methodological Limitations

Several limitations of the current study warrant further consideration. Firstly, due to the small sample size it is not clear whether these findings are reflective of the experiences of mothers with BPD in general. In particular, the heterogeneity of BPD is such that the differential experiences of these mothers may be wide-ranging and thus not fully reflected by a small study. Consequently, the findings need to be tested within different contexts and with a wider range of women with BPD. Furthermore, there may have existed a bias in the women who chose to take part in the study. It was anticipated prior to recruitment that mothers who had concerns over their own parenting or who feared the involvement of Social Care may not choose to

participate. Consequently, it is interesting that both of these factors emerged from the analysis. In addition, the inclusion criteria stipulated that mothers must be currently parenting their children and therefore excluded women whose children had been removed from their care. It must be noted that this group of women may have had distinctly different experiences of parenting to the current sample. It must also be acknowledged that the inclusion criteria for this study did not require women to have received a formal diagnosis of BPD from a psychiatrist as it was felt that this would limit the sample. However, all participants had been assessed by a mental health professional and informed that they had difficulties consistent with a diagnosis of BPD, and some of the participants had received a formal diagnosis. Finally, it must be noted that the accounts provided by the mothers may have been restricted by the interview schedule. For example, the women were not directly asked about their experiences with their children's fathers or the impact of their own childhoods.

2.5.3 Recommendations for Future Research

The current findings highlight a number of possibilities for future research. Due to the paucity of research in this area, further studies investigating the experiences of parenting for mothers with BPD are needed. Studies including mothers' parenting under different circumstances to those in the present study, such as women who have had children removed from their care, would make a valuable contribution to the literature. Investigation into the role of children's fathers for this population may shed further light on both the experience of isolation for these mothers and their children's experiences. Building on the current findings, further research focusing on the roles of fear of abandonment and splitting in the relationships of mothers with BPD and their children would provide further insight into the way in which these specific traits, associated with BPD, translate into

parenting and impact upon mothers' responses to their children. Finally, the perceived positive impact of their mental health on their children described by some mothers participating in the current study may warrant further investigation and provide insight into potential support systems for children of women with BPD.

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CHAPTER THREE: REFLECTIVE PAPER

Motherhood and Me

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3.1 ABSTRACT

This paper discusses the progression of the author's perceptions of motherhood during the course of the research. It focuses in particular on the analysis of a series of motherhood-related dreams that occurred during the author's final year of clinical training. An 'objective' method of dream analysis is used to explore the dreams. Both the professional and personal meanings found within the dreams are discussed. The implications of having completed parenting-related research and exploring these dreams are considered, focussing on the impact on the author's clinical practice and personal views of motherhood.

Keywords: reflective practice; dreams; mother*; parenting

3.2 INTRODUCTION

During the completion of my research, I have become increasingly aware of its impact, along with my experience of completing a specialist perinatal placement, on my views of motherhood and I will use this reflective paper to explore this further. Over the course of my research I have had a number of dreams relating to motherhood and I have been curious about their relevance. I will analyse and reflect upon these here, considering their meaning in relation to me both professionally, as a trainee clinical psychologist, and personally, as someone who may become a mother one day. Finally I will consider how carrying out my research and reflecting on my parenting dreams have influenced me both as a clinician and, on a personal level, as a potential parent.

3.3 REFLECTIONS ON MOTHERHOOD

In conducting research and clinical work relating to parenthood I have found myself spending much more time thinking about mothers, in particular those who struggle, and thus noticing things that I had not previously thought about in any detail. I have become acutely aware of how little mothers' struggles are talked about in our society despite the fact that most mothers feel like they are struggling to cope with the demands of parenthood at some point. Many mothers appear to feel pressurised to uphold an image of being able to cope and consequently mask their difficulties from those around them, which may serve to exacerbate the problem. Within my research interviews, the mothers described their beliefs that there is a 'right' way to parent and the pressure they felt under to 'get it right'. At these moments, I found myself working hard to refrain from telling them that "there is no

‘right’ way to do it” and that mothers without mental health difficulties struggle too, this is just not spoken about openly. I felt frustrated at the lack of acknowledgement of the struggles of the average mother as this has resulted in some mothers thinking that “every other mother’s getting it ‘right’ so why can’t I?”.

In reflecting on this, I am reminded of the concept of ‘good enough’ parenting (Winnicott, 1953) that is frequently referred to within children and families mental health services. I have previously felt quite comfortable with this idea and even thought that I knew what it was. However, I now find myself wondering if, whether we call it ‘good enough’ parenting or ‘perfect’ parenting, mothers continue to perceive it as something to be idealised, that they must measure up to. Consequently, a concept that was initially intended to empower and reassure mothers may, in practice, do the opposite. This appears particularly pertinent for mothers with mental health difficulties who may perceive themselves as having greater difficulties with parenting than typical mothers, and have a tendency to judge themselves more harshly.

3.4 DREAM ANALYSIS

3.4.1 Reasons for Dream Analysis

After attending a workshop about working with dreams in therapy during my final year of clinical training, I became intrigued by the possibility of accessing my unconscious through my dreams and excited by the opportunity for self-reflection and learning through dream analysis. In addition to this, since embarking on my

research investigating parenting experiences and developing an interest in perinatal clinical work, I had begun to have a number of dreams relating to pregnancy and parenting that intrigued me. It is hypothesised that dreams reflect waking concerns that are at the forefront of our minds and thus can guide personal growth (Hall & Nordby, 1972; Jung, 1985). Consequently, I decided to start keeping a dream diary of these particular dreams in order to understand their relationship to my research and clinical work, and what I could learn about myself and my views of parenting from them.

3.4.2 Dream Recall and Recording

Whilst I dream frequently and I am typically aware of snapshots of my dreams on waking, I have often struggled to remember my dreams in detail and I find that they dissipate rapidly as soon as I get up in the morning. Consequently, in order to record my dreams, I kept a dream diary kept next to my bed, and on waking from a relevant dream I attempted to stay in the same position and recall the dream in as much detail as possible as recommended by Delia Cushway during the workshop. I then noted down a basic account of the dream in my diary. Where possible this was done immediately, before engaging in the day. However, on some occasions this proved difficult for practical reasons and dreams were not noted down until later in the day or the following day. On these occasions I noticed a significant reduction in the amount of the dream I was able to recall. Where possible, day residue was also noted as suggested by Cushway and Sewell (1992). Descriptions of each of my dreams can be found in appendix I.

3.4.3 Dream Analysis Methodology

I considered a number of methodologies when thinking about analysing my dreams. I decided to use an ‘objective’ method as these appeared more accessible to a novice interpreter analysing dreams outside of the therapeutic environment. I felt that the ‘objectifying the dream’ methodology described by Cushway and Sewell (1992; page 46) was the most appropriate for me. This method appealed to me as it is based on a Jungian approach to dreaming and stays close to the dream experience by recounting the dream in the first person. I also found that this method provided a structured way of analysing my dreams whilst posing questions that I found thought-provoking and useful in developing insight into the possible meanings behind my dreams. This method provides an ordered set of stages for the dreamer to follow, aiming to assist the dreamer in drawing out the meanings within the dream and also integrating the dream into his or her ongoing experience (Cushway & Sewell, 1992). An example of dream analysis using this method is provided in the following section.

3.4.4 Example of Stages of Dream Analysis

Here I have analysed dream five using the ‘objectifying the dream’ method:

Recount the dream in the first person, present tense.

I am sitting by a window in my home in a chair holding a baby boy. My partner and a close friend (who is also a mother) are also there. I’m holding our son who I know is six weeks old. I’m trying to breastfeed my baby in front of my friend and I’m trying to hide the fact that I don’t know how to do this. I feel like a fraud and I’m

worried that my friend will 'find me out'. I think to myself that I'm not a good mother and I feel afraid, apprehensive, and daunted by the task of breastfeeding. I manage to latch my son on, he feeds and I feel relieved. I pretend that I have been doing this since his birth as I know that I should have been but I haven't, it feels very new to me.

What, briefly, is the dream ego doing and not doing in this dream?

The dream ego is pretending to be something she's not, but she is succeeding in fooling others. She is not being honest because she feels inadequate.

What are the main contrasts and similarities in the dream, and how do they interrelate?

There is a contrast between me feeling clueless about breastfeeding at the start of the dream and me successfully feeding my baby at the end of the dream. There is a similarity between myself and my friend in the dream as we are both mothers and I feel a sense of alliance with her because of this.

What sequences, if any, are in the dream?

Trying to feed my baby.

Successfully feeding my baby.

What are the major symbols and what are the relations between symbols?

Breastfeeding = providing (perhaps a fear of not providing enough?), nurturance.

Friend = someone I admire, a 'good mother' (that I want to match up to?).

Baby = vulnerability, dependency, a representation of a part of myself?

The 'breastfeeding' and 'friend' symbols are linked as I am aware that this is something the friend is able to do.

What are the issues, conflicts and unresolved situations in the dream?

I've lied to a close friend, I haven't let her see the real me who is struggling. Succeeding in breastfeeding has only served to cover up my need for support.

What are the positive symbols, resolutions, relations, etc in the dream?

I am able to feed my baby in the end, suggesting a sense of coping and resilience.

What relation does anything in this dream have to any other thing in other dreams?

I am insisting on doing things for myself as in dream 3 and I am minimising my difficulties as in dream 4.

What are the possibilities for relations and resolutions which have not yet materialised in the dream?

My friend could help me with breastfeeding and new motherhood (if I let her).

How would you summarise the particular character or identity of this dream?

I think that this dream is about my tendency to hide my struggles from others and try to do everything on my own due to a fear that others may judge me negatively if they see that I cannot do things. As a result of this, I often feel like people see me as an achiever who can do whatever they set their mind to when I don't always feel like this.

What have you learned so far?

It's ok to show people that I'm struggling; maybe they can help me if I let them. If I deliberately hide myself, how can people really know me?

3.4.5 Dreams

I analysed each of my motherhood-related dreams using the methodology outlined in the previous section. The key themes that emerged from the analysis of each of my dreams and the things that I learned in analysing them are presented in table three.

Table 3: Dream Themes and Learning.

	Date	Key Themes	Learning
1	18.10.2011	Avoidance and lack of awareness. Hidden difficulties.	I may need to be more self-aware and honest with myself in order to face things before the time comes/I am forced to by something outside of my control.
2	21.10.2011	Getting priorities wrong. Lack of foresight.	I may need to get better at recognising when I need help and what is really important in my life.

3	23.11.2011	Not accepting help. Uncertainty about what I want/need.	I may benefit from accepting help from others rather than insisting on doing things alone.
4	22.12.2011	Minimising difficulties. Not showing enough care/concern.	It is important for me to engage in self-care and accept care from others.
5	03.01.2012	Hiding struggles from others. Fear of others seeing me as incapable/not good enough.	I do not have to be perfect. It is ok to show people that I am struggling; maybe they can help/support me if I let them.
6	08.02.2012	Showing myself to others. Positivity about myself.	I do not need to be afraid to show myself to others if I feel content with myself.
7	01.03.2012	Lack of awareness of the size of the task ahead. Loss of lifestyle. Splitting myself into parts. Going on a journey.	Sometimes things are harder than I expected but there is an end to the journey and others may be able to help me get there.

3.4.6 Reflections on Dream Analysis.

The meaning of a dream is based on the personal judgment of the dreamer and thus a dream is only satisfactorily interpreted when the interpretation makes

sense to the dreamer (Cushway & Sewell, 1992; Jung, 1985). Consequently, there is no one correct interpretation of a dream and dreams may hold multiple meanings for the dreamer. Here I have considered both the professional and personal meanings that I found within my dreams.

3.4.6.1 Professional Reflections

In dreams one and two I am seemingly unprepared or unaware of what is happening to me (labour) or about to happen to me (having a baby). On reflection, I think that this is representative of the situation I was in at the time. These two dreams occurred at the start of my third year of training and I had been told during my second year that that was the toughest year of the course and that things got easier in third year. With hindsight, these dreams now appear to be a form of warning that this may not be the case and that things, similarly to being in labour, were soon to become a lot more painful and difficult. Dream three came after the realisation had dawned that third year was going to be tough and it appears to reflect a conflict within myself, that part of me wanted to run away and hide whilst another part was motivated by the challenge and determined to succeed.

Dreams four and five occurred over the Christmas break when I took some time off. They reflect how I had been feeling about the course as I had been struggling to manage both my research and placement but felt unable to tell my placement supervisor this for fear of looking like I could not cope with the placement demands. Dream six then occurred after I had returned to my placement and re-

negotiated my workload with my supervisor. I think the sense of pride in showing myself that I felt within the dream reflected this, as I was finding things more manageable as a result of having been open about my situation and concerns.

My final dream occurred as the thesis study block was looming. I think that my lack of awareness of the fact that I was having more than one baby in this dream reflects my lack of awareness of the size of the task I had ahead in writing my thesis. The triplets may symbolise the three parts of my thesis (literature review, empirical paper and reflective paper) and reflect a sense of having to split myself into three to manage them all. The feelings that I experienced within the dream are reflective of the sacrifices I feel I have made during this period and the distinct feeling that my life is on hold until after my thesis is handed in. My attempts to travel home in the final part of the dream seem to reflect the journey that I have been on in completing my thesis and my strong sense that if I can just finish it everything will be fine.

Overall, the themes of recognising my own needs and accepting support from others run through this interpretation of my dreams reminding me of the importance of self-care as a clinical psychologist.

3.4.6.2 Personal Reflections

My dream analysis also offers opportunities for learning on a more personal level in relation to myself and motherhood. I feel that my lack of awareness in dreams one and two reflected my naivety to the realities of motherhood before

completing my research and specialist perinatal placement. This seemed to be reflected in dream one when the dream jumped from the start of labour to holding a baby thus avoiding the painful reality of labour, and in dream two where I was in labour but not experiencing any of the pain or difficulty of it. Whilst I have been interested in parenting from a clinical perspective for a number of years, I had not spent much time talking to mothers about pregnancy or parenthood specifically and thus was relatively unaware how women experience these. As someone who hopes to be a mother one day, I feel my research and clinical experiences as a trainee have opened my eyes to the realities of motherhood resulting in this now feeling like a much more daunting task than previously.

Dream three reflects my ambivalence about motherhood as, whilst a part of me is keen and excited to become a mother one day, another part of me is scared and daunted by this idea. This dream also highlights my tendency to insist on doing things myself rather than asking for help and makes me aware that this may not be a helpful approach to motherhood. In completing my research interviews and perinatal placement, I have had many discussions with mothers about support with parenthood (or lack thereof). I have been struck by how alone some mothers feel and I am aware that in my own motherhood I may need to force myself to both seek and accept support from others.

Dreams four and five clearly reflect my fears that I will not be a good enough mother. These echo the themes of self-judgement and criticism that emerged from my empirical paper and allow me to, in a small way, empathise with the women I

interviewed. Whilst during my research interviews I was tempted to tell mothers that “there is no ‘right’ way to do it” when they worried about ‘getting it right’, I am also sure that I would feel similarly in motherhood. These two dreams may also serve as a warning about my tendency to minimise my difficulties. Whilst in some instances this comes with few costs, in motherhood the potential for negative consequences feels much greater. Meanwhile, dream six emphasises a contrasting view to this and encourages me to feel competent and confident in motherhood, something that I hold onto tightly.

Dream seven provides a reflection of how much I have learned about motherhood over the course of my research and clinical work. In this dream I am clearly aware of the sacrifices of motherhood, as were the women I interviewed. This causes me to wonder if I will also feel a sense of loss of identity in dividing myself between being a mother and being me. My reaction to the triplets in this dream is indicative of how I view the size of the task of motherhood, and how overwhelmed I sometimes feel by the idea of this. The theme of going on a journey that emerged from the analysis of this dream is symbolic of my view of parenthood and I ultimately envisage learning a great deal about myself by becoming a mother.

Overall, a theme of realisation of the realities of motherhood and a fear of these run through this interpretation of my dreams reminding me of the size of the challenge that women (including myself) face in becoming a mother.

3.5 IMPLICATIONS FOR CLINICAL PRACTICE

Completing my research and reflecting on my dreams and ideas about motherhood here have influenced my views on parenting and will therefore have implications for my clinical practice when working with parents and families. Whilst I have long held an interest in maternal mental health and its impact on children, after completing my empirical study I feel more confident and comfortable in focussing clinical formulations on parent-child interaction and family dynamics as oppose to solely child-focussed formulation. I also feel more able to promote a systemic view of child referrals within services, regardless of parental mental health.

Within my research, I was struck by the mothers' desire for parenting groups specific to those with mental health difficulties as this is not a provision that I have encountered within services, potentially due to the perceived stigma that it may create. However, I would now feel more comfortable in promoting this type of service. I have also felt for some time that services to support children of parents with mental health difficulties are lacking in the U.K. and hope that having greater knowledge in this area may help me to develop these types of services as a qualified clinical psychologist.

I have found myself wondering about the impact of having children oneself on clinicians working with children and families and reflecting on both the pros and cons of this in clinical practice. As a clinician who is not a mother, I sometimes worry that I cannot truly understand what the parents I meet are experiencing.

However, I also believe that this allows me to be more objective than some clinicians who are parents.

3.6 IMPLICATIONS FOR MOTHERHOOD

My research, placement, and dream analysis have also impacted on me on a more personal level. Dreams are said to reveal the parts of ourselves that we do not wish to acknowledge in waking life or would not normally show to the world (Jung, 1985). As well as emphasising how daunted I have become by the idea of being a mother, my dreams revealed a part of me that is ambivalent towards becoming a mother, of which I was previously unaware. I have felt uncomfortable contemplating the idea that this part of me could reject a baby, not be too concerned by its illness, and put its needs after my own as in my dreams.

In the previous section I considered the impact of being a parent on clinical practice; however, I am also mindful of the potential impact of being a psychologist on parenting. Whilst theoretical knowledge about parenting may be helpful in some respects, it could also prove detrimental to being a parent. As a mother, in the future, I can envisage questioning myself due to my knowledge as I wonder whether I am providing a secure base, using enough positive reinforcement or providing enough containment for my child's emotions. This may lead me to experience more anxiety in parenting than I would have without this knowledge.

3.7 CONCLUSION

I have enjoyed analysing my dreams within this paper and I have been surprised by the multiple meanings that it has been possible to find within them simply by appraising them differently. I have become aware that the format I have adopted in writing this chapter reflects the wider situation I often find myself in. My views and beliefs as a professional run parallel to my personal thoughts and feelings with the two parts of me sometimes wanting and needing different things or holding different perceptions. For me, this represents a conflict that is often found in clinicians' professional worlds and is important to be aware of in both our professional and personal lives.

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APPENDIX A: AUTHOR GUIDELINES

- 1. Personality and Mental Health**
- 2. Personality Disorders: Theory, Research, and Treatment**
- 3. Psychology of Women Section Review**

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The language of the journal is English. 12-point type in one of the standard fonts: Times, Helvetica, or Courier is preferred. Please double-line space your manuscript. Manuscripts should not normally exceed 5,000 words in length, or equivalent in text, references and tables and should include a word count where possible. Longer articles, particularly reviews, may be considered on a case-by-case basis. Please contact a member of the editorial team to discuss before submission. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.

- The **title page** must list the full title, a short title of up to 40 characters and names and affiliations of all authors. Give the full address, including email, telephone and fax, of the author who is to check the proofs on this page as *Personality and Mental Health* operates a 'blind' reviewing system.
- Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)** .
- Enter an **abstract** of up to 200 words for all articles, except book reviews. This should be a concise summary of the whole paper, not just the conclusions, and should be understandable without reference to the rest of the paper. It should contain no citation to other published work.
- Include up to ten **key words** that describe your paper for indexing purposes.
- Include an indication of the classification of the paper (e.g., Research Article, Case Study, Introduction, Book Review, Editorial).

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References should follow the conventions laid down in the Fifth Edition of the Publication Manual of the American Psychological Association.

All references must be complete and accurate. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. Where possible the DOI for the reference should be included at the end of the reference. Online citations should include date of access. References should be listed in the following style:

1. The Geriatric Website. 1999. <http://www.wiley.com/oap/>[1 April 1999]
2. Thierry , K. L., & Spence, M. J. (2004). A real-life event enhances the accuracy of preschoolers' recall. *Applied Cognitive Psychology* , 18 , 297-309. DOI: 10.1002/acp.965

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Further Information

For accepted manuscripts the publisher will supply proofs to the submitting author prior to publication. This stage is to be used only to correct errors that may have been introduced during the production process. Prompt return of the corrected proofs, preferably within two days of receipt, will minimise the risk of the paper being held over to a later issue. Free access to the final PDF offprint of your article will be available via author services only. Please therefore sign up for author services if you would like to access your article PDF offprint and enjoy the many other benefits the service offers. Further reprints and copies of the journal may be ordered. There is no page charge to authors.

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To link to an article from the author's homepage, take the DOI (digital object identifier) and append it to "http://dx.doi.org/" as per following example: DOI 10.1002/hep.20941, becomes <http://dx.doi.org/10.1002/hep.20941>.

To include the DOI in a citation to an article, simply append it to the reference as in the following example:

Thierry , K. L., & Spence, M. J. (2004). A real-life event enhances the accuracy of preschoolers' recall. *Applied Cognitive Psychology* , 18 , 297-309. DOI: 10.1002/acp.965

Personality Disorders: Theory, Research, and Treatment[®]

Editor: Carl W. Lejuez

ISSN: 1949-2715

eISSN: 1949-2723

Published: quarterly, beginning in Spring 2010

Instructions to Authors:

Please consult APA's Instructions for All Authors for information regarding

- Manuscript Preparation
- Submitting Supplemental Materials
- Abstract and Keywords
- References
- Figures
- Permissions
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- Ethical Principles

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Submit manuscripts electronically through the Manuscript Submission Portal (.rtf, .doc, or .pdf files).

Carl W. Lejuez, PhD
Department of Psychology
1123c Biology/Psychology Building
University of Maryland
College Park, MD 20742
Email

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Keep a copy of the manuscript to guard against loss.

Masked Review Policy

Personality Disorders: Theory, Research, and Treatment[®] (PD:TRT) uses a masked reviewing system for all submissions. Omit the authors' names and affiliations on the first page of the manuscript, but include the title of the manuscript and the submission date.

List five keywords on the title page to facilitate the selection of peer reviewers. Additionally, provide a cover letter indicating the proposed category under which the manuscript was submitted (e.g., Brief Report) and up to four suggestions for potential reviewers.

Types of Manuscripts

Four types of manuscripts will be accepted:

- full-length articles
- brief reports
- target conceptual articles
- practice reviews (jointly written by a researcher and primary clinician)

Additionally, Invited peer commentaries in response to the target conceptual articles will be published online at the *PD:TRT* homepage. Further, the journal will operate an open-access message board to foster continuing dialogue on the target conceptual article.

Full-Length Articles

Manuscripts presenting empirical findings may be submitted as full-length articles. Full-length articles should not exceed 36 pages total (including cover page, abstract, text, references, tables, and figures), with margins of at least 1 inch on all sides and a standard font (e.g., Times New Roman) of 12 points (no smaller). The entire paper (text, references, tables, etc.) must be double-spaced.

Brief Reports

In addition to full-length manuscripts, *PD:TRT* will consider brief reports of empirical findings. Brief reports are to be prepared in line with the guidelines for full-length articles, yet they may not exceed 18 pages.

Target Conceptual Articles

Manuscripts that evaluate and synthesize the research literature and/or make important theoretical contributions are sought for target conceptual articles. Four commentaries invited by the journal will be published on the *PD:TRT* homepage, along with the author's response to the commentaries.

PD:TRT will operate an open access message board for further discussion of the target conceptual articles and the commentaries.

Target conceptual articles are to be prepared in line with the guidelines for full-length articles, yet they may not exceed 40 pages.

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In line with the journal's commitment to bridging science and practice, practice reviews will present an issue from clinical practice, review relevant research, and provide a practical recommendation informed by the reviewed research.

Practice reviews **MUST** be coauthored by at least one individual with a primary focus in clinical practice and at least one individual with a primary focus in research. This partnering of individuals with a different professional emphasis is crucial for practice reviews to provide a credible bridge between research and practice.

When submitting a practice review, provide a description of each individual's primary professional focus in the cover letter. Manuscripts not meeting this partnering requirement will be returned without review. New collaborations are especially encouraged.

Practice reviews are to be prepared in line with the guidelines for full-length articles, yet they may not exceed 30 pages.

POWS Review

The *Psychology of Women Section Review* provides a forum for discussion of issues and debates around all aspects of the psychology of women in research, teaching and professional practice. It aims to promote and support academic research and debate on issues related to the development of theory and practice concerning gender and other social divisions.

POWS Review encourages submissions from individuals at all stages of their career, including undergraduate and postgraduate students. It promotes a positive reviewing process.

POWS Review publishes:

- theoretical and empirical papers;
- reviews of relevant books and research;
- special issues and features; and
- short papers, commentaries, interviews and other non-traditional submissions in its 'Agora' section.

Contact:

Sally Johnson (*Editor and enquiries for Research Reviews*)

s.e.johnson2@bradford.ac.uk

Amanda Holt (*Assistant Editor, Book Reviews*)

Amanda.Holt@port.ac.uk

Jemma Tosh (*Assistant Editor, Agora*)

jmtosh@hotmail.co.uk

Notes for Contributors

1. All papers and submissions for the Agora section will be peer-reviewed.

2. Copies of all submissions should be sent by e-mail attachment (in Word format) and/or three hard copies to the Editors (or Assistant Editor where specified). A separate cover page should be provided with the title of the paper, the author's names, their institutions, addresses and email addresses clearly marked. Authors are also invited to provide brief biographical information. Manuscripts should have the title clearly marked on the first page, and pages should be numbered. However, authors' names should not appear on the manuscript itself.

3. All figures should be of reproducible standard. References should conform to Society style, which is similar to the American Psychological Association (APA) system. The Society's *Style Guide* can be downloaded from: www.bps.org.uk/publications/submission-guidelines/submission-guidelines_home.cfm

4. Papers should be between 3000 and 6000 words long, and submissions for the Agora between 200 and 2000 words. An abstract of up to 150 words should be provided with papers, however, no abstract is needed for Agora submissions.

5. Book reviews and reviews of research papers will normally be commissioned by the relevant Assistant Editors. Anyone interested in reviewing books or research papers should contact the Assistant Editor directly.

6. Authors should avoid the use of any sexist, racist, heterosexist or otherwise discriminatory language.

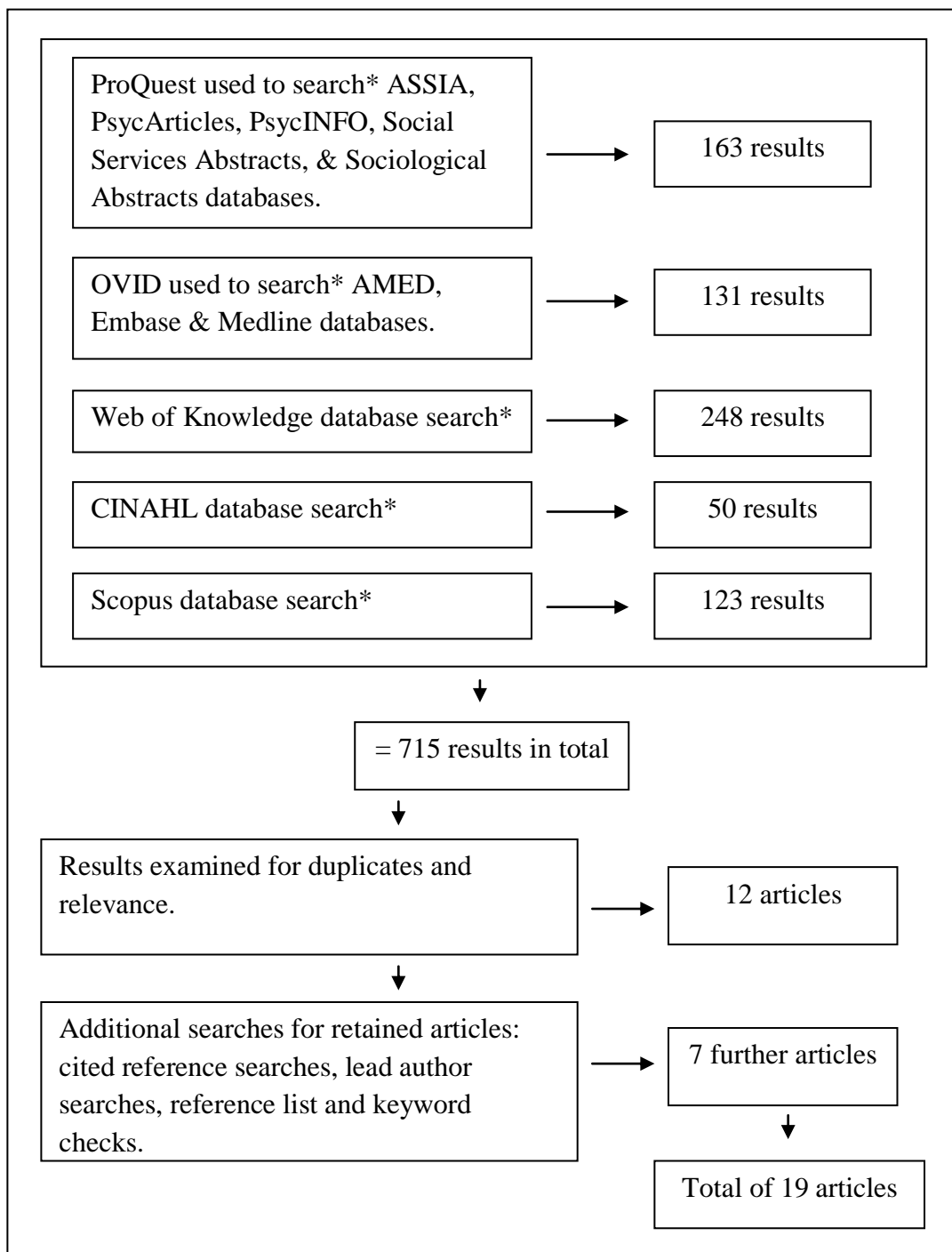
The views expressed in this publication are those of the authors, and not necessarily those of the organisations or institutions that they work for.

Please send all correspondence to:

Sally Johnson
Centre for Psychology Studies
Department of Social Studies and Humanities
University of Bradford
Richmond Road
Bradford BD7 1DP
E-mail: s.e.johnson2@bradford.ac.uk

APPENDIX B:

MAP OF LITERATURE REVIEW SEARCH STRATEGY



Each database was searched for [("borderline personalit")(AB)] AND [(attitude* OR belief* OR opinion* OR perception* OR view OR views OR reaction* OR response* OR countertransference OR "therapeutic relationship*") (AB)] AND [(staff OR clinician* OR profession* OR *therapist* OR nurse* OR worker* OR practitioner* OR psychiatrist* OR psychologist*)(AB)].

APPENDIX C: ETHICAL APPROVAL

- 1. Coventry University**
- 2. Birmingham East North & Solihull NHS Research Ethics Committee**
- 3. Coventry & Warwickshire NHS Partnership Trust Research &
Development Committee**
- 4. Birmingham & Solihull NHS Mental Health Foundation Trust Research
& Innovation Department**

Coventry University
Priory Street
Coventry CV1 5FB
Telephone 024 7688 7688

Professor Ian M Marshall
Pro-Vice-Chancellor (Research)



TO WHOM IT MAY CONCERN

RRU/Ethics/Sponsorlet

24 March 2011

Dear Sir/Madam

Researcher's name: Rose Stewart
Project Title: The Experience of Parenting for Mothers with Mental Health Difficulties:
A Qualitative Study.

The above named student has successfully completed the Coventry University Ethical Approval process for her project to proceed.

I should like to confirm that Coventry University is happy to act as the sole sponsor for this student and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully

Professor Ian Marshall
Deputy Vice-Chancellor, Academic

Enc

Pro-Vice-Chancellor's Office
Direct Line 024 7679 5293
Fax 024 7688 8030

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National Research Ethics Service
NRES Committee West Midlands - Solihull

REC Offices
Prospect House
Fishing Line Road
Enfield
Redditch
B97 6EW
Telephone: 01527 582532
Facsimile: 01527 582540

02 June 2011

Miss Rose Stewart
Clinical Psychology Doctorate Programme
Faculty of Health and Life Sciences
Coventry University
Priory Street
Coventry
CV1 5FB

Dear Miss Stewart

Study title: The Experience of Parenting for Mothers with Mental Health Difficulties: A Qualitative Study.
REC reference: 11/WM/0116

Thank you for your letter dated 27 May 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter		27 May 2011
Evidence of insurance or indemnity		01 July 2010
GP/Consultant Information Sheets		
Interview Schedules/Topic Guides	1	01 December 2010
Investigator CV		21 March 2011
Letter from Sponsor		24 March 2011
Letter of invitation to participant		
Other: Academic Supervisor CV		
Other: Research tutor CV		
Other: Clinical Psychologist CV		
Participant Consent Form: Consent Form	1	01 December 2010
Participant Consent Form: Consent to be Contacted	1	01 December 2010
Participant Information Sheet: bsmhft	2	27 May 2011
Participant Information Sheet: covworkpt	2	27 May 2011
Protocol	1	01 December 2010
REC application	3.1	29 March 2011
Referees or other scientific critique report	3	18 March 2011
Response to Request for Further Information		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.


We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/WM/0116

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely


Dr Rex J Polson
Chair

Email: Karen.green@westmidlands.nhs.uk

Enclosures: "After ethical review – guidance for researchers" SL-AR2

Copy to: Professor Ian Marshall, Coventry University

Ms Kelly Spencer, Coventry and Warwickshire Partnership NHS Trust

West Midlands (South) Comprehensive Local Research Network
 Fourth Floor, West Wing (ACF40002)
 University Hospitals Coventry & Warwickshire NHS Trust
 University Hospital
 Clifford Bridge Road
 Coventry
 CV2 2DX

04th July 2011

Miss Rose Stewart
 Clinical Psychology Doctorate Programme
 Faculty of Health and Life Sciences
 Coventry University
 Priory Street
 Coventry
 CV1 5FB

Dear Miss Stewart,

Project Title: Parenting Experiences of Mothers with Mental Health Difficulties
R&D Ref: PAR190411
REC Ref: 11/WM/0116

I am pleased to inform you that the R&D review of the above project is complete, and the project has been formally approved to be undertaken at Coventry and Warwickshire Partnership NHS Trust. Your research activity is now covered by NHS indemnity as set out in HSG (96) 48, and your trial has been entered onto the Trust's database.

The following documents were reviewed:

Document	Version	Date
NHS R&D Application Form	69240/208241/14/512	Signed 13 th May 2011
NHS Site Specific Information Form	69240/206220/6/936/86209/210689	Signed 13 th May 2011
REC Favourable Opinion Letter	11/WM/0116	2 nd June 2011
Protocol	1	1 st December 2010
Participant Information Sheet	2	27 th May 2011
Consent Form	1	1 st December 2010
Consent to be Contacted	1	1 st December 2010
Clinician Letter	1	1 st December 2010
Interview Schedule / Topic Guides	1	1 st December 2010
Letter of Invitation to Participant	1	1 st December 2010
Evidence of insurance or indemnity		1 st July 2010
Letter from sponsor		24 th March 2011

Your responsibilities are set out in the attached agreement, which must be signed and returned to the R&D Office. You should keep a copy for your records.

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF) and to ICH-GCP standards. In order to ensure that research is carried out to these standards, the Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors.

The duration of Trust approval extends to the date specified in the R&D application form. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors. Research must commence within two years of the REC approval date and within six months of NHS Permission.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely



Tabitha Kavoi
R&D Facilitator

Enc: CI Agreement

Cc: Dr Fiona MacCallum, Academic Supervisor, University of Warwick
Professor Ian Marshall, Coventry University

Document	Date	Version
Letter from sponsor	24 th March 2011	1
Evidence of insurance or indemnity	1 st July 2010	1
Letter of invitation to Participant	1 st December 2010	1
Guides	1 st December 2010	1
Interview Schedule / Topic	1 st December 2010	1
Clinician Letter	1 st December 2010	1
Consent to be Contacted	1 st December 2010	1
Consent Form	1 st December 2010	1
Participant Information Sheet	27 th May 2011	2
Protocol	1 st December 2010	1
REC Favourable Opinion Letter	2 nd June 2011	1
Form	2011	10889
NHS Site Specific Information	Signed 13 th May 2011	602402082114813
NHS R&D Application Form	Signed 13 th May 2011	602402082114813

Research & Innovation
Suite O
Radclyffe House
66/68 Hagley Road
Edgbaston
Birmingham
B16 8PF

Tel: 0121 678 4327
Fax: 0121 678 4319

Miss Rose Stewart
Trainee Clinical Psychologist
Faculty of Health & Life Sciences
Coventry University
Priory Street
CV1 5FB

20th June 2011

Dear Rose

Re: Parenting experiences of mothers with mental health difficulties

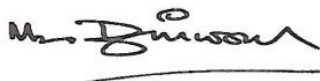
Thank you for providing us with the documentation to support your application for R&I approval. This research was approved by the Director of Research & Innovation and we have received notification of a favourable ethical opinion. You may therefore commence the work.

Please note that the Trust's approval of this research is given on the understanding that you are aware of and will fulfil your responsibilities under the Department of Health's *Research Governance Framework for Health and Social Care*, including complying with any monitoring/auditing of research undertaken by the Research & Innovation Department.

In particular, whilst conducting your study you should respect the confidentiality of data obtained from participants.

Please do not hesitate in contacting the Research & Innovation Department should you require any advice or support on any aspect of your project. When contacting us it would be helpful to quote our reference number for this project: **NRR1083**.

Yours sincerely



Max Birchwood
Director of Research & Innovation

APPENDIX D: INFORMATION FOR PARTICIPANTS

1. Letter to Participants

2. Information Sheet

Dear

I would like to invite you to take part in a research study that I am conducting as part of my studies at Coventry University and the University of Warwick. The study is called:

The Experience of Parenting for Mothers with Mental Health Difficulties.

By conducting this study I am hoping to listen to and understand the experiences of motherhood for women with mental health difficulties, in particular difficulties consistent with a diagnosis of Borderline Personality Disorder, from their own perspective.

The enclosed information sheet will give you some more information about the study and I would be very grateful if you could take the time to read through it. If you then decide that you would like to find out more or to take part please complete the 'consent to be contacted' form. Return this to me in the envelope provided **as soon as possible** and I will get in touch with you.

Thank you for taking the time to read this,

Yours Sincerely,

Rose Stewart

Trainee Clinical Psychologist

Version 2: 27th May 2011

PARTICIPANT INFORMATION SHEET

The Experience of Parenting for Mothers with Mental Health Difficulties

Researcher: Rose Stewart

I would like to invite you to take part in my research study. Before you decide whether or not you would like to take part it is important that you understand why I am carrying out the study and what taking part would involve for you. Below are the answers to some questions you may have about the study.

What is the purpose of the study?

This study aims to listen to the views of mothers with mental health difficulties, in particular difficulties consistent with a diagnosis of Borderline Personality Disorder (BPD), and understand their experiences of parenting from their perspective.

Why have I been invited to take part?

This information is being passed on to you by your mental health service but they have not passed any of your personal details to me. We are sending this information sheet to women within this service who have difficulties consistent with a diagnosis of BPD and who also have one or more child(ren) aged between 12 months and 18 years.

Do I have to take part?

Taking part in the research is entirely voluntary so you can choose whether or not you would like to be involved. The aim of this information sheet is to give you enough information to make that choice. If you choose not to take part in the study, your clinical care will not be affected in any way.

What would taking part involve for me?

If you choose to take part this will involve an interview that would last about 1 to 1.5 hours. You can choose whether you would like this to be at your home or if you would prefer to come to an NHS building. During the interview I would like to get an idea of your experiences of motherhood and your feelings about being a mother. You would not have to answer any questions you did not feel comfortable with. I would record our interview with a dictaphone.

Dean of Faculty of Health and Life Sciences

Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Chair of Department of Psychology

Professor Liz Robinson BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

What are the possible disadvantages of taking part?

Some women might find talking about their experiences difficult or upsetting. It is important to remember that you do not have to talk about anything you do not wish to. If you were to feel distressed after the interview we would discuss what to do next, this may involve contacting your care co-ordinator or a **Crisis Resolution/Home Treatment Team (Local team telephone number)**.

What are the possible benefits of taking part?

Some women might find the interview process therapeutic and enjoy talking about their experiences. You may also feel some satisfaction in knowing that the information you give in your interview, along with that from other mothers, will help people to understand the views and feelings of women in your position.

Will my taking part in the study be kept confidential?

Your care co-ordinator at your mental health service will be informed that you are taking part in the study. This means that they will be aware of the nature of the research should you wish to discuss it with them either before or after taking part. The information you provide during the interview will be kept confidential except where you might disclose information that is linked to your own or to another person's health, safety, or well-being. If that happened I would talk to you about how best to ensure your own or the other person's well-being and I may need to pass this information on to other relevant professionals (such as your care co-ordinator or social care).

What will happen if I decide I don't want to take part in the study anymore?

You can withdraw from the study at any point and ask for your interview to be destroyed. You do not have to give a reason for not wanting to take part anymore. Your decision to withdraw will not affect your clinical care in any way.

What will happen to my interview and the results of the research study?

Your interview will be transcribed and both the recording and the transcription will be kept in a secure place, accessible only by the research team. The information you provide will be kept separate from your name so that you cannot be identified from it. I will write up the results of the study and submit the write-up as part of my doctoral course. I may also publish it in an academic journal at a later date. This may include quotes from participants' interviews. However, these quotes will always be anonymous and you will not be identified at any point in the write-up. Following the completion of my research, the recording of your interview will be destroyed. The transcription and

write-up will be kept securely by my university according to their policy. You will be able to receive a written summary of the results of the study if you wish to.

Who has reviewed the study?

In order to protect your interests, all research in the NHS is looked at by an independent group of people called a 'Research Ethics Committee' (REC). This study has been reviewed and approved by Birmingham East North and Solihull REC. The study has also been approved by the Research and Development Committees for Coventry & Warwickshire Partnership NHS Trust and Birmingham & Solihull Mental Health NHS Foundation Trust.

What if there is a problem?

If you have a concern about the study or wish to make a complaint you can contact me directly (stewar26@coventry.ac.uk) or you can approach one of my supervisors: Dr. Julia Conneely (tel: 01788 513717; e-mail: Julia.Conneely@covwarkpt.nhs.uk) or Dr. Fiona MacCallum (tel: 024 76523182; e-mail: Fiona.MacCallum@warwick.ac.uk). If you remain unhappy and wish to complain formally you can contact your NHS Trust's complaints department. Please ask us if you require their contact details.

Who is organising the research?

My name is Rose Stewart and I am a Trainee Clinical Psychologist. I am carrying out this research study as part of my doctorate course in Clinical Psychology at Coventry University and The University of Warwick. My research is being supervised by Dr. Julia Conneely (Rugby Adult Psychology Service) and Dr. Fiona MacCallum (University of Warwick). I can be contacted via e-mail at stewar26@coventry.ac.uk.

What do I need to do now if I want some more information or to take part?

If you would like to find out more about the study please complete the 'consent to be contacted' form that you received with this information sheet and return it to me in the envelope provided. I will then contact you to discuss the research and answer any questions you may have. You can take as much time as you need to think about whether or not you would like to be involved. If you do then decide you would like to take part we can arrange a time to meet for your interview. If you would like some independent advice about taking part in research you can contact your NHS trust's Patient Advice and Liaison Service (telephone number and e-mail address).

Thank you for taking the time to read this information sheet.

APPENDIX E: CONSENT FORMS

- 1. Consent to be contacted form**
- 2. Consent to participate form**

Version 1: 1st Dec 2010

Consent to be contacted

I, give my consent to be contacted by Rose Stewart (Trainee Clinical Psychologist) regarding the research study entitled 'The Experience of Parenting for Mothers with Mental Health Difficulties'.

Name:

Address:

.....
.....
.....

Telephone number(s):

.....

Please could you tell me the days and times at which it would be most convenient to contact you by telephone:

Thank you for completing this form.

CONSENT FORM

Title of research study: **The Experience of Parenting for Mothers with Mental Health Difficulties.**

Name of researcher: **Rose Stewart**

I confirm that I have read and understood the participant information sheet dated 27th May 2011 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and I have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my clinical care or legal rights being affected in any way.

I understand that my interview will be audio-recorded and transcribed and that anonymous quotes from it may be used in the write up of this research study.

I agree to take part in the above study.

.....

Name of participant

.....

date

.....

signature

.....

Name of researcher

.....

date

.....

signature

APPENDIX F: LETTER TO CLINICANS

[CLINICIAN NAME]
[BASE ADDRESS]

[DATE]

Dear [CLINICIAN NAME],

Re.: [PARTICIPANT NAME]; [D.O.B.]

Your client, [NAME], has agreed to take part in a research study that I am conducting entitled 'The Experience of Parenting for Mothers with Mental Health Difficulties'. The study is focussing in particular on mothers with difficulties consistent with a diagnosis of Borderline Personality Disorder. I am carrying out the study as part of my doctorate course in Clinical Psychology at Coventry University and The University of Warwick. Participation in the study involves a one-off interview which will last approximately 1-1.5 hours. I have spoken with [NAME] and we have scheduled her interview to take place on [DATE] at [LOCATION].

I have enclosed a copy of the information sheet that [NAME] received, which explains the study in more detail. Please feel free to contact me should you require any further information. I also request that you contact me should you have any concerns about [NAME] taking part in this research study or foresee there being any risk to a researcher interviewing her either at an NHS facility or alone in her own home.

Yours Sincerely,

Rose Stewart
Trainee Clinical Psychologist
stewar26@coventry.ac.uk

APPENDIX G: INTERVIEW GUIDE

Interview guide

Reminder: you don't have to answer any questions that you don't feel comfortable with and you can ask to take a break or end the interview at any point if you feel that you need to stop.

Employment status: unemployed / part-time / full-time

Present or most recent occupation:

Level of education:

Type of housing/accommodation (owned, rental, council, length of residence (stable address or frequent moves)):

.....

How would you describe your ethnicity?:

Mental health

Have you ever been given a mental health diagnosis or a name for your mental health difficulties? if so when? by who?.....

.....

(if not) What do you feel that your main mental health difficulties are/have been?

.....

.....
What therapeutic support have you received for your mental health: (when? how long for?).....
.....

Do you take any psychiatric medication?

To start off I'd like to get an idea of who's who in your household (*draw out **genogram**, include child(ren)'s dob(s), fatherhood, who lives where, participant's relationship status (length and stability)*).

Now it would be a great help if you could tell me in your own words what your child(ren) is/are like, so that I can get a picture of him/her/them in my mind before we go on (*ask about each child in turn (eldest first), probe for what they are like, what her relationship with each of them is like (attachment), and how she feels they behave towards her*).

Do any of the children have any mental health difficulties? Are they receiving any treatment?

- Indicates questions that must be asked, additional questions are optional.

The experience of parenting:

Now I'd like to get an idea of your experiences of parenting [child(ren) name(s)].

{probes: could you tell me a bit more about that? Could you give me an example of what you mean by that?}

- Could you start off by telling me how you would describe yourself as a parent?
- What gives you the most joy in being a parent?
- What gives you the most pain or difficulty in being a parent?
- What would you say are your main worries about parenting your children?

In what ways do you think that having, and raising, your child(ren) has changed you as a person?

How do you feel when you have to leave your child(ren) or are separated from them?

How do you feel when your child(ren) is/are upset?

How do you feel your relationship(s) with your child(ren) has/have affected them?

- Looking back over the years, what stages of parenting have been the hardest for you?

Probe for examples of difficult periods

What are your best and worst memories of that/those time(s)?

What was difficult about that/those time(s)?

How did that/those period(s) affect you?

Did your relationship with (child) change as a result of that period?

Prompt regarding:

How did you feel when you found out you were pregnant with (name)?

- How did you find parenting your child(ren) when they (as applicable):

- were newborn babies? (*probe regarding bonding with baby*)
- were toddlers?
- started going to school?
- became teenagers?

If you could start parenting your child(ren) all over again, knowing what you know now, what would you do the same and what would you do differently?

- In general do you think that you've had more or less difficulties with parenting than most other mothers?

In what way?

Do you have any ideas as to why that may be?

Maternal mental health:

Now I'd like to ask you a bit about how being a mother might affect your mental health and vice versa.

- What's your understanding of your mental health difficulties and how they impact on/effect you?

(if not mentioned probe regarding effect on relationships with other people, managing of own emotions)

- Do you think that your mental health is affected by the fact that you're a mother?

In what way?

- Do you think that your mental health difficulties make parenting more difficult for you at all?

In what way?

Support for parenting:

Now I'd like to ask a few questions about any support you might have with your parenting.

- Do you ever feel that you really need emotional support as a parent?

What kinds of situations make you feel this way?

How do you handle your feelings of needing support?

- Is there anything that makes parenting easier for you?

Is there anyone you can turn to for help or advice about parenting?

- Have you received any support with your parenting from services in the past that was helpful?
- At times when you might have felt you've needed support with parenting, what kind of help do you think would have been best for you?

Close interview with: finally is there any advice that you would give other mothers who are in a similar situation to you?

Opportunity to ask questions.

Would you like to receive a written summary of the results of the study once it has been completed? Yes / No

**APPENDIX H: IPA METHODOLOGY AND
SAMPLE INTERVIEW TRANSCRIPT ANALYSIS**

Interpretative Phenomenological Analysis (IPA) provides a methodical way of analysing data and is suitable for use in interview studies with small numbers of participants (Smith, Flowers, & Larkin, 2009). IPA was chosen as the method of analysis for the current study as it views the participants as experts on their own experiences and aims to capture and explore the meanings that they assign to their experiences (Reid et al., 2005). These factors were felt to be particularly important given that women with Borderline Personality Disorder (BPD) are often vulnerable and marginalised, meaning that their voices go unheard (NIMHE, 2003).

The current study employed the procedure outlined by Smith et al. (2009) to analyse the interview transcripts. The stages of analysis that were completed are outlined below.

For each transcript the following process was undertaken:

- 1) Reading of transcript: the transcript was read thoroughly in order for the analyst to become familiar with the data.
- 2) Initial noting: notes of significant points were then made in the right-hand margin of the transcript. These included descriptive, linguistic, and conceptual comments in order to summarise the data, make initial interpretations and highlight interesting or significant points.
- 3) Developing emergent themes: notes of emerging themes were then made in the left-hand margin of the transcript. These aimed to condense the initial descriptive, linguistic, and conceptual notes into concise phrases representing the interview.

- 4) Finding connections across themes: emergent themes were then grouped into larger themes that represented the interview. Whilst performing this part of the process the chief investigator attempted to put aside the themes that had been generated from previously analysed transcripts in order to treat each case individually.
- 5) Reliability and validity checks: a proportion of each transcript was checked by another individual, who was not directly involved in the research but who was suitably qualified to do so, in order to ensure that the emergent themes identified were grounded within the interview transcript. This helped to ensure the reliability of the analysis and interpretation of the data.

The six analysed transcripts were then brought together and the following stages of analysis were carried out:

- 1) Looking for patterns across cases: shared themes for the group as a whole were identified. These were termed subordinate themes.
- 2) Developing super-ordinate themes: the chief investigator then looked for connections between these subordinate themes and clustered them together to form super-ordinate themes for the group of participants as a whole.
- 3) Confirmation of themes: the chief investigator then checked back to the transcripts to ensure that each theme that had been generated appeared to be represented by the data and reported by a significant proportion of the participants.
- 4) Identification of quotes: at the end of the analytic process, suitable quotes from the transcripts that represented each of the generated super-ordinate and subordinate themes were identified for use in the write-up of the study.

SAMPLE INTERVIEW TRANSCRIPT ANALYSIS

Line no.	Emergent themes	Transcript I=Interviewer; P=Participant	Initial notes
470	<p>Self-harm when daughter absent.</p> <p>Support with parenting from others when unwell.</p> <p>MH crisis as hardest stage of parenting.</p>	<p>I: Ok, so what happened to [daughter] in all of that when you were unwell were you looking after her or was it someone else or?</p> <p>P: she, when I actually took the overdose she was at her dad's house, um, and then, I can't remember, someone went and picked her up from her dad's house and brought her to my mum's and my mum sort of helped me look after her, so, I think I stayed with her for about 4 or 5 days until I sort of pulled myself together again yeah,</p> <p>I: Yeah, ok. Kind of looking back over the years, what stages of parenting have been hardest for you? Is that the hardest?</p> <p>P: That's the hardest.</p> <p>I: have there been other bits?</p> <p>P: Probably now to be honest.</p> <p>I: Ok.</p>	<p>Took an overdose whilst daughter not there.</p> <p>Support with parenting from own mum when very unwell.</p> <p>Hardest stage of parenting was when she was so mentally unwell she was nearly hospitalised.</p>
480	<p>Struggles with daughter's behaviour.</p> <p>Empathy for daughter.</p> <p>Struggles when daughter is defiant.</p> <p>Self-blame (daughter's behaviour).</p>	<p>P: Cos she's, she has um, it's a bit worrying at the minute because she is, she has started having tantrums again and I don't know if it's just because the last year and a half have been quite hard for her and I don't know if it's all just sort of caught up with her, but in the last few months, I mean she is lovely, she's absolutely lovely, she's good as gold when she wants to be, absolutely sweet, butter wouldn't melt, but in the last few months she's got quite, I dunno, stubborn, so you can't, you know things that she'd do before, you say "go tidy your room", "no I don't want to, I'm not going to do that, I'm not gonna do my homework, what you gonna do make me?" you know, it's like having a teenager, so um, but like I say I don't know if that's because, obviously me and her dad split up and cos we were so on and off I think she was sort of used to the fact that he always used to come back and now she</p>	<p>Finding parenting hard currently as struggles when daughter has tantrums.</p> <p>Recognition that the last year has been tough for her daughter.</p> <p>Struggles when daughter is defiant/doesn't do as she says/talks back.</p> <p>?feeling daughter's presentation is partly her fault.</p>

490	Fears re. father's input.	<p>knows he's not and then him telling her that oh you know "I can't come home cos mummy won't let me" and having loads of different women and you know being a bit odd with her arrangements and stuff, and then there's moving here, I think it's all just a bit much for her so it's quite difficult at the minute.</p> <p>32:56</p> <p>I: Have you got ideas in your head about how this period might affect her in the future?</p>	<p>Managing situation with daughter's father is difficult/out of her control. Father blaming her/telling daughter it's her fault they're not a nuclear family.</p>
500	<p>Optimistic that difficult period won't have a lasting effect.</p> <p>Being open with daughter. Recognition of need to provide a secure base.</p>	<p>P: Um, I'm hoping that it won't, because I keep talking to her, I'm very, if I have a problem I do tend to try and talk about it cos I've found in the past if you ignore it it just gets worse and everyone I've spoke to says you know "don't worry about it it's a phase", she'll get used to it you know, as long as me and [partner] provide the stability they think that it will be ok, as long as she's got us to fall back on and she knows we're here for her and it's secure and it's not gonna go away that it'll be ok, but um, I dunno, it's hard for me to think like that so,</p> <p>I: yeah, looking back to your most difficult time when she was sort of 18 months old, what impact do you think that period had on her?</p>	<p>Optimistic that this period won't have a lasting effect on daughter. Aware of need to talk to and be open with daughter. Tries to talk openly with daughter as feels ignoring things makes them worse.</p> <p>Recognition of need for her and partner to provide stability/secure base for daughter.</p>
510	<p>Hiding MH from daughter/others.</p> <p>Forcing self to behave 'normally' for daughter.</p> <p>"fall apart" when daughter absent.</p> <p>Hoping having hidden MH will have protected</p>	<p>P: I don't know to be honest, I don't think she was really very aware of it, um, because I did, I mean even though I say I think I had a nervous breakdown I hid it quite well, no one really knew, um you know, I'd be, I'm quite good at hiding things, I'd be completely fine all day, I'd force myself to you know get up in the morning, make breakfast, play with her, watch TV with her, go for a walk, go to the shop, make dinner, everything else, it was only when she was asleep that I'd sort of fall apart.</p> <p>I: Right.</p> <p>P: Or when she wasn't there that I'd fall apart, so, um, that's why it's hard to say whether or not I had a bit of a nervous breakdown because I did have some sort of control so I don't think she was really, maybe</p>	<p>Feels daughter wasn't aware of most difficult time with her mental health as she hid it from her/everyone.</p> <p>Forcing herself to behave 'normally' for daughter when struggling with mental health to put on a front/hide it from her – then falling apart when daughter goes to sleep.</p> <p>Falling apart when daughter wasn't there.</p> <p>Hoping this will have protected daughter</p>

<p>520</p> <p>530</p> <p>540</p>	<p>daughter.</p> <p>Belief that she (“the way I am”) has had an impact on her daughter.</p> <p>“bad mother”.</p> <p>Feeling like she can’t do anything ‘right’.</p> <p>Wishing she could be like other parents.</p> <p>Comparing self to other parents.</p> <p>Praise for own parenting.</p> <p>Trying not to be negative.</p> <p>Encouraging daughter to behave differently to self.</p>	<p>that’s naive I don’t know, but I don’t think she was aware of it, so,</p> <p>I: sounds like you really tried to hide it.</p> <p>P: Yeah.</p> <p>I: Do you think it’s had an impact perhaps on your relationship or how you were with her at all?</p> <p>35:02</p> <p>P: I think me, the way I am has had an impact on my relationship because I’ve been, cos it’s took me ‘til like the last year, 18 months, to realise what I’m like I’ve sort of, oh forgot where I was going, I’ve sort of made things difficult, because I’m quite negative I’ve sort of made myself believe that I’m a bad mum and I’m never gonna be able to do anything right and stuff, so um, I think that’s had an impact on her because I’ve made myself believe it, I haven’t tried as hard as I could with her, does that make sense? So, I’m getting lost in what I’m thinking now, sorry,</p> <p>I: Do you still think that now? That you’re a bad mum?</p> <p>P: um, err, I do and I don’t, cos like I said earlier, I look at some parents I think god you know I wish I could be like that, I wish I could, but then there’s other parents you look at and think thank god I’m not like that, so I think I’m, I think I’m doing the best that I can do, considering the circumstances I think I’m doing quite well, although it’s hard for me to accept that but I do, I do think I do it quite well, so, I mean I do everything I can with her, I do her homework with her and I try and explain things to her and you know if she asks me thing about how the world works and stuff I’ll try and give her, you know, the best sort of answer and try not to be negative and try and encourage her to do things and make friends and try different things and stuff so I don’t think there’s much else I could do, so.</p>	<p>from it.</p> <p>Belief that she (“the way I am”) has had an impact on her daughter.</p> <p>Reiterates worry about her own negativity.</p> <p>Belief that she’s a bad mother. Feeling like she can’t do anything ‘right’ (belief that there’s a ‘right’ way to do things).</p> <p>Recognition of the impact believing she’s a bad mother has on daughter – not trying as hard with her as she could (self-defeating attitude).</p> <p>Wishing she could be like other parents she sees. Comparing self both negatively and positively – recognition that there are some parents she wouldn’t want to be like.</p> <p>Self-recognition – doing well given the circumstances – but finds this hard to accept/say about herself.</p> <p>Trying to help daughter on a practical and emotional/psychological level.</p> <p>Trying to hide her mental health from daughter by behaving differently and encouraging daughter not to be like her (e.g. to try things, make friends, think positively even when mum finds these hard).</p>
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APPENDIX I: DREAM DESCRIPTIONS

1. I am in a hospital, high up. I'm pregnant but I do not look like I am as I have no bump. My boyfriend is present. We're standing in a waiting area when I start having contractions and realise that I'm in labour. I telephone my parents quickly to tell them that I am having a baby and they are going to be grandparents. The dream then jumps to me holding a baby boy after having given birth.

2. I am walking around somewhere that I know is a hospital but it looks like my primary school. I am aware that I'm in labour but I don't feel any pain at all. There is no one else around and I have a feeling that there is something I have to do/somewhere I have to go within the school/hospital.

3. I give birth to a baby girl and leave the hospital straight away. The baby's father is someone I went to school with. I return to the hospital wanting to see/have my baby. The father's sister is at the door and on seeing me approaching up a grassy bank she says "oh my goodness are you Rose?" and I nod. I enter into a big room which is jammed full of people/strangers. I know that the father and our baby are in the next room. I really want my baby girl, having left her at the hospital feels like an unusual thing for me to have done but not shameful or wrong. I don't think I'll be able to breastfeed my baby as I didn't do it straight away. The baby's father and I are not a couple and I intend to raise our baby myself. I feel maternal.

4. I am out walking near the sea with my boyfriend and our child who is about two-years-old. We arrive at a summer home where there is a man in the front

garden. He passes a baby over the fence to me and I am aware that he is my ex-partner and this is our baby. The baby is a boy and he is about ten months old, he is able to crawl but not walking yet. The baby is naked and has a rash on his bottom and arm. I ask my ex-partner what the rash is and “have you taken him to the doctors?”, he replies “yes but he (the doctor) didn’t know what it was, he’s asking his colleagues”. I feel concern for my baby and protective of him but not as much concern as I normally would have in that situation. Later on I wonder why the baby was with his father and not with me.

5. I am sat by a window in my home in a chair holding a baby boy. My partner and a close friend (who is also a mother) are also there. I’m holding our son who I know is six weeks old. I’m trying to breastfeed my baby in front of my friend and I’m trying to hide the fact that I don’t know how to do this. I feel like a fraud and I’m worried that my friend will ‘find me out’. I think to myself that I’m not a good mother and I feel afraid, apprehensive, and daunted by the task of breastfeeding. I manage to latch my son on, he feeds and I feel relieved. I pretend that I have been doing this since his birth as I know that I should have been but I haven’t, it feels very new to me.
6. I am in my parent’s garden, there’s a wide flowerbed down one side with head-height plants in it. I am standing in the flower bed so I can’t be seen. I step backwards out of the flower bed onto the patio and I am pregnant. My sister and her friend are on the patio in front of me. There are long, thick, lumpy, green roots/stems coming out of me from my stomach/crotch

stretching down and dragging on the floor across the flower bed as I step out of it. They look a bit like the tubulars that sprout out of old potatoes but massive and green and floppier. I show them off to my sister and her friend in the way that one shows off the size of a pregnancy bump. I feel very proud as the fact that they are so big means that I am heavily pregnant and I feel pleased and proud about this.

7. Set in Australia. I am heavily pregnant and I go into labour so I go to the hospital with my boyfriend. We arrive at the hospital and a doctor takes one look at me and says “so you’re having twins”. I’m shocked as I didn’t know this but as I look down at my stomach it seems so obvious to me as it’s very large (about four times the size of a typical full-term pregnant woman). I can see, protruding out of each side of my stomach (like babies hands or feet sometimes do), the outline of some wicker like the edge of a Moses basket and I think to myself how obvious this is that these are clearly two babies in Moses baskets in my stomach. The Dr. Says “yes twins, maybe more” and looking down again at the size of my stomach I can see that it’s so wide that the two Moses basket outlines are so far apart there could easily be room for another baby in between them and I realise that the doctor is right. I give birth to triplets, a boy and two girls (but no recollection of this part of the dream). After giving birth I look down at my babies and I think to myself ‘I’ll never travel the world now, that’s it, my life’s over, I can’t do anything I want to now’. As we’re in Australia, I know that I have to get the babies home to England with me but that I don’t have plane tickets for them only for myself so I need to smuggle them onto the plane somehow. The dream then

cuts to me trying to get my children onto a plane (which looks more like a boat) but the children are much older now and look different ages. The boy and one girl look the same age, about four-years-old, and the second girl looks older, about six or seven-years-old. The older girl is trying to help sneak the other two children onto the plane/boat and they run off somewhere. I am worried but hopeful that my children will be ok and that they will not be found out and that the older looking girl will look after the other two children.